



DEPARTMENT OF THE TREASURY  
WASHINGTON, D.C. 20220

94-133371

April 21, 1994

**MEMORANDUM FOR SECRETARY BENTSEN**

**FROM:** Marina L. Weiss  
Deputy Assistant Secretary for Economic Policy

**SUBJECT:** Health Care Briefing on Outsourcing

Date & Time April 22, 1994 3:00 pm

Location Your office

**PARTICIPANTS:**

Treasury Marina Weiss  
Les Samuels  
Eric Toder  
Linda Robertson  
Alicia Munnell  
Brad De Long  
J. Paul Whitehead

**BRIEFING:** Memo attached

**CONTACT:** Marina L. Weiss

**BACKGROUND:** Status report on several health reform issues of interest to Treasury.



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April 15, 1994

MEMORANDUM SECRETARY BENTSEN

FROM: Staff working on health reform. Memo regarding outsourcing and subsidies by Eric Toder; Pay-go rules changes by Alan Cohen and Marina Weiss; cover memo and update on miscellaneous issues by Marina Weiss.

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1. A description of work underway in Tax Policy on modifications to the subsidy provisions of the Health Security Act as submitted to Congress. In addition to the review of alternative ways to structure the subsidies, the memo outlines the state-of-play with regard to the difficult issue of outsourcing and its impact on the estimates of the cost of the subsidies.
2. Staff is deeply concerned about the erosion of funding for the plan. Using material developed by the Office of Tax Analysis plus information from CBO and the Ways and Means Subcommittee staff, we have developed a "scorecard" of what we believe to be a rough approximation of the current deficit in financing. That deficit is attributable to several factors, the most significant of which are listed below.
  - a. CBO's re-estimate of the Health Security Act concludes that the Administration's bill would add \$74b to the deficit over the years 1994-2000.
  - b. It is widely assumed by the committees of jurisdiction that the level of savings from Medicare and Medicaid proposed by the Administration exceeds what Members of Congress are willing to support. Thusfar, only the Ways and Means Health Subcommittee has taken action on cuts in Medicare, reducing the level of available "savings" by \$8b in the year 2000. No estimate has been made of the 5 year effect of this less aggressive cut in the rate of growth in Medicare spending.
  - c. The "premium cap" cost containment provisions of the Health Security Act were scored by CBO as 100% effective.

Other proposals for savings, however, may not be viewed by the estimators as foolproof. For example, the Ways and Means Subcommittee "global budgets/maximum payment rate" limits are presumed to be only 50% effective. Of course, there are virtually no savings associated with the managed care provisions of the Cooper bill.

d. Finally, there is reason to believe that some of the revenue provisions proposed by the Administration may be modified, phased-in more slowly or dropped altogether.

3. As you are aware, the Budget Resolution now under consideration in Congress would modify the year by year portion of the pay-go rules for mandatory spending and revenues. This is good news for health reform and Alan Cohen has provided for your review a status report on the Congressional negotiations over this initiative as well as an explanation of how the change could impact the health reform bill.

4. Finally, we have included an update on recent developments in health reform, with particular emphasis on the Senate Democrats' weekend retreat, the NFIB job-loss study, and the new Cooper bill estimates.



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WASHINGTON

April 15, 1994

MEMORANDUM FOR SECRETARY BENTSEN

FROM: ERIC TODER *ET*  
DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)

SUBJECT: Effects of Outsourcing on Employer Subsidies Under HSA

**SUMMARY** -- Under the Health Security Act (HSA), a firm's required contributions for the comprehensive benefit package would be capped at 7.9 percent of its payroll. This approach ensures that no firm in the regional alliance would pay more than 7.9 percent of its payroll for the costs of the comprehensive benefit package. Employer subsidies will generally be provided only to lower-wage firms.

At the Presidential meetings last summer, Treasury supported an individual wage cap over a firm payroll cap. During the past month, other Administration officials and Hill staff have expressed interest in replacing the firm payroll cap with an individual wage cap. In large part, this renewed interest in individual wage subsidies is based on CBO's analysis that the firm payroll cap may raise employer subsidy costs by as much as 23 percent, in the long-run, because of the effects of outsourcing.

On April 12, Marina Weiss and I, along with representatives from OMB and HHS, met with John Hilley of Senator Mitchell's staff to discuss options which will be presented at the Senate Democratic retreat. These options included replacing the 7.9 percent firm payroll cap with a 12 percent individual wage cap. Senator Kennedy's staff have also raised questions with Treasury staff about the effects of an individual wage cap.

In addition, the interagency health reform policy group (under the chair of Alice Rivlin) requested a presentation by Gillian Hunter, of the Office of Tax Analysis, comparing the effects of a firm payroll cap and an individual wage cap. Copies of the preliminary analysis were also provided to OMB staff with the approval of Deputy Secretary Altman. The analysis used a methodology similar to CBO for predicting the impact of outsourcing on the costs of employer subsidies in the long-run. The principal findings are:

- Using the CBO estimates of the costs of the comprehensive benefit package, a 7.9 percent firm cap could be replaced with a 10 percent individual wage cap for roughly the same budget costs.
- An 8 percent individual wage cap could be combined with a reduction in the benefit package. For example, a scaled-back benefit package could be designed

to cost as much as the Administration's estimates of the current benefit package. Using the lower premiums, an 8 percent individual wage cap would cost as much as the 7.9 percent firm payroll cap with CBO's higher premium estimates.

- With the 7.9 percent firm cap, the costs of the subsidies are roughly the same regardless of the firm size cut-off for joining regional alliances. The effects of outsourcing largely offsets the effect of reducing the size thresholds for firms eligible to join the regional alliance and obtain subsidies

**BACKGROUND** -- At the Presidential meetings last summer, Treasury argued in favor of an individual wage cap instead of a firm payroll cap. An individual wage cap can better mitigate the effects of an employer mandate on low-wage workers. In response to an employer mandate to provide health insurance, firms will likely reduce the wages of their workers who are currently uncovered or receiving less costly benefit packages. For low-wage workers, these reductions may be significant as a share of their total income. An individual wage cap would ensure that firms pass on only a portion of the costs of the employer mandate to their low-wage workers. In contrast, a firm payroll cap does not provide any subsidy for firms with high average wages. Consequently, a firm cap of 7.9 percent could still cause some low-wage workers to suffer a wage reduction of more than 7.9 percent.

A firm cap may also cause high-wage firms to reorganize in order to obtain the benefits of the HSA's employer subsidies. For example, a firm could spin off their low-wage workers into a separate entity. Alternatively, they may contract (or "outsource") with a low-wage firm to do the work their less skilled workers once did, or they may purchase intermediate products rather than producing the products in-house with low-wage workers. Although low-wage workers will remain employed, they may find it more difficult to advance in a firm which specializes in low-skilled labor. Moreover, the segregation of low-wage workers in low-wage firms could cause them to lose pension coverage and other benefits typically provided by large firms with a diversified workforce.

An individual wage cap will generally be more expensive than a firm payroll cap, unless the individual wage cap is higher than the firm payroll cap. But some firms would pay more than 7.9 percent of their payroll for health insurance with, for example, a 9.5 percent individual wage cap. The prospect that some low-wage firms would pay more than 7.9 percent of payroll for health insurance under an individual wage cap was a critical factor in the President's decision to support a firm payroll cap.

Three events are causing a reconsideration of the individual wage cap. First, Congressional staff have expressed interest in an individual wage cap. Second, the Chamber of Commerce, reportedly the original promoter of the 7.9 percent firm payroll cap, did not support the Clinton plan. Third, new estimates of the effects of alternative subsidy approaches on outsourcing lower the budgetary savings from using a firm payroll cap instead of an individual wage cap and highlight the potential economic and social disruptions from policies that encourage outsourcing.

Financing Shortfalls to Date

(\$ Billions)

	2000	1994 – 2000
CBO's Reestimate of HSA's Effect on Deficit 1/	10	74
50% Effectiveness Rating on Premium Caps 2/	14	31
Medicare Changes in Stark Bill	8	n.a.
Tobacco Tax 3/	<u>3</u>	<u>37</u>
Total	35	142+

April 15, 1994

Notes:

1/ According to Administration's estimates, HSA would have reduced the deficit by \$58 billion between FY 1994 and 2000. In contrast, CBO estimates that HSA will increase deficit by \$74 billion over the same period.

2/ Assumes that Congress passes HSA with its premium caps but eliminates some of the enforcement tools contained in the Administration's bill. Further assumes that CBO would give the enforcement mechanisms a 50 percent effectiveness rating.

3/ Assumes that Congress enacts a 50 cent increase in the tobacco tax which is phased-in over five years.

## BUDGET ACT PAY-GO RULES AND HEALTH REFORM

Under the pay-go rules currently under discussion in the Congress, legislation must be deficit neutral in the first year, over five years, and over the second five years.

There is some possibility that the requirement for deficit neutrality for the second five years will be further liberalized. Under such liberalization, the legislation would need to avoid causing a significant increase in the deficit, rather than being precisely deficit neutral. However, such liberalization may not occur in the final language for the point of order in this year's conference report on the budget resolution.

In addition, it is worth noting that unlike the situation in previous years, it will no longer be a requirement to have the legislation be deficit neutral year by year.

These modifications in the year-by-year scoring of pay-go provisions are critical to enactment of health reform, as it is highly unlikely that the final bill will be perfectly deficit neutral in each year of the phase-in. The current thinking is that the tobacco tax increase may make it possible to meet the first year deficit neutrality requirement [in fact, CBO and Administration estimates suggest that the Health Security Act would actually reduce the deficit in 1995 by about \$10 to \$11b], but that the plan will not be deficit neutral in each of the subsequent years.

## UPDATE ON HEALTH REFORM

Retreat: Majority Leader Mitchell is scheduled to make a health reform presentation at the Senate Democratic retreat in Williamsburg this weekend. The presentation was characterized by Pat Griffin's office as covering the "levers for modifying the Health Security Act." Griffin's office also indicates that an effort will be made to have Chairmen Kennedy and Moynihan sit at the table with Mitchell while he makes his remarks. Both the President and First Lady are expected to attend a portion of the retreat.

Specifically, Mitchell is said to be prepared to discuss alternative subsidy schemes, with particular emphasis on approaches that target subsidies to firms on behalf of actual wages paid to individuals as opposed to the structure under the HSA which targets subsidies to firms based on average wages paid. This is the same issue that was debated before the President last year, and there is a growing concern in the Congress over the approach incorporated in the Administration's bill.

Mitchell will also present some deficit reduction options to address Members' desire that the Senate bill include budget savings -- at least in the out-years of the 10 year estimating period. OMB indicates that the savings options under consideration include reduced subsidies; a downsized benefit package; more revenues from the 1% corporate assessment -- by reducing the 5,000 threshold to 1,000. Also under discussion among some Members is an increase in the tobacco tax, though it is not clear that Mitchell will introduce a tobacco provision as part of his list of options.

You might be interested to know that Mitchell had wanted to present an option to reduce the employer contribution under the mandate to 50% [instead of the 80% proposed in the President's bill], but Ira Magaziner told Mitchell's staff that the Administration would prefer he not present that option -- however, if it came up as part of the discussion then the Administration would not oppose Mitchell's offering some comments on it. Treasury has not been provided paper describing these proposals, though it is clear that White House and OMB staff were involved in developing the options.

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April 20, 1994

**MEMORANDUM FOR SECRETARY BENTSEN**

**FROM:** Marina Weiss  
Deputy Assistant Secretary for Economic Policy

**SUBJECT:** Speech to Leadership Oklahoma Briefing

Date & Time Thursday, April 21, 1994

Location Hart Building, Rm. 902

**PARTICIPANTS:**

Treasury Secretary Bentsen

**BRIEFING:** Overview  
Background Materials

**PRESS:** No

**CONTACT:** Brooks Richardson 224-4707

**BACKGROUND:** Tab A: Delegation  
Tab B: Economy on Oklahoma  
Tab C: Fact Sheet on Health Care  
Tab D: Q and A's  
Tab E: Senator Boren's Talking Points  
Tab F: Historical and Political Aspects



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WASHINGTON, D.C. 20220

April 20, 1994

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Marina L. Weiss

SUBJECT: Health Reform

ACTION FORCING EVENT: Meeting with Oklahoma young leaders

BACKGROUND/ANALYSIS:

Attached for your review are background materials on the Oklahoma delegation prepared by Legislative Affairs; a piece on the economy and Oklahoma prepared by Economic Policy; a fact sheet on health care in Oklahoma; and the Q and A's we prepared for your use in Utah. Also appended for your use are Senator Boren's talking points on health care which were provided to us by his office.

You might get a question from someone in the audience about the recently released CONSAD study on job loss associated with the employer mandate. Economic Policy staff is reviewing the study carefully and will prepare a detailed memo for your use. For the moment, you should know that CONSAD estimates the job loss at between 850,000 and 3.8m. The 850,000 is within 50,000 of the preliminary number that Laura Tyson's staff developed some months ago -- CEA now is on record saying that the number could swing negative or positive by approximately 600,000 jobs. Again, if asked your view on job loss, I'd recommend you shift the thrust of the question toward the fact that studies are mixed and that you do expect there will be job shift -- particularly toward home care.

Issues: According to Boren's office, the young leaders you will talk to are largely from the business community and somewhat more moderate on the issue of health reform than what you might expect with an older business group such as the Chamber.

They will be sympathetic to the need to make health care affordable for small business, will relate to the problems you raise with respect to portability, pre-existing condition exclusions and the need for preventive health care for children.

Boren's office reports that Oklahoma is reacting to the Administration's health reform plan pretty much as expected -- not unlike Texas. This is true especially with respect to the issues of rural providers [the Administration's bill offers special tax credits for nurses and doctors who locate in underserved areas]; the employer mandate [Oklahoma businesses

that do not now offer health insurance believe that the subsidies are insufficient]; impact of reform on independent insurance agents; and cuts in Medicare that impact both the elderly and the medical school at the University of Oklahoma.

With respect to the Medicare concerns, you can stress that the "cuts" are really reductions in growth of health spending which will be applied to private as well as public insurers.

One final point, in the last Congress Boren was the Senate sponsor of the Cooper managed care bill. His staff now reports that the Senator has "moved away from Cooper because he feels a more viable strategy is to work with John Chafee in the Finance Committee." You will recall that Chafee's bill reaches universal coverage through an individual mandate -- though the Chafee bill is somewhat more generous with respect to benefits and also more regulatory than the individual mandate proposed by Senator Nickels. On the issue of Nickels, Boren's staff expressed the view that the more Nickels discusses his bill...the better for Boren who appears to be more measured and bipartisan.

**DAVID BOREN (D)  
OKLAHOMA**

David Boren has served as United States Senator from Oklahoma since 1978. There is speculation, however, that his third term will be his last, that he will resign to become president of Oklahoma University. He has been meeting with campus groups and the Associated Press emphatically reported this week that "he is coming to OU."

If he should accept the University's post, it will not be due to his lack of popularity among Oklahoma's voters, who elected him to the governorship as a darkhorse candidate in 1975, and who have chosen him by landslide margins in each of his three senatorial races. His resignation would come as a mild surprise to Washington-watchers, as he once stated that he would "very much like to be President."

As the third ranking Democrat on the Finance Committee, Sen. Boren has been active in maintaining the interests of the oil industry, and gained national recognition for striking a compromise with the Administration on the BTU tax in the Clinton Budget.

On health care, Sen. Boren has been fairly quiet, as he has not made any firm decisions about supporting any particular plan, but will no doubt be a major player, and has touted a "bipartisan, consensus" approach toward creating health care reform

During this Administration, Boren has been consistent in voting with the President on key issues, as he eventually voted in favor of the Budget, RTC funding, NAFTA, and the Brady bill.

**Senator David BOREN (D-OK):**

Senator Boren is a moderate Democrat and a key swing vote on the Finance Committee. He also serves on the Agriculture and Intelligence Committees and chairs the Joint Committee on the Organization of Congress. His state is comprised of oil, gas, and farm industries.

Senator Boren's initial reactions on health care have been cautious -- he applauds the effort but worries about financing. He favors other funding mechanisms such as taxing more generous benefits packages. He supports universal coverage but perhaps not as rapidly as the time table set out in the HSA. Boren also supports state flexibility, insurance market reform, and managed competition.

Boren considers himself a strong supporter of rural health care and small business. He has "serious misgivings" about 80% employer contributions and would be more comfortable with a 50 - 50 split. He wants to ensure that small business is not left "holding the bag" for the under-estimated cost of health care reform. He also wants people to pay some amount for doctors' visits in order to discourage overuse of the system.

He recently expressed concern about the alliances, saying that he would like larger small businesses to be able to opt out and self-insure. Boren is being targeted by the health insurance industry in its campaign to block health reform.

**Recent Developments:**

Reports out of Oklahoma note that Senator Boren will leave the Senate at the end of the year to become president of Oklahoma University. He has not confirmed or denied these rumors but Congressmen Brewster and McCurdy are already jockeying for the seat.

*Votes:*

**FOR:**

Family & Medical Leave

Budget Reconciliation

NAFTA

**AGAINST:**

**Senator Don NICKLES (R-OK):**

As Chairman of the Senate Republican Policy Committee, Senator Nickles has been very active in setting the overall tone of Republican policy. In addition to his seat on Indian Affairs, he also serves on two key money committees -- Budget and Appropriations.

In the 102nd Congress, Senator Nickles cosponsored Senator Dole's Medicare reform bill. When asked during that term to identify a point of agreement between Republicans and Democrats, he replied, "Streamlining and coordinating administrative costs in health care."

Today, Nickles continues to advocate the conservative views that first brought him to Congress. During his most recent reelection campaign, Senator Nickles emphasized medical malpractice reform and vouchers for people unable to afford health insurance. His "Consumer Choice and Personal Health Security Act," introduced last November, would provide refundable tax credits to help Americans buy health insurance policies. These credits would be financed by eliminating deductions for health insurance costs and by \$141 billion in Medicare and Medicaid cuts over the next five years. Nickles claims his bill is modeled after the FEHBP and says it would guarantee more choices than the HSA.

Last year, Nickles said, "Certainly I will oppose having abortion offered in any standard health benefits package." More recently, he attacked the President's plan, saying that it would "subsidize the destruction of innocent unborn human beings."

He has said that the HSA has "fatal flaws" and particularly mentioned the employer mandate, national health budget, and limited choices for consumers. In late February, he told 400 members of Pat Robertson's coalition, "The President and the First Lady are proposing a massive socialist agenda."

*Votes:*

**FOR:**  
**NAFTA**

**AGAINST:**  
Family & Medical Leave  
Budget Reconciliation

Senator Nickles' health care plan, entitled "Consumer Choice Health Security Act" currently has 25 Republican cosponsors. The plan would accomplish the following:

- Universal coverage; insurers could not exclude based on preexisting conditions.
- Refundable individual tax credits would be provided for consumers and paid for via \$139 billion in cuts to Medicare and Medicaid over five years beginning in 1997. (This system is similar to the EITC, where the employers would reduce their tax liability and the credit would appear as income with which to purchase insurance.)
- Medical Savings Accounts (MSAs) would be created where consumers would pay into an account and pay their medical bills or receive benefits not covered by their insurance plan. The MSA would have a family limit of \$3000 plus \$500 for each dependent, and for every \$100 paid into such an account, the individual or family would pay \$25 less in taxes.
- Every individual and family would be required to purchase health insurance to cover necessary "acute medical care" including emergency hospital visits, regular physician services, and prescription drugs.
- Individuals and families would still have the option of buying health insurance through their employers, and employers would still be responsible for withholding premiums from their employees' paychecks.
- A limit of \$250,000 would be placed on "noneconomic" malpractice suits.

**S. 1743**  
**CONSUMER CHOICE**  
**HEALTH SECURITY ACT**

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**FACT SHEET**

November 20, 1993

*Sponsors (25):* Nickles, Hatch, Mack, Bennett, Brown, Burns, Coats, Cochran, Coverdell, Craig, Dole, Faircloth, Grassley, Gregg, Helms, Hutchison, Kempthorne, Lott, Lugar, Murkowski, Simpson, Smith, Stevens, Thurmond, and Wallop.

## WHAT IT DOES

### The Consumer Choice Plan

- Provides the security of universal health care coverage for all Americans, guaranteeing them access to insurance that is portable, and available regardless of pre-existing conditions. It would take effect on January 1, 1997.
- Provides individuals and families with a maximum choice of health insurance plans with a wide variety of benefits and costs, including the ability to keep the employer-sponsored benefits they have now. That's more choice than most Americans have now.
- Individuals and families are provided with the resources to purchase the health insurance plan that best fits their needs with tax credits in place of the current employee tax exclusion for health care expenses. People whose health expenses consume a larger percentage of their incomes would get a bigger tax credit.
- Controls rising health care costs by empowering consumers with choice and individual responsibility and infusing real competition between insurance companies for the consumer's health care dollar.
- Further reduces rising health care expenses with real reform of medical malpractice laws, including capping awards for noneconomic damages.
- Creates Medical Savings Accounts, or MSAs, which can be used to pay medical bills or to pay for extra benefits.

- Modeled after the 33-year-old Federal Employee Health Benefit Program (FEHBP), giving consumers the same option of choice now enjoyed by U. S. Senators and Representatives. The FEHBP's annual cost increases have averaged a third less than other private health insurance programs.

## What it does NOT do

- The plan has no new, job-killing mandates on employers to provide and pay for health insurance for their employees. Employers must only give their employees the option of retaining their current benefits, or "cashing out" their benefits and joining another plan.
- The plan requires no new taxes.
- The Consumer Choice and Health Security Act does not wipe out existing health insurance policies, unlike the Clinton plan, which would outlaw nearly every health insurance plan now in existence. Under the Consumer Choice Act, people who are happy with their employer-sponsored coverage can keep it.
- The plan places no price controls or "premium caps" on insurance plans that could reduce the quality of coverage and even result in the rationing of health care.
- The plan creates no new national health board or government bureaucracies.
- There is no government coercion to purchase benefits not wanted or needed, beyond a minimum catastrophic insurance requirement.

## HOW IT WORKS

### Insurance Reforms to Guarantee Access

- The Consumer Choice and Health Security Act provides for guaranteed issue of health insurance policies. Insurers could not exclude coverage of any preexisting medical condition of any applicant who switches from one insurance plan to another or of any currently uninsured person who buys insurance.
- Insurers cannot cancel or refuse to renew coverage of a health insurance policy except for non-payment of premiums or fraud or misrepresentation. Insurers could not offer bonuses to brokers for selling insurance to "healthy" people or avoiding the sale of policies to

- Health insurance underwriting would be limited, allowing insurers to vary premiums only on the basis of age, sex and geography. However, because of the importance of prevention and healthy lifestyles, the legislation would allow insurers to give incentive discounts to promote healthy behavior, prevent or delay the onset of illness, or provide for screening or early detection of illness.
- Certain state laws pertaining to mandated benefits and services, anti-managed care laws, and mandated cost-sharing would be preempted.

## Tax Credits

- Individual tax credits would replace the current tax exclusion for company-sponsored health plans.
- Tax credits, which would become available on January 1, 1997, would be structured to give all Americans a basic level of tax relief on all of their health expenses, with greater tax relief targeted to those individuals and families who, because of illness or below average incomes, face proportionately higher health expense relative to their income. The credits would be structured as follows:

Health Insurance Premiums and Unreimbursed Medical Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10 percent	25 percent
10 to 20 percent	50 percent
20 percent or more	75 percent

- At a minimum, for every \$100 which is spent on health insurance premiums, or contributed to a Medical Savings Account (MSA), or spent on ANY out-of-pocket medical expenses, the individual or family would pay \$25 less in taxes. The greater the ratio of health costs to income, the greater the tax benefits. Low-wage persons with higher percentage health costs would receive greater benefits. The tax credit would be as much as \$75 per \$100 spent on health care, and would be refundable as explained below.
- The credits are refundable, meaning that if the value of the credit is more than an individual's or family's tax liability, the government would pay the difference. Much like the treatment of the Earned Income Tax Credit (EITC), employers would reduce their tax liability and provide the tax credit as additional income in the employees' paycheck, so they could purchase insurance.

## **Family Security Benefit Requirements**

- Society should not have to pay the price for irresponsible individuals who refuse to purchase insurance and then expect us to pick up the tab when they become seriously ill or injured. Every individual and family would be required to have minimum health insurance coverage to cover medically necessary "acute medical care," including:
  - Physician services
  - Inpatient, outpatient, and emergency hospital services and appropriate alternatives to hospitalization
  - Inpatient and outpatient prescription drugs
  - A maximum deductible amount of \$1,000 for an individual and \$2,000 for a family and an out-of-pocket limit of \$5,000. These amounts would be indexed to inflation in future years.
- For Medical Savings Accounts, or MSAs, the Consumer Choice plan would provide the same basic 25% tax credit for deposits. Each household would be permitted to have one MSA and to make an annual deposit no greater than the sum of \$3,000 plus \$500 for each dependent. The funds in an MSA could be used to pay medical bills not covered by their insurance plans, and to pay health insurance premiums.
- Transitional Rules: In order to provide individuals and families with secure, portable benefits, insurers and employers who currently provide health insurance coverage would be required to offer policyholders the option of converting their existing coverage to an individual or family plan. Employers would also be required to add the value of the coverage they now offer to their workers' wages. Thus, workers could take their coverage with them when they changed jobs or could use the money to buy a different plan that better suited their needs.

## **Employer Provisions**

- Individuals and families could still purchase health insurance through their employers. This would not be their only option, since they would be able to receive the same tax relief if they purchased coverage on their own or through other groups such as unions, churches, farm bureaus, business coalitions, professional associations, or through some other group — similar to the choices that more than 10 million Federal employees, retirees and their families have today.
- To ensure that individuals and families are able to make regular premium payments on their health insurance, employers would be responsible for withholding premiums from their employees' paychecks and sending these premiums to the employees' chosen insurer. Employers would also be responsible for adjusting their workers' tax withholding to

reflect the new tax credits. Thus, taxpayers would not need to wait until they filed their tax returns to claim back the new tax credits.

- Individuals who fail to enroll in private health insurance plans would be ineligible to claim the personal exemption on their federal income taxes. Employers would adjust their withholding to reflect this increased income tax liability.

## **Financing the Consumer Choice Plan**

- Because the Consumer Choice tax credit is more generous than the tax deductions and exclusions that it would replace, it will result in a net revenue loss to the federal government of \$133 billion between 1997 and 1999. To offset this revenue loss, the bill calls for savings in the Medicare and Medicaid programs of \$139 billion over five years.
- Federal Medicaid payments to states for acute care would be distributed on a per capita basis beginning in fiscal year (FY) 1995. The capitated amounts would be set at 20 percent above the FY 93 level in FY 95. In subsequent years, the capitated payment would rise by one percent above the consumer price index (CPI). Total federal Medicaid acute care payments to a state for FY 95 could not exceed the payment for FY 93 plus 20 percent. In subsequent years, the total federal acute care payment to any state could not exceed the previous year's payment plus CPI plus 2.5 percent. This will produce a five-year savings of \$72 billion. States would be given broad latitude in how they deliver acute medical care services to their Medicaid population.
- Medicare savings will be achieved by eliminating payments to "disproportionate share" hospitals, reducing payments to hospitals for indirect medical education costs, continuing the transition to a prospective payment system (PPS) for outpatient services, and by updating PPS payments on January 1 of each year, rather than on October 1. Further savings would be achieved by placing a 20-percent coinsurance requirement on laboratory and home health services. These changes will save the Medicare program \$67 billion over five years.

### **Comparison of Savings Achieved The President's health plan and the Consumer Choice plan**

<b>Program</b>	<b>Consumer Choice</b>	<b>President</b>
<b>Medicare</b>	<b>\$67 Billion</b>	<b>\$152 Billion</b>
<b>Medicaid</b>	<b>\$72 Billion</b>	<b>\$225 Billion</b>

## **Cutting Costs through Malpractice, Paperwork Reforms**

- The Consumer Choice plan would place a \$250,000 limit on noneconomic damages, provide for periodic payment of malpractice awards that exceed \$100,000, and limit the liability of a defendant for noneconomic and punitive damages to their percentage of fault, as determined by the trier of fact. It would also cap attorney fees, provide for offsets from collateral sources, and set forth rules for any health care malpractice claims filed in state or federal court or resolved through arbitration.
- The Secretary of Health and Human Services would have the power to require all health care providers to submit claims to health insurance companies in accordance with standards developed by the Secretary, if providers are not voluntarily complying with the standards. The Secretary is also directed to adopt standards relating to data elements for use in paper- and electronic-claims processing of health insurance claims, uniform claims forms and uniform electronic transmission of data.

## **Helping the Disadvantaged**

- The Medicaid Disproportionate Share program — now used to reimburse providers to help defray the cost of uncompensated care — would be converted into grants to states for health insurance coverage, health promotion and disease prevention. The program would target assistance to individuals who are not eligible for Medicaid, who have incomes less than 150 percent of poverty, and whose unreimbursed payments for health insurance premiums and medical care, net of federal tax credits, exceed 5 percent of their adjusted gross income.

## **Consumer Protections**

- The Federal government will continue to police insurance programs to protect consumers from being defrauded. Federal criminal penalties are established against health care providers and insurers who knowingly defraud persons in connection with a health care transaction.

## **Anti-Trust Provisions**

- The bill will create "safe harbors" from federal anti-trust laws for: certain groups of providers; medical self-regulatory entities that do not operate for financial gain; certain joint ventures for high technology and costly equipment and services; and certain hospital mergers. It directs the Attorney General to create additional "safe harbors" for health care joint ventures that would increase access to health care, enhance health care quality, establish cost efficiencies from which consumers would benefit, and otherwise make health care services more effective, affordable and efficient.

- The Attorney General also is required to establish a program through which certain providers may obtain certificates exempting from anti-trust laws activities relating to the provision of health care services.

### **Long-Term Care**

- Amounts withdrawn from individual retirement accounts (IRAs) and 401(k) plans for long-term care insurance are excluded from income. The bill also provides that certain exchanges of life insurance policies for long-term care insurance policies are not taxable. It also exempts from taxation any amount paid or advanced from a life insurance contract to a terminally or chronically ill individual who is confined to a hospice or nursing home.

**Congressman Bill BREWSTER (D-OK-3rd District):**

In his second term, Congressman Brewster is a conservative member who serves on the Ways and Means Committee and is a member of both the Mainstream Forum and the Conservative Democratic Forum. His district is extremely conservative, and constituents have expressed concerns ranging from excessive alliance regulation to charges of socialized medicine. Doctors, especially rural doctors, in his district are nervous about a gate keeper system that could exclude them. He is being targeted by the insurance industry in its campaign to block health reform.

A licensed pharmacist, he is one of five health professionals in the Congress. He has not yet cosponsored any health care reform legislation. Brewster supports reform of rural health and primary care. He also supports abortion rights but will not vote for government funding of abortion.

He is concerned about small business and the many minimum wage employers in his district -- he would like workmen's compensation more fully integrated into the HSA. In addition, he urges that the plan endorse utilization review. Brewster is also concerned about the ongoing funding for health reform. He likes global budgets, believes the revenue base must be strong and permanent, and wonders whether sin taxes will be sufficient to finance health care reform. He is skeptical of all the major health care plans that base their financing on Medicare and Medicaid savings. He has said that in Oklahoma up to 70 percent of rural hospitals' receipts come from those programs and he would not support further cuts in them.

After the President's State of the Union address, Brewster voiced concern about health care reform and indicated that Congress might pass a much smaller package than the President wants.

In February, Brewster wrote to the Administration seeking clarification on sections of the HSA pertaining to pharmacy services, particularly the proposed Medicare outpatient prescription drug benefit and the existing COBRA '90 moratorium on reducing pharmacy reimbursement that is due to expire on December 31, 1994. He has also reiterated that he would only support a bill with a "willing provider" provision, meaning that any doctor of pharmacy that can meet an insurance plan's price should be allowed to offer its services.

In the AP in early February, he was reserved and contemplative: "I am simply helping the Administration to communicate the specific funding mechanism of their plan to the people who will be directly affected by their proposals." Brewster will not endorse any plan because he wants to retain full flexibility in his negotiating position. He does not feel compelled to pass a major health care reform bill this year.

**Recent Developments:**

Two small businesses in his district, Max Moore and Oklahoma Steel Wire, recently testified before Ways & Means about a health care fund they created. Their employees can use the funds as needed and any unspent funds are returned to them. These funds seem to resemble medical savings accounts advocated by Senator Gramm.

Brewster has said that the alliance structure in the HSA is problematic and too bureaucratic. He said he would support strong tort reform and small group market insurance reforms. He believes the latter point could be the basis of a consensus package.

He would support a single payer system before he would support the Cooper bill. He believes that single payer is a better means to achieve cost containment. Brewster has claimed that the Rowland bill would be worth considering because it provides incremental reform and covers uninsured people with community health centers. He said that Rowland was "trying to be really rational" about reform, but he did not cosponsor the bill.

His primary issue continues to be the willing provider provision. Brewster fears that, under the HSA, large providers would underbid, get the market share, later increase costs and develop HMOs. He also fears that fee-for-service would then not be viable.

Senator Boren may resign at year end. In preparation, Brewster has begun fundraising to run for the seat.

*Votes:*

*FOR:*  
NAFTA

*AGAINST:*  
Family & Medical Leave  
Budget Reconciliation

**Congressman James M. INHOFE (R-OK-1st District):**

Inhofe serves on the Public Works & Transportation, Armed Services, and Merchant Marine & Fisheries Committees. His district includes Tulsa and its surrounding areas and is home to Oral Roberts' 60-story City of Faith Hospital. He has a very conservative voting record -- voting against abortion rights and opposing tax increases. He castigated members of Congress as "communists" and executive agencies as "gestapo bureaucracies."

Inhofe is a Michel cosponsor who believes that cost and price controls plus government-run bureaucracies will doom the Health Security Act. He claims the Clinton plan will mean fewer choices and less care.

In March, he cosigned a letter to the Administration which related relief to the oil and gas industry with health care legislation.

If Senator Boren resigns at the end of the year, Inhofe is expected to run for his seat.

*Votes:*

*FOR:*

*AGAINST:*

Family & Medical Leave

Budget Reconciliation

NAFTA

**Congressman Ernest IIm ISTOOK, Jr. (R-OK-5th District):**

Before his election to the House, freshman Rep. Istook served three terms in the state legislature. He represents a solidly Republican area, which includes Oklahoma City and is by far Oklahoma's most conservative district. He serves on the Appropriations Committee.

Istook has not sponsored or cosponsored any major health legislation. He opposes abortion rights.

After the President's health care speech last September, Istook said, "Private businesses are already working hard to bring down health care costs. We need to help those efforts, rather than give up on them."

Last October he called the President's plan a "government take-over of the medical system that must be blocked." More recently, in the Washington Times, he said, "Most Republicans came out of the box saying, 'Oh, we're certainly glad the President has put the issue on the table. We certainly agree with the sorts of principles he's talking about.' My reaction is very different. What principle are we agreeing with? Government control of health care? Price setting? We're only dickering over the price. The principle gets lost real quick."

*Votes:*

***FOR:***  
**NAFTA**

***AGAINST:***  
**Family & Medical Leave**  
**Budget Reconciliation**

**Congressman Dave MCCURDY (D-OK-4th District):**

Congressman McCurdy is a conservative Democrat who wants to be a player on the national scene. He actively considered running for President in 1992. Some felt he hurt his chances to become Secretary of Defense by pushing too hard. He then exacerbated his situation by criticizing the new Administration. In addition, he got himself into more trouble with the House leadership by openly discussing the possibility of challenging Tom Foley for Speaker of the House. Foley "rewarded" him by stripping him of his Chairmanship of the House Select Committee on Intelligence.

McCurdy does not does not serve on any committees of jurisdiction. He sits on the Armed Services Committee, chairs the Mainstream Forum, and is a member of the Rural Health Care Coalition. He is a cosponsor of the Cooper bill but does not have a strong record in health care policy.

Last May, McCurdy noted that his wife is a psychiatrist and he will have to justify the package to her. He wants the Administration to move toward the center on this and all issues. He believes the center will be there because it can attract some Republicans and liberals will have nowhere else to go.

In December, McCurdy became chairman of the Democratic Leadership Council. He has since complained that the DLC is the President's "most reliable base, and there are those within the White House who sometimes don't appreciate that." He has also said, "The DLC will fight those who would water down our agenda. ... It is our job to fight those ... who would turn health care into a government bureaucracy." He believes that the Democratic members of the DLC will "provide the deciding votes" in the health care debate, that the final form of the bill will be far different from the HSA but will include universal coverage.

If Senator Boren resigns, McCurdy will probably seek his seat.

*Votes:*

*FOR:*

NAFTA

Family & Medical Leave

*AGAINST:*

Budget Reconciliation

**Congressman Mike SYNAR (D-OK-2nd District):**

Congressman Synar is a member of the Energy and Commerce Committee and is a strong advocate for rural health concerns. He co-founded the Rural Health Care Coalition and cosponsored bills to improve rural health services as well as access to basic health care services for needy children.

In the last Congress, he worked with Congressman Wyden to create the Stark-Gephardt compromise on health reform. Synar supports reform and wants to be helpful to the Administration as a link to southern and moderate members. He is a cosponsor of the HSA and the Cooper bill. Although he is also a cosponsor of the McDermott bill, the NEA reported that he now opposes single payer but supports a state single payer option. He believes that managed competition is the only plan that has a chance of being approved. Synar supports universal coverage with comprehensive benefits, parity for public and private employers, and benefits for early retirees. He opposes the idea of taxing basic benefits, but believes that supplemental benefits should be taxed.

Congressman Synar is fiercely opposed to smoking, has fought to restrict tobacco advertising and promotions and to regulate the sale of tobacco products to minors. This did not endear him to the tobacco lobby, which fought hard, and unsuccessfully, against his reelection.

*Votes:*

*FOR:*

Family & Medical Leave  
Budget Reconciliation  
NAFTA

*AGAINST:*

## OKLAHOMA ECONOMY

### **SUMMARY:**

The Oklahoma economy improved in 1993 from a lackluster performance the previous year. The clearest evidence of improvement is employment growth of 2.7 percent, a turnaround from the modest decline in 1992. Moderate growth is expected in the coming year as the national expansion continues. While manufacturing and services are increasingly important in the state, Oklahoma's economy is highly dependent on the oil and gas industry. Consequently, the state thrived during the oil boom years of the early 1980s and was cushioned from the most severe impacts of the recent recession. The state's economy is lagging the nation at the current time given the continued weak world-wide energy demand.

### **Boom and Bust**

- At the height of the oil boom in 1982, Oklahoma's per capita income was 98.5 percent of the U.S. per capita. By 1993, the state's per capita income was 81.8 percent of the national figure.
- Oklahoma's unemployment rate was 59 percent of the national rate in 1982 but was just above the rate for the nation by 1993.

### **Employment**

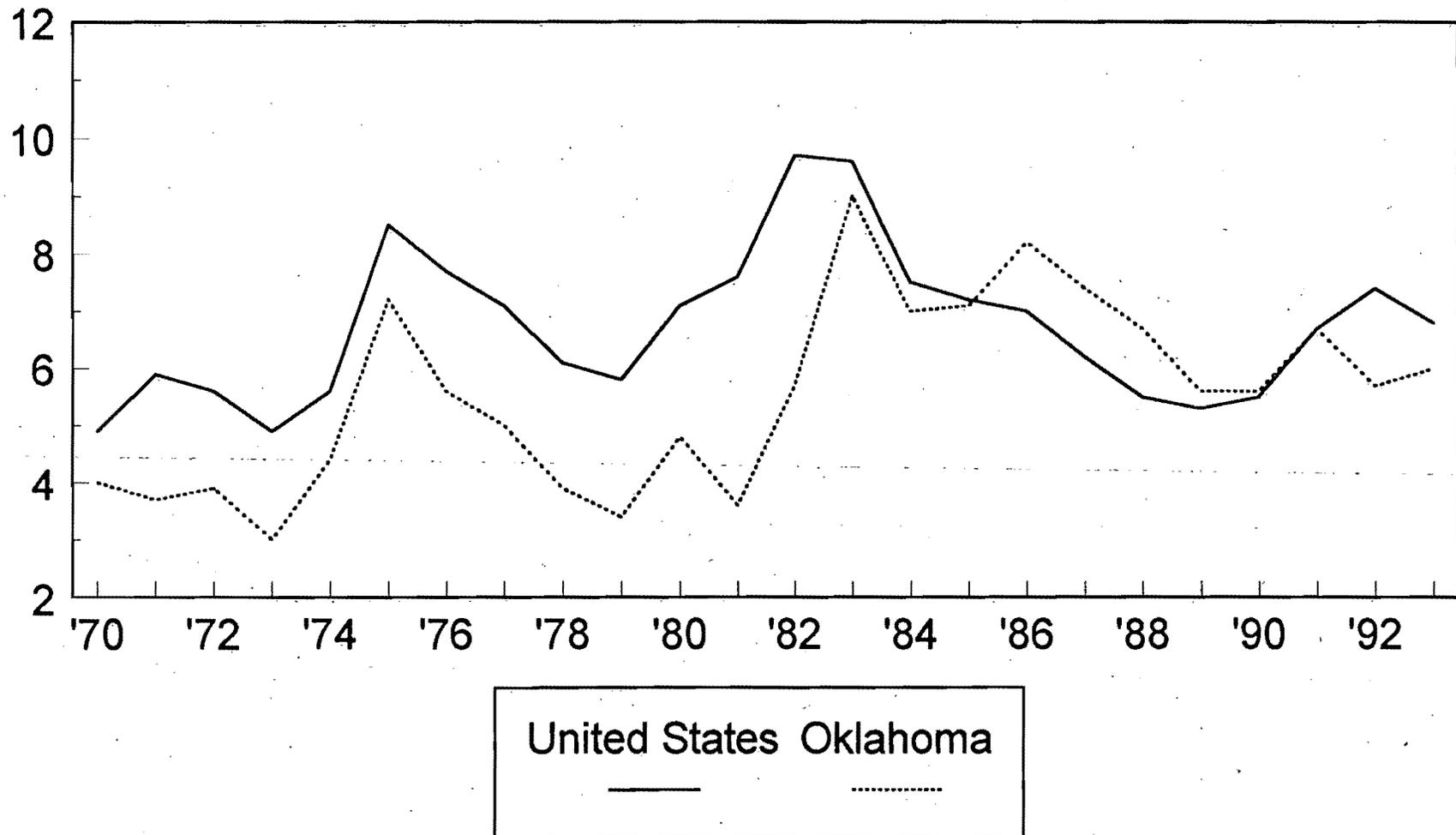
- While the national unemployment rate decreased from 6.9 to 6.5 percent from February 1993 to February 1994, the rate in Oklahoma increased from 5.7 percent to 6.9 percent for the same period.
- Much of this increase, however, resulted from an expansion of the state's labor force.

### **Regional Variation**

- Oklahoma City did well in 1993, while the Tulsa area lagged. Tulsa's subpar performance is related to reduced defense spending in the area.

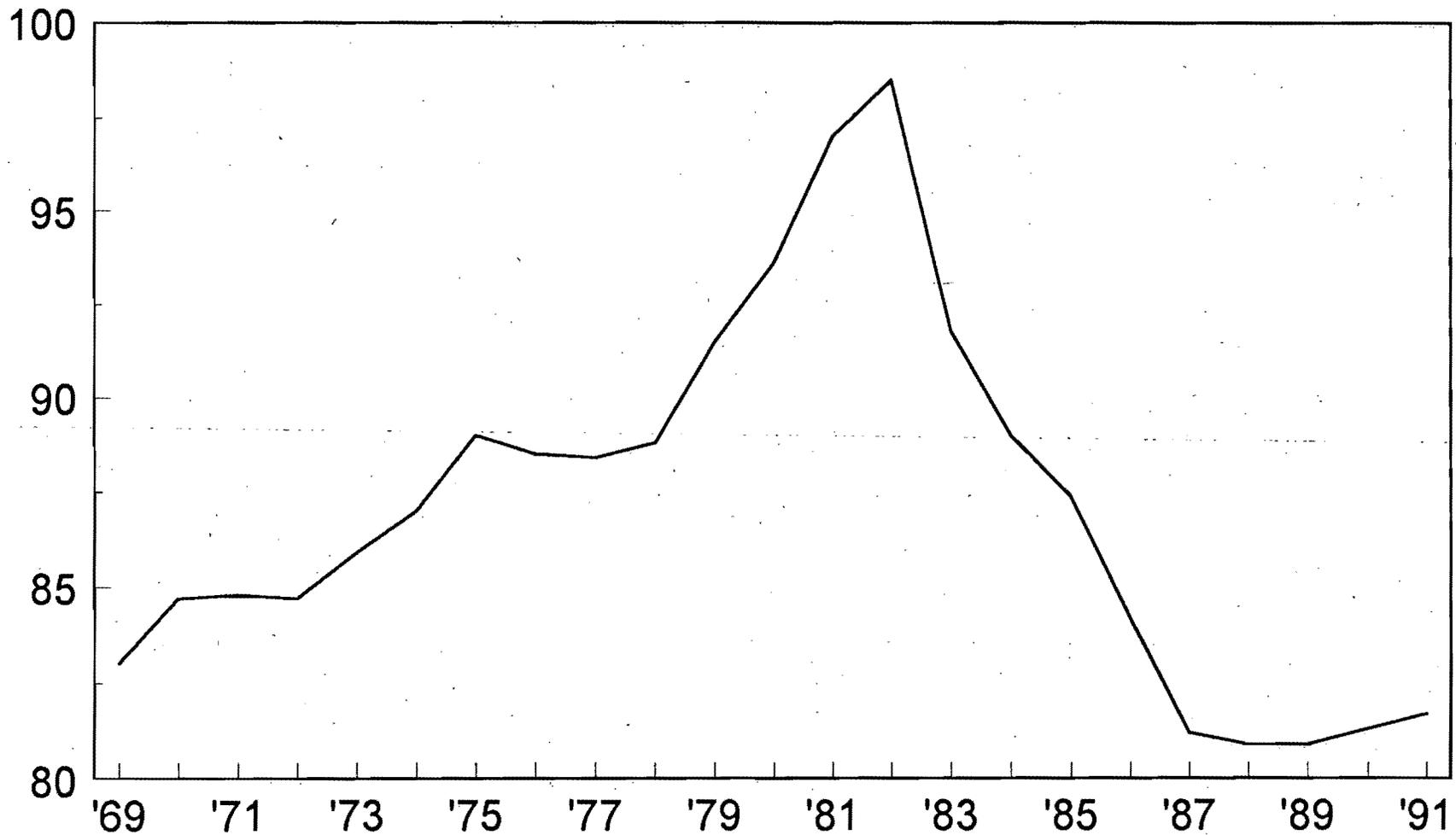
Office of Economic Policy

# Annual Average Unemployment Rates US and Oklahoma 1970 - 1993



# OKLAHOMA PER CAPITA INCOME

percent of US



## OKLAHOMA

April 20, 1994

- o Total population is 2.7 million.  
68.0% of the population is privately insured.  
57.1% are insured through their employer.  
14.4% are publicly insured [other than Medicaid].  
8.3% are covered under Medicaid.  
0.6 million persons are uninsured [22.3% of the population].

Note that 0.6 million persons are uninsured [22.3% of the population as compared to the national average, 16.6%].

- o Oklahoma does not have a State-based high risk pool.
- o 184,000 residents of Oklahoma are enrolled in HMO's or 5.8% of the population, as compared with a national average of 14.2%
- o Total number of hospitals in the state is 137, with an average occupancy rate of 60.2%, putting their occupancy rate below the national average of 29.5% and well below optimal occupancy which is 85%.
- o Oklahoma has a physician to population ratio of 158.1 per 100,000; which is low compared to the national average of 223.4:100,000.

## TREASURY Q'S AND A'S

1. Draft Question: Mr. Secretary, on Tuesday of last week, the "Congress Daily" news service reported that Chairman John Dingell of the Energy and Commerce Committee is close [within one vote] of having the 23 Democratic votes he needs to report out a revised version of H.R. 3600, the President's Health Security Act. Are you surprised that Dingell may actually be able to get a bill, given that his subcommittee chairman, Mr. Waxman was unable to do so?

Response: It is my understanding that Chairman Dingell and Subcommittee Chairman Waxman have been working together to develop the modifications of H.R. 3600 needed to satisfy Members of Energy and Commerce. I thought their strategy -- to compromise only once at full committee instead of having to go through two rounds of modifications -- was exactly right and I commend them for their hard work.

[Mr. Secretary, Congressman Dingell is said to be 3-4 votes short.]

2. Question: Mr. Secretary, before the recent recess, Congressman Stark's Ways and Means health subcommittee -- on a vote of 6/5 -- reported out an alternative to H.R. 3600, which creates a large public program [Medicare Part C], and gives to the IRS a very prominent role in collecting premiums and disbursing subsidies. What is your view of Stark's bill? Do you agree that using the IRS is preferable to relying on mandatory Regional Alliances to handle premium collections and subsidies?

Response: The Administration is very enthusiastic about the progress that Congressman Stark and his colleagues in the Ways and Means subcommittee have made in moving a health reform bill, this subject is complex and the decisions contentious -- so I salute Pete Stark for a job well done. As to the use of the IRS to handle some of the functions the Administration's bill assigned to the Regional Alliances, that's a little more tricky for me to answer, as you might guess. President Clinton's preference, which I share, is to keep health care decision-making as close to the community level as possible. Moreover, we did not believe that the purchase of private insurance was something with which the IRS had a great deal of expertise. Hence the Administration's plan uses an organizational structure that is local and tailored to the needs of each State/community [and I appreciate that Pete Stark's mark allows for voluntary alliances]. But, in my judgment, the Congressional committees responsible for writing the legislation on health reform will structure the administering organization according to what their jurisdictional prerogatives allow -- Ways and Means and Senate Finance are likely to find a role for the IRS and the Department of HHS; the Labor Committees will place significant responsibility with the Labor Department; and the Energy and

Commerce Committee is likely to rely on HHS and a State based system for their version of the plan. The final compromise will have to be worked out with input from each of the Committees and the Administration...and of course I am not prepared to speculate on what the final bill will contain. [Mr. Secretary, as you know, mandatory Regional Alliances are not faring well on the Hill -- Members argue, with considerable justification, that it is financially dangerous for the Federal government to allow States/localities broad authority over collection and disbursement of Federal funds, with no risk to the State or local government...the final work-out is likely to involve a more prominent role for the IRS, among other Federal agencies.]

3. Draft Question: Mr. Secretary, Senator Dole has said that, while he has cosponsored a bill that includes an individual mandate [the Chafee legislation], he is pessimistic about Congress approving any mandate this year. Last week Senator Dole also speculated that there was only a 50-50 chance that Congress would pass a health reform bill this year. What is your reaction to Senator Dole's comments?

Response: I continue to believe that the Congress can and will enact comprehensive health reform this year. In my view, the key to getting approval of a requirement that employers help pay for the cost of health insurance for their workers is the subsidies [discounts]. As you know, most employers -- including small employers -- already provide their employees with health insurance. They are struggling against worsening odds [35%-40% higher administrative costs; rates of increase each year that are staggering; abrupt cancellation of policies; pre-existing condition exclusions; etc.] to continue to do so, and I think they are counting on us to enact a bill that gives them relief this year. A bill that levels the playing field by moving to community rating coupled with deep discounts for small, low-wage firms will make insurance coverage affordable for these employers and their workforce.

4. Draft Question: Mr. Secretary, Hawaii and Washington State have enacted employer mandates to assure health coverage. How do they handle small business subsidies?

Response: That's a good question. Hawaii, which enacted its universal coverage plan in 1974, operates under an ERISA waiver. Low income persons have subsidized coverage, and there is a small business fund to help such businesses when they are having trouble paying their premiums. I am told that, since 1974, the fund has not had to spend more than about \$85,000 to \$90,000 to provide this help. [Fund is available to firms of 8 and fewer employees.]

In Washington State, which just last year enacted its reform measure, the State has set aside a guaranteed stream of funding for small businesses from the increased tobacco tax. Firms of 25 and fewer workers can apply for help on a time limited basis with

the assistance tailored to the needs of the individual firm. Priority will be given to firms just starting up, firms in disadvantaged areas, firms with serious cash-flow problems, and minority owned firms. Since the program is so new, we don't have much information about how it is working.

5. Draft Question: Mr. Secretary, I understand that Senator Mitchell may have presented to Senate Democrats at the weekend retreat a proposal to lower the cost of health coverage for small businesses by reducing the employer contribution from 80% of the premium to 50% of the premium -- with the employee picking up the difference. In addition, I am told that the Majority Leader has asked the Administration to run some other cost reducing options such as less generous subsidies for individuals and less expansive benefits [lower premiums]. My question is this, is Senator Mitchell working with Chairmen Moynihan and Kennedy on these alternatives? Has the Administration provided him technical assistance? What is the Administration's position on a 50% employer contribution?

Response: I understand that Chairmen Moynihan and Kennedy are fully aware of the list of options for modifying the Administration's plan that the Majority Leader is reviewing. Yes, the Administration has provided Senator Mitchell with some technical assistance in preparing estimates of alternative options. The Administration is treating Senator Mitchell's request as it has other requests from Members, that is, we are working hard to prepare preliminary estimates of cost/savings; we have made technical comments about administrative feasibility; and we are not endorsing or opposing any particular option.

6. Question: Mr. Secretary, CBO's reestimate of the Administration's health plan shows that, over the first 6 years [1995-2000], it would increase the deficit by over \$70b, a far cry from the Administration claim that the plan would reduce the deficit by more than \$50b. Chairman Rostenkowski has been lukewarm to some of the revenue measures in the President's plan, notably the size and implementation schedule for the tobacco tax. In addition, Pete Stark's subcommittee, notoriously tough on providers, couldn't find the votes to endorse the full \$118b in Medicare savings contemplated in the President's plan. Assuming that this trend continues, and that Dingell's committee can't marshal the votes to cut Medicaid either, what will you do to make up the shortfall?

Response: I can tell you this, we won't enact a bill that is not fully paid for...in fact, the President has made it clear that he wants to see deficit reduction from health reform, so I expect we'll have to do better than just paying for the plan.

Possible areas of adjustment include a slower phase-in; a less generous benefits package; and of course, alternative revenues and/or program cuts if the Members want to move in that direction. I am interested to note that every poll I've seen

says that the American people want health reform so much that they are willing to pay more taxes and tighten their belts in current programs to get it.

7. Draft Question: Mr. Secretary, you have not been as high visibility on health reform as you were on NAFTA and the Budget bill. May we assume that today's press event signals your return to the trenches on the health reform issue?

Response: I am an enthusiastic supporter of health reform, and will do what I can to help bring this initiative to a successful conclusion. You may not be aware of every aspect of my involvement in working toward enactment of health reform, for example, I was with the President at a children's hospital event in Dallas about two weeks ago; I visited a community health center in Pittsburgh last week; I have talked at some length with Senators Chafee and Moynihan about Finance Committee action; I've met with business groups and have consciously woven health reform into my formal remarks at a number of events. This week I met with Harold Ickes and Pat Griffin on legislative strategy and next week I'll be in Salt Lake visiting a small business. Don't count me AWOL on this one...and one more point, Deputy Secretary Altman and a large number of Treasury staff are deeply involved in this issue every day.

8. Draft Question: Mr. Secretary, if you were still Chairman of the Finance Committee, would you try to move this bill on a bipartisan basis? Will the House's decision to press forward on a partisan basis impact comity in the Senate? What do you make of Congressman Gingrich's thinly veiled threat to Republicans that cooperation with the Democrats/Administration on health reform could result in loss of plum committee assignment?

Response: First, I think that on an issue as significant as this one bipartisan action is the way to go, the American people expect us to set aside our partisan differences to solve this problem...he or she who tries to make this a partisan debate risks a backlash at the polls in November. I have heard gossip about Congressman Gingrich's discussion/memos to House Republicans, but I have seen no specific letter or memo and I assumed any message he might have intended to convey was a generic one designed to encourage his colleagues to work together on a wide array of issues -- a message I would expect any Party leader to send his colleagues.

9. Draft Question: Mr. Secretary, Speaker Foley is quoted as having said that enactment of health reform could spill over into next year. Given the number of retirements on the Finance Committee, the fact that Senator Mitchell and Congressman Michel are leaving, and that the urgency of health reform is falling in the polls, do you think you'll be able to enact reform if it is not accomplished this year?

Response: I understand that Speaker Foley's remarks were taken out of context...he was asked a hypothetical and he made the technically correct point that, if necessary, a vote on health reform could occur next year. It is my understanding that Speaker Foley is completely dedicated to enactment of health reform this year. Of course the retirements of key Members will impact this issue...these are individuals who have worked for years on this issue and I feel sure they will not want to leave the Congress without a significant victory on an issue of deep concern to so many Americans. In short, I think the impending changeover on the Finance Committee and within the leadership will enhance our chances for enacting a comprehensive bill this year.

10. Draft Question: Mr. Secretary, the NFIB recently released a report showing that enactment of the President's bill would result in the loss of 850,000 jobs to the economy? Does this trouble you? Is NFIB's projection going to carry any weight?

Response: The NFIB is a very active and aggressive organization with whom I have sometimes agreed and at other times disagreed. Regrettably, this is an issue over which we disagree. CBO, the Employee Benefits Research Institute -- which is funded by the business community --, the Council of Economic Advisers and many respected economists have concluded that the Health Security Act will save small businesses money over time, and will actually create jobs in the health sector.

11. Draft Question: Mr. Secretary, what is your view on the issue of cost containment? Will the Administration's "caps on premiums" survive? Is it appropriate for the Federal government to restrict the rate of growth in privately purchased insurance?

Response: As you know, we feel that the Health Security Act will generate savings for individuals, employers, and governments [State, local and Federal] by leveling the premium playing field [community rating], and ensuring that everyone is covered. But CBO and the actuaries don't recognize the extent of savings we think -- and others have shown -- can be achieved, so as a way of complying with the deficit neutrality requirements of the Budget Enforcement Act, we included premium caps as a failsafe. This is not our first line of defense in cost savings, it is our redundancy.

As to your question about whether it is appropriate for the Federal government to be concerned about private health spending, as long as the taxpayers are paying for the individual and business discounts [subsidies], the answer is unequivocally yes.

12. Question: Mr. Secretary, what of the Cooper-Breaux bill, do you think it will be the ultimate compromise? As we understand it, Cooper-Breaux is the "pure managed competition" alternative developed largely by the Jackson Hole group. It is said that Senator Moynihan finds it attractive, and of course it does not

contain some of the more contentious provisions -- employer mandates; large mandatory health alliances; premium caps; and limits on the numbers of residents who will be permitted to train for careers in Medicine.

Response: I am waiting to see what the official CBO estimates of the Cooper-Breaux bill may be, there were stories circulated in the press last week that the bill was estimated by CBO to increase the deficit by \$150b over the period 1995-2000, and that it would still leave 25m of the currently 37m uninsured. I know that Congressman Cooper has said he would adjust the bill to bring it into deficit neutrality, but if the \$150b figure is correct, that will be a difficult undertaking.

[Mr. Secretary, the CBO estimate is being held up so that Cooper, Breaux and others can review it before it goes public...However, you should be aware that the 1992 estimate of the precursor to Cooper-Breaux was estimated by CBO to increase the deficit by \$70b over 5 year.]

## EMPLOYMENT IMPACT OF HEALTH CARE REFORM

Question: Today the National Federation of Independent Businesses is releasing a report that concludes the President's plan would produce horrific job losses. You have not seen the report—perhaps this briefing is being held now so you can say you have not seen the report—but would you please comment on the issues that we know their report will raise?

Answer:

As you say, I have not seen the report. When we did our own internal analyses, we concluded there would be little if any negative impact from the plan—and immense harm if we did not reform health care.

The independent Congressional Budget Office did its own analysis, and quibbled with some of our assessments—higher premiums, worse federal budget impact. But the CBO, also, found little if any negative impact.

The CBO did predict that a number of people—between 300,000 and 1.2 million—would leave their jobs, in large part either because guaranteed private insurance assured them that they could retire early, or because they were at work solely to get the health insurance that did not come with their spouse's job. But providing health security is not a drawback.

We do worry about firms that are close to the edge of profitability and would feel the employer mandate as a heavy burden, and about families that do not now contribute to insurance because they cannot afford it. We have a generous subsidy program—that CBO estimates will cost \$128 billion in 2000, our estimate is lower—because health reform should be an economic plus for all businesses and workers.

If you want to see negative economic impact, just do nothing. The rise in health care costs in excess of GDP over the past decade and a half has taken \$1,000 per year out of the average worker's wages. Last year's projection was that it would take \$600 per year out of wages in the rest of this decade, and I do not believe spiraling costs will go away without action.

Treasury Economic Policy  
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## BURDEN ON BUSINESSES

Question: Hasn't it become clear in the past months that the Administration proposal puts too heavy a burden on business, especially small business?

Answer: If there is this perception, it is a misconception. I believe this Administration is very good at making the right policy choices—in the budget, in NAFTA, in the necessity for health reform—but somehow we always find ourselves facing an uphill struggle to convince the public. We seem to have more steak than sizzle.

Many aspects of health care reform are extremely advantageous to business, especially small business:

**Cost containment**—I don't need to tell you, again, the importance of health cost containment for the economic health of businesses that provide health insurance.

**Community rating**—small businesses, especially those with any employee suffering from anything that might be seen as a risk factor, pay extremely high amounts for health care under our current system if they can get health care at all. Community rating will make it much easier, cheaper, and fairer for small business to get health care.

**Administrative savings**—some estimates suggest that small businesses today pay up to 40% of their health costs for administration.

**Our subsidy program** to make sure that paying for health care does not unduly burden businesses. Erskine Bowles likes to highlight the cases in which our subsidy program pushes the employer cost of health coverage to 70 cents a day. A small, low-wage firm under the 3.5% of payroll cap pays 15 cents an hour to cover a minimum-wage worker. A large firm under the 7.9% of payroll cap pays 35 cents an hour. Large high-wage firms pay higher amounts—\$1.20 an hour for an uncapped firm—but almost all large high-wage firms already pay for insurance.

Treasury Economic Policy  
April 13, 1994

## CBO AND OUTSOURCING

Question: The CBO report on the Administration's plan concluded that there would be considerable "outsourcing": firms without subsidies—and thus paid \$1.20 an hour for health care—firing workers and hiring subcontractors who did qualify for subsidies—and thus paid 15 cents an hour for health care—thus saving more than \$1 an hour in labor costs.

CBO believes that such "outsourcing" costs an extra \$12 billion a year. It disrupts the lives of millions of people who find that their employer has "outsourced" their job to a firm that qualifies for higher subsidies. Are you rethinking elements of your plan in response to CBO's and others' criticisms of their economic and financial impact?

Answer:

The President put forward a plan recognizing that the plan would be changed. Congress writes the laws. The President will have won an enormous victory for America as long as the plan that Congress ultimately passes achieves his basic goals. We are working with Congress, and the plan will change.

The Administration decided on subsidies—capping each firm at a fixed percentage of payroll—for many reasons. It is simple to administer. It is easy for a business to calculate. It seemed politically attractive: at the time the Chamber of Commerce was advocating a cap on business payroll. It seemed good to signal that we were eager to accept their ideas.

But now many are worried about the subsidies, and this "outsourcing" problem that CBO has assessed as costing an extra \$12 billion a year, and disrupting jobs. One way to deal with these problems would be to shift from a firm to an individual wage cap: total contributions for an individual worker might be capped at a percentage of the worker's wages.

I think we should look long and hard at different ways to target subsidies, and accept the consensus on how to do the most good with the least money.

Treasury Economic Policy  
April 13, 1994

## WHAT DO YOU THINK OF THE STARK PROPOSAL?

QUESTION: Mr. Secretary, what do you think of Chairman Stark's health reform plan that was recently approved by the Subcommittee on Health of the Ways and Means Committee?

ANSWER: First, I would like to commend Pete Stark for making a major contribution to health care reform by moving the legislative process forward so effectively.

The proposal approved by Chairman Stark's Subcommittee incorporates significant elements of the Administration's plan, though it departs from our plan in some major respects. As you know, we have said that we are willing to be flexible with respect to the specifics of our proposal, but the one element the President will insist upon is guaranteed health insurance for everyone. I am pleased that Chairman Stark's proposal, like the Administration's bill, would guarantee coverage for all Americans, and would do so by calling upon employers to take responsibility for their fair share of the cost.

I don't think it would be useful for me to comment on the specifics of Chairman Stark's proposal because it is now a work-in-progress being considered by Chairman Rostenkowski's full Ways and Means Committee. In addition, it is premature to comment on the particulars because CBO has not yet estimated the effects of the Stark proposal.

### Background Note

The Stark plan would not fully meet the standard of guaranteed private health insurance for all Americans, in that it provides for a public plan ("Medicare Part C") to cover low-income individuals and employees of small businesses that choose the public plan. However, the Stark proposal is far from being a single-payer plan.

## WHAT DO YOU THINK OF THE DINGELL PLAN?

QUESTION: Mr. Secretary, what are your views on the proposal reportedly being circulated by Chairman Dingell among the members of the House Energy and Commerce Committee? In this connection, what does the Administration think of the so-called "carveout" proposals that would basically exempt small employers from an employer mandate?

ANSWER: So far as I am aware, my good friend John Dingell is continuing to craft his proposal, so at this point his plan is still a work-in-progress.

A number of people in Congress and elsewhere have discussed possible proposals to exempt small business entirely from the responsibilities that all other employers would be asked to bear in helping to achieve guaranteed private health insurance coverage for all Americans.

There is no question that it is extremely important to consider carefully the impact of any health reform plan on small business and on business generally. As you know, the approach taken in the Administration's bill is essentially to

- provide a premium cap for all employers that places an upper limit on their responsibility for the costs of covering their employees
- provide substantial premium discounts to small and low-wage firms, including self-employed people, and
- assist many small businesses by making health care premiums 100% tax deductible for the self-employed.

In considering the alternative approach of exempting small employers entirely from any requirement to contribute to cover their employees, it is important to think through the possible consequences very carefully. For example -- in addition to the key question of how much a total exemption would cost -- to what extent would such a "carveout" encourage firms below the size threshold to stop growing, while encouraging firms above the threshold to take special measures to reduce their size, such as

- "outsourcing" work they now do in-house by subcontracting with smaller firms, perhaps spinning off part of their work force or dividing up into smaller entities, each of which might qualify for the carveout;
- reclassifying their employees as independent contractors, or
- simply terminating some employees in order to "downsize"?

These kinds of responses by employers may be more likely to result from a carveout that creates a "cliff" effect, as opposed to a sliding-scale approach that phases down the employer's obligation as it gets larger [the Administration's approach]. "Outsourcing" could cost billions in terms of additional subsidies for business, and employer attempts to "game" the system in order to qualify for exemption could make it significantly harder to enforce the rules.

A small-business carveout would also raise the question whether it is appropriate to ask the employees of the exempt firms to pay more because their employers would not be paying any portion of the premium.

# J.S. Senator David Boren of Oklahoma

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**FOR IMMEDIATE RELEASE**  
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## **BOREN URGES CAUTION ON HEALTH CARE REFORM**

Senator David Boren, speaking before the annual banquet of the Wewoka Chamber of Commerce, said tonight that the health care plan put forward by President Clinton needs to be "substantially changed" by Congress during consideration this year. Boren delivered his most detailed criticism of the Administration's health care proposal since it was unveiled by the President.

"While the American people want health care reform, Congress must remember that we are dealing with one-seventh of our total economy," said Boren. "Any major mistakes could be devastating to our economy."

As Congress prepares to consider the Clinton health care reform proposal when it reconvenes January 25, Boren outlined 8 key principles that he said must guide any changes to the American health care system. Boren, a member of the Senate Finance Committee which has jurisdiction over health care, said his guiding principles in the upcoming debate are as follows:

- o **Freedom of Choice Must Be Maintained** -- People should not be forced to go into group plans if they do not want to do so. Patients must be allowed the option of selecting individual doctors and specialists if they want. The doctor-patient relationship is too important and too personal to force patients and doctors who do not want to work together to do so.
- o **Don't Eat Dessert Before the Spinach** -- Costs should be reduced first and savings found before promising new benefits. By enacting savings first, we can avoid providing benefits that we later find we cannot afford. Benefits should be phased in only as we have the money for them under a "pay-as-you-go" plan.
- o **Small Businesses Cannot Be Left Holding the Bag** -- If costs of health care are underestimated, then payments to small businesses to offset costs could be reduced or eliminated, leaving them with much of the burden. Since small businesses create most of the new jobs, the economy would be severely damaged by putting small firms out of business.

- o **Don't Overlook Rural Areas and Small Communities** -- There are not enough incentives in the current plan to assure survival adequate medical services in rural areas. Wewoka saw its hospital close in 1991. More needs to be done to assure Americans living in rural area have access to quality health care.
- o **Be Fair To Small Insurance Companies and Health Providers** -- The final plan should not put small companies and providers out of business and leave only a few huge companies in existence. Smaller companies that do a good job should have a chance to survive.
- o **Cut Red Tape** -- More red tape, bureaucratic overhead, and new paperwork requirements will only increase costs.
- o **Centers of Excellence Must Be Maintained** -- Centers like the Mayo Clinic, M.D. Anderson, Sloan Kettering, our own University of Oklahoma Health Sciences Center, and others associated with research and medical education must not be disadvantaged because they provide the facilities and training to keep American medicine best in the world.
- o **Control Costs Through Medical Malpractice Reform** -- Tort reform and a limitation of huge judgements in lawsuits must be a part of any plan if we really want to reduce costs.

"While I believe in reform, including universal coverage and portable benefits, we must be very careful not to destroy the good parts of our present system and avoid wrecking the economy by underestimating the costs," said Boren. "It is very hard to give benefits to 30 million people not now receiving them and keep down costs without reducing the quality of health care.

"I believe the Clinton plan still has a long way to go to meet these objectives -- Congress must work hard to improve it."

## HEALTH CARE TALKING POINTS

- o While I believe in reform, including universal coverage and portable benefits, we must be very careful not to destroy the good parts of our health care system. The plan put forth by President Clinton must be substantially changed by Congress during consideration this year.
- o The American people want health care reform, but Congress must remember that health care spending is one-seventh of our total economy. Any major mistakes would certainly be devastating to our country's economic well being.
- o I believe the following eight principles should guide the debate on health care reform:
  1. **Freedom of Choice Must be Maintained --** People must not be forced to go into group plans if they do not want to do so. Patients must have the option to select individual doctors and specialists if they want. The doctor-patient relationship is too important and too personal to force patients and doctors to work together who do not want to do so.
  2. **Don't eat the Dessert Before the Spinach --** We must not promise more benefits than we can afford. Costs should be reduced first and savings found before promising new benefits. By enacting savings first, we can avoid providing benefits that we later find we cannot afford. Benefits should be phased in only as we have the money to pay for the them under a "pay as we go" plan.
  3. **Small Businesses Cannot be Left Holding the Bag --** If the costs of health care reform are underestimated, then payments to small businesses to offset costs could be reduced or eliminated leaving them with much of the burden. Some

studies indicate that in the first year of the Clinton plan, employer spending could increase by \$28.9 billion. Without guaranteed subsidies, an employer mandate would certainly put small firms out of business.

4. **Don't Overlook Rural Areas and Small Communities --** I am concerned the current plan does not assure adequate medical services to the one quarter of the U.S. population in rural areas. In the last decade, undeserved rural areas have struggled to recruit physicians and to keep hospitals operating.
5. **Be Fair to Small Insurance Companies and Health Providers --** The final plan should not put small companies and providers out of business and leave only a few huge companies in existence. Smaller companies that do a good job should have a chance to survive.
6. **Cut Red Tape --** More red tape, bureaucratic overhead, and new paperwork requirements will only increase costs. Today, almost 25 cents of every dollar on a hospital bill goes to bureaucracy and paperwork -- not patient care.
7. **Centers of Excellence Must be Maintained --** Centers like the Mayo Clinic, M.D. Anderson, Sloan Kettering, our own University of Oklahoma Health Sciences Center, and others associated with research and medical education must not be disadvantaged because they provide the facilities and training to keep American medicine the best in the world.
8. **Help Control Costs Through Medical Malpractice Reform --** Tort reform and a limitation of huge judgements in lawsuits

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## OKLAHOMA

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The history of Oklahoma has been one of sudden exhilarating boom and protracted sickening bust. It was settled in a rush, first by the Five Civilized Tribes driven west by Andrew Jackson's troops over the Cherokees' Trail of Tears in the 1830s, then by white settlers one morning in April 1889, when, in the great land rush memorialized in an Edna Ferber novel, the Rodgers and Hammerstein musical and half a dozen Hollywood movies, thousands of would-be homesteaders drove their wagons across the territorial line at the sound of a gunshot, the most adventurous or unscrupulous of them literally jumping the gun—the Sooners. The heritage of these rushes remains. Oklahoma celebrated the Year of the Indian in 1992, honoring the state's 67 tribes and spotlighting their council houses, historic sites and festivals. Oklahoma has the second largest Indian population of any state, 253,000 in the 1990 Census, though there are no reservations; but there has been much intermarriage over the years, and many Oklahomans proudly claim some Indian blood; assimilation into everyday life plus commemoration of historic traditions seem to have provided a better life for Native Americans here than approaches elsewhere.

Statehood came to Oklahoma late, in 1907, at which point it filled up with farmers, rising from 1.5 million people in 1907 to 2.4 million in 1930. Then, a decade of bust. Oklahoma literally went up in smoke, or rather dust, as soil loosened by erosion was whipped into giant dust clouds: the Dust Bowl. "On a single day, I heard, 50 million tons of soil were blown away," John Gunther reported later. "People sat in Oklahoma City, with the sky invisible for three days in a row, holding dust masks over their faces and wet towels to protect their mouths at night, while the farms blew by." Okies headed in droves west out U.S. 66 to the green land of California and Oklahoma's population sank to 2.3 million in 1940 and 2.2 million in 1950, not to reach its 1930 level again until 1970.

Then another boom—this time from oil. As the oil shocks of 1973 and 1979 sent oil prices up, Oklahoma's population rose from 2.5 million in 1970 to 3 million in 1980 and 3.3 million in 1983. Then, with the collapse of oil prices and of Oklahoma's farm economy as well, bust again. A giddy rise was followed by a giddier fall: the rig count fell from 882 in January 1982 to 232 in February 1983, 128 in 1986 and 93 in 1989. Just as the dust cloud symbolized Oklahoma's 1930s bust, so the auction of oil drilling equipment was a symbol of the 1980s calamity. The 1990 Census reported just 3.1 million Oklahomans. The nation's lowest unemployment state in the early 1980s recession, Oklahoma suffered during the late 1980s boom, but it was hurting less than most states by the early 1990s recession and the unemployment rate actually declined in 1992.

But in the meantime, Oklahoma has been going through extraordinary political turbulence. Its partisan patterns had seemed well-set: most of its early settlers were southerners, and historically it has been Democratic. But the Oklahoma City and Tulsa metropolitan areas, which now contain more than half the state's people, have been trending Republican since the 1950s; Little Dixie in the south remains Democratic, while the northern wheat counties are Republican. The post-oil boom years saw the election of a Republican governor in 1986 and a Democrat in 1990; Oklahoma voters were disgusted by a stubborn budgetary crisis and were among the first in the nation to impose term limits on their state legislators in 1990. Then they saw their governor afflicted by bizarre personal tragedy and charges of tawdry corruption. Amidst all this, it was probably a good idea to focus on Oklahoma's not too lengthy history and on its Indian heritage, and to build an appreciation of enduring strengths.

**Governor.** The governor of Oklahoma, Democrat David Walters, has had one of the most turbulent terms of any governor in the land. He came to office after an eight-year career as a real estate developer and a 1990 campaign in which wild charges were hurled, and which has

generated charges that still dog him more than two years later. The initial favorite in 1990 was Little Dixie Congressman Wes Watkins who raised over \$1 million, called for more jobs and attacked Walters for "illegally financing" his 1986 gubernatorial bid; Walters contended that Watkins had gotten rich while representing a poor district. Watkins led by 3,838 votes after the Democratic primary; stressing term limits, Walters won the runoff 51%-49%. In the Republican primary, restaurateur and former TV anchorman Vince Orza led with 40% and former federal prosecutor Bill Price had 27%; in that runoff Price, stressing his conservative credentials, won with 51%. The general election, featuring many personal charges, resulted in a 57%-33% Walters victory; this was not just a partisan triumph, as Republicans won for treasurer and corporation commissioner.

Almost immediately, Walters was the subject of a federal grand jury investigation of his campaign finances, which ended without an indictment. He was also beset with tragedy when his 19-year-old son committed suicide, after being arrested on drug paraphernalia possession charges and badgered by television newsmen; Walters devoted his 1992 state of the state message to a bitter denunciation of the media, and said later, "If it were not for several thousand negative headlines and two years of an incredibly unusual and trying investigation, my son would still be alive." But in early 1993, Attorney General Susan Loving, a Walters appointee, was conducting a state grand jury investigation of whether Walters supporters exceeded contribution limits by giving money in the name of friends and relatives; a top Walters aide was indicted for forgery in February 1993. It was also investigating whether Walters was given a briefcase with \$30,000 in cash from nursing home owners during the campaign; Walters angrily denied all the charges.

While all this was going on, Walters was making a record in many ways successful. When he came to office, state government was still struggling to adjust to a two-thirds drop in the oil and gas revenues that had provided one-third of the state budget, and a controversial \$230 million education-tax reform package. Walters got his version of the state education reform package endorsed in a 1991 referendum. In 1992, he got approval of a higher education bond package and held down taxes and spending. In February 1993, he proposed a 9% across-the-board cut in most spending but an increase in education. In March 1993, Walters proposed a lottery, with half the proceeds to be used for capital spending. In early 1993, it was not clear whether Walters would run in 1994, and whether the central accomplishment of his administration would be governmental success or political scandal. Possible rivals include Democrats Watkins, Lieutenant Governor Jack Mildren and state House Speaker Glen Johnson; Republican possibilities include Orza, former Justice Department appointee Frank Keating, state Corporation Commissioner J. C. Watts, one of the few statewide elected black Republicans in the country, and Oklahoma City Mayor Ron Norick.

**Senators.** One of the few senators with memories of Washington in the 1940s, when he was a congressman's son, David Boren is an active member of the Senate in the 1990s. A key vote on the Senate floor and especially on the Finance Committee, Boren has been pushing for process and procedural reforms in response to the complaints so many citizens have about the workings of Congress. He also has played a role on foreign policy, as chairman of the Intelligence Committee from 1987 to 1993. Although Boren bucked the Bush Administration on some issues, voting against the Gulf war resolution in January 1991, he also cleared the way in fall 1991 for the confirmation of CIA Director Robert Gates. Boren rotated off Intelligence in 1993, but retains an interest in foreign aid programs, pushing for a probe of the BNL scandal and working for a consensus on aid to Russia.

But a great crusade for Boren is campaign finance reform. His bills, supported by most Democrats as well as Common Cause, are the leading legislation for providing limits on campaign spending and PAC contributions and some measure of public financing (he has never accepted PAC money himself). But his attempts to bridge the gaps with Republicans opposed to spending limits and public financing have failed: a Bush veto in 1992, and most recently in seemingly deadlocked meetings with Kentucky Senator Mitch McConnell in early 1993. Boren

still has hopes to win enough votes to get cloture, and passage of a bill through the Senate. His water problem may be the House, where Democrats are loath to give up the enormous financial advantages they enjoy under the current system. Boren would also further restrict lobbying by ex-officials, in agreement with President Clinton (although Clinton aide George Stephanopoulos appears to have trespassed on the existing law when he met with his former House bosses during the 1992 campaign). Now co-chairman, with Congressman Lee Hamilton, of the Joint Committee on the Organization of Congress, Boren has promised to come out with reform proposals by late 1993.

As a moderate to even conservative Democrat, Boren started off 1993 as a thorn in the Democrats' side. He and John Breaux of Louisiana pushed in early 1993 for cuts and delays in spending in the Clinton economic stimulus package until deficit reduction measures had actually been passed. Robert Byrd used parliamentary procedures to prevent any vote on Boren-Breaux, which had it been accepted might have prevented the successful Republican filibuster. On the Finance Committee, which Democrats control only 11-9, Boren, always hostile to energy taxes and regulation, quickly opposed the Clinton energy tax and threatened to use his swing vote against any type of Btu tax.

Boren has long been a popular figure in Oklahoma politics. He was elected governor in 1974 as a reformer, with 64% of the vote against current 1st District Congressman James Inhofe. He has won 65%, 76% and 83% in successive elections for senator—the last two are Oklahoma records. In 1990, against a candidate who filed at the last minute, he carried 2,352 of 2,354 precincts.

In 1980, Don Nickles was a 31-year-old small businessman from Ponca City, a Catholic running for the Senate with the support of Protestant evangelicals—a strong base in the home state of Oral Roberts. Since that time, he has been a U.S. senator of strong convictions and durable political strength and one of the most conservative members. Several threads run through his record. One is opposition to energy taxes and regulations; he backed the successful fights to deregulate oil and natural gas prices, to repeal the windfall profits tax and to repeal the 55-mile-per-hour speed limit. He supported drilling in the Arctic National Wildlife Refuge and opposed increasing CAFE standards for cars. He put into the 1992 energy bill measures changing the alternative minimum tax for oil and natural gas and strongly opposed the Clinton Btu tax. Another thread is protection against the AIDS virus: he legislated a procedure for AIDS testing of convicted rapists and sex offenders and got the Senate on record during the first session months, 76-23, against allowing HIV-positive immigrants into the U.S. Nickles favors internal reforms like limiting congressional franking and applying to Congress the laws it applies to others; he was one of the backers of the 203-year old Madison amendment which banned mid-term changes in congressional pay. He is strongly supportive of Israel, and passed a bill to stop military and economic aid to Jordan. He advocates judicial changes such as blocking criminals from using bankruptcy to avoid paying restitution to victims, and linking recipients welfare payments with their children's school attendance. He wants to shore up the Pension Benefit Guaranty Corporation to prevent savings and loan-type losses.

Nickles is solidly partisan and headed the National Republican Senatorial Committee during the 1989-90 cycle, when Republicans lost one seat with the upset victory of radical Democrat Paul Wellstone in Minnesota. In December 1990, Nickles ran for Republican Policy Committee chairman, and beat Pete Domenici 23-20 on the second ballot. Domenici backed the 1990 budget summit tax increases while Nickles opposed them insisting, "You are going to see a Republican Party that is unified against tax increases." Evidently so: in December 1992 Nickles kept the post without opposition. In Oklahoma, Nickles has run stronger than many in Washington expected. In 1986, he faced Jim Jones, Ways and Means member and Budget chairman in the first Reagan term. But Jones ran some smirky ads, and Nickles's sincerity seemed to strike a chord with voters; he won 55%-45%. In 1992, his Democratic opponent was Steve Lewis, who had worked his way up from poverty to become speaker of the state House, and had run unsuccessfully for governor in 1990. Nickles attacked him as a Ted Kennedy clone

who would raise taxes, and won 59%-38%, the best showing for a Republican Senator in Oklahoma since 1924.

**Presidential politics.** Oklahoma in many elections has been the most Republican of southern states; in 1992 it was the least Democratic, casting 34% for next-door neighbor Bill Clinton (but then, George Bush and Ross Perot are neighbors as well). There are relatively few blacks here, no large quarter of urban singles, not many Mexican-Americans and no liberal-inclined Native American voting bloc; Oklahomans with a Democratic heritage tend to be conservative on cultural, foreign and some economic issues, and find national Democrats unappealing, even southerners like Bill Clinton and Jimmy Carter.

Oklahoma was not on anyone's list of target states in 1992. Nor was it the subject of much attention as one of the southern Super Tuesday primaries, when it voted overwhelmingly for Clinton and Bush. It was more interesting in 1988, when it voted solidly for Al Gore (a very distant relation of onetime Oklahoma Senator Thomas Gore, grandfather of writer Gore Vidal) and by the narrowest of margins for George Bush over Kansas neighbor Bob Dole:

**Congressional districting.** For the 1990s, Oklahoma was fortunate not to lose a congressional district. Control was in Democrats' hands, and in May 1991 the Governor signed the legislature's "incumbent protection plan," as one state legislator called it. The plan strengthened Democrat Mike Synar in the 2d District and Republican Jim Inhofe in the 1st by slicing heavily Republican southeast Tulsa from the 2d and restoring it to the 1st.

**The People:** Est. Pop. 1992: 3,212,000; Pop. 1990: 3,145,585, up 2.1% 1990-1992. 1.3% of U.S. total, 28th largest; 32% rural. Median age: 33.2 years. 13.5% 65 years and over. 82.1% White, 8.0% American Indian, 7.4% Black, 2.7% Hispanic origin, 1.1% Asian, 1.3% Other. Households: 57.7% married couple families; 28% married couple fams. w. children; 44% college educ.; median household income: \$23,577; per capita income: \$11,893; 68.1% owner occupied housing; median house value: \$48,100; median monthly rent: \$259. 5.7% Unemployment. Voting age pop.: 2,308,578. Registered voters (1992): 2,302,279; 1,452,949 D (63%), 775,754 R (34%), 73,576 unaffiliated and minor parties (3%).

**Political Lineup:** Governor, David Walters (D); Lt. Gov., Jack Mildren (D); Secy. of State, John Kennedy (D); Atty. Gen., Susan Loving (D); Treasurer, Claudette Henry (R); Auditor, Clifton Scott (D). State Senate, 48 (37 D and 11 R); State House of Representatives, 101 (68 D and 33 R). Senators, David Lyle Boren (D) and Don Nickles (R). Representatives, 6 (4 D and 2 R).

**1992 Presidential Vote**

Bush (R) .....	592,929	(43%)
Clinton (D) .....	473,066	(34%)
Perot (I) .....	319,878	(23%)

**1992 Democratic Presidential Primary**

Clinton .....	293,266	(70%)
Brown .....	69,624	(17%)
Woods .....	16,828	(4%)
Other .....	36,411	(9%)

**1988 Presidential Vote**

Bush (R) .....	678,367	(58%)
Dukakis (D) .....	483,423	(41%)

**1992 Republican Presidential Primary**

Bush .....	151,612	(70%)
Buchanan .....	57,933	(27%)
Other .....	8,176	(4%)



DEPARTMENT OF THE TREASURY  
WASHINGTON, D.C. 20220

94-136255

July 18, 1994

**MEMORANDUM FOR SECRETARY BENTSEN**

**FROM:** Kevin Varney  
Scheduling Office

**SUBJECT:** Health Care Briefing for Economic Team

Date and Time Tuesday, July 19, 1994 11:30 am

Location Roosevelt Room

**PARTICIPANTS:**

Treasury Secretary Bentsen  
Alicia Munnell  
Marina Weiss  
Roger Altman

Others Bob Rubin  
Laura Tyson  
Alice Rivlin  
Secretary Ron Brown  
Secretary Reich  
Gene Sperling  
Erskine Bowles  
Others TBD

**BRIEFING:** Please refer to attached briefing from Economic Policy



DEPARTMENT OF THE TREASURY  
WASHINGTON

ASSISTANT SECRETARY

July 18, 1994

MEMORANDUM FOR SECRETARY BENTSEN  
DEPUTY SECRETARY ALTMAN

FROM: Alicia Munnell

SUBJECT: Health Care Briefing for Economic Team in  
Preparation for Wednesday, July 20, 1994  
Press Briefing

Date and Time July 19, 1994, at 11:30 a.m.

Location Roosevelt Room, White House

PARTICIPANTS:

Treasury Secretary Bentsen  
Deputy Secretary Altman  
Alicia Munnell  
Marina Weiss

Others Commerce Secretary Brown  
Labor Secretary Reich  
Robert Rubin  
Laura Tyson  
Alice Rivlin  
Erskine Bowles  
Gene Sperling  
Others TBD

BRIEFING: TAB A - Overview  
TAB B - Profile of the Uninsured - Myth vs.  
Reality  
TAB C - Draft Comments for Wednesday Press  
Briefing  
TAB D - Sample State/District Summary Sheets  
TAB E - Questions and Answers

## Overview

One hour press events are being planned for Wednesday and Thursday for Secretary Bentsen, Bob Rubin, Laura Tyson and Alice Rivlin to discuss about health care issues. A pre-briefing is scheduled for Tuesday at 11:30 am in the Roosevelt Room.

The format of the press events will be as follows;

- o Secretary Bentsen will welcome the press and introduce the speakers
- o Each speaker will talk for approximately 7 minutes.
  - Laura Tyson -- insurance reform.
  - Alice Rivlin -- cost containment.
  - Secretary Bentsen -- characteristics of the uninsured.
  - Robert Rubin -- workforce issues.
- o A half - hour question and answer session will follow the presentations.

July 18, 1994 (3:14pm)

### PROFILE OF THE UNINSURED: MYTH VS. REALITY

As health reform reaches a critical stage in Congress, fashioning the right solution requires having a clear understanding of the characteristics of the uninsured. Contrary to popular myth, the uninsured are not all poor, elderly, or otherwise vulnerable. In fact, over half of the uninsured live in families where at least one spouse is a *full-year, full-time* worker. Roughly 84 percent come from families whose head works at least part of the year. In addition, while even short exposures without insurance put people at significant financial and health risk, being uninsured is predominately a long-term problem. Finally, those who do purchase insurance, and taxpayers as a group, bear much of the burden of the uninsured -- through both "cost shifting" to private insurance premiums and increased spending on public programs.

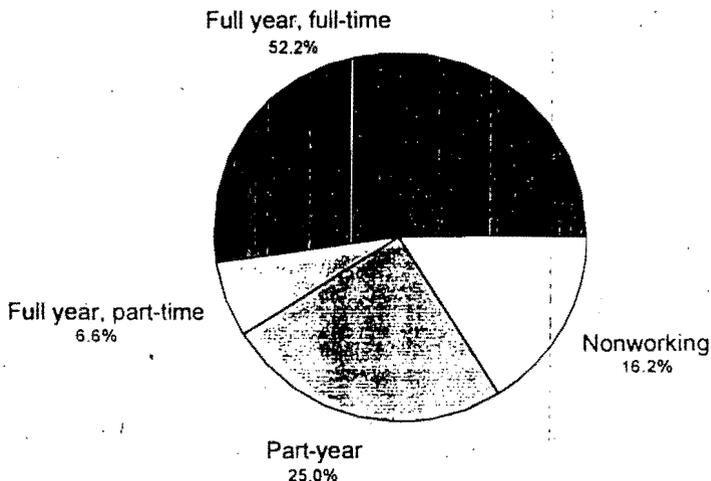
**Myth #1:**     *The uninsured are unemployed.*

**Reality:**     The uninsured are working Americans.

The vast majority of the uninsured -- 83.8 percent -- belong to working families. Federal programs already cover most of the non-working population. Medicare provides near-universal coverage for those over 65, and Medicaid covers 50 percent of those in poverty and 25 percent of those just above the poverty line.

As a result, large numbers of the uninsured are clustered in working families with moderate incomes, who do not qualify for Medicaid. Insurers in general charge higher rates to the self-employed and small businesses, which makes it difficult for them to obtain affordable coverage.

#### Job Status of the Uninsured



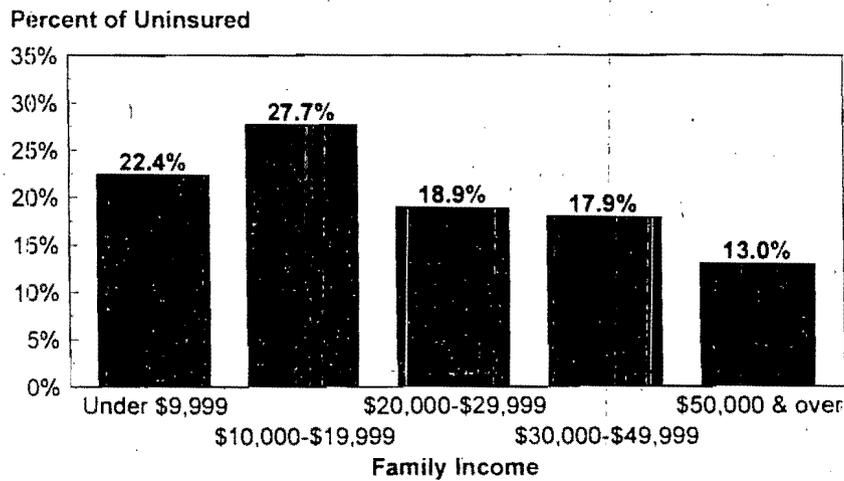
**Myth #2:** *The uninsured are poor.*

**Reality:** The bulk of the uninsured have moderate incomes; many are middle-class.

The vast majority of the uninsured -- 72 percent -- have incomes above the federal poverty threshold. While the average uninsured American family is a lower-income family, it is far from being in poverty.

The bulk of the uninsured are in hard-working families for whom health insurance is unaffordable. Because small businesses and the self-employed have difficulty obtaining affordable insurance, almost one in three of the uninsured is a member of a family making more than \$30,000 a year.

### Family Income of the Uninsured

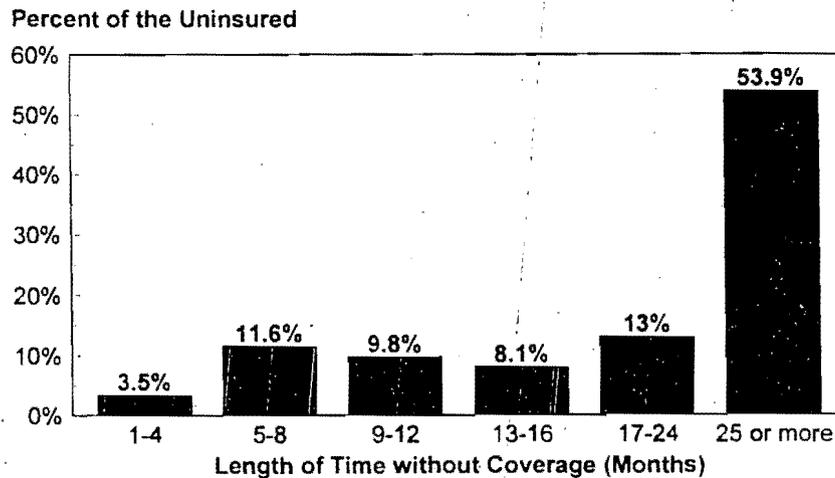


**Myth #3:** *For most of the uninsured, being without health insurance is a short-term, rather than a long-term, problem.*

**Reality:** 54 percent of those uninsured today will be uninsured for more than two years. 75 percent will be uninsured for more than a year.<sup>1</sup>

Some have suggested that being uninsured is a short-term problem, not a long-term condition. Even short periods of time without insurance do put people at significant financial and health risk. But being without health insurance is not a short-term problem. A researcher from the University of Missouri reports that nearly 75 percent of uninsured Americans are "chronically" uninsured, and will remain uninsured for longer than one year. Less than one in twenty out of those uninsured today will obtain health coverage before they have been uninsured for five months.

**Distribution of Uninsured, by Time without Coverage**

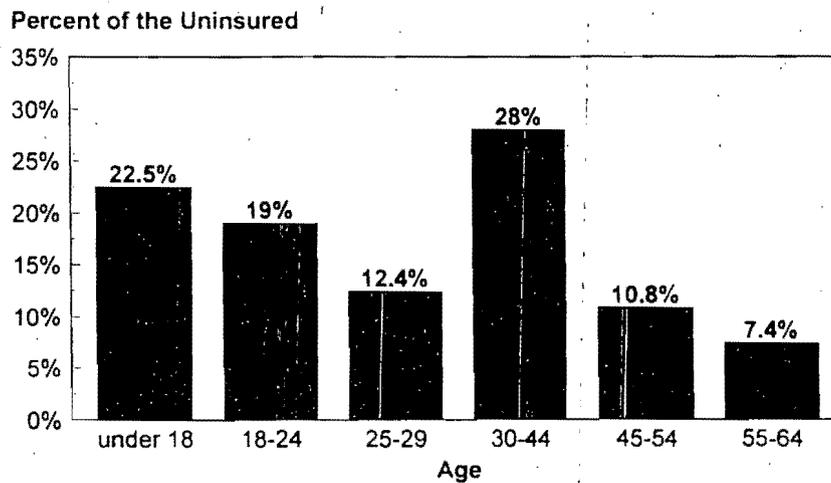


**Myth #4:** *The uninsured are mainly young and healthy; they choose not to buy insurance.*

**Reality:** Almost one quarter of the uninsured are children. Nearly half of the uninsured are over 30. Less than 30 percent of the uninsured are between 18 and 30 years of age.

While a disproportionate share of the uninsured are young, this is the result of low incomes and poor access to affordable insurance.

### Age of the Uninsured



**Myth #5:** *I have health insurance—the uninsured do not affect me.*

- Reality:**
- Americans who lose their jobs may well become uninsured.
  - Private insurance costs are high because of the uninsured.
  - Taxes are higher because of high Federal health costs.

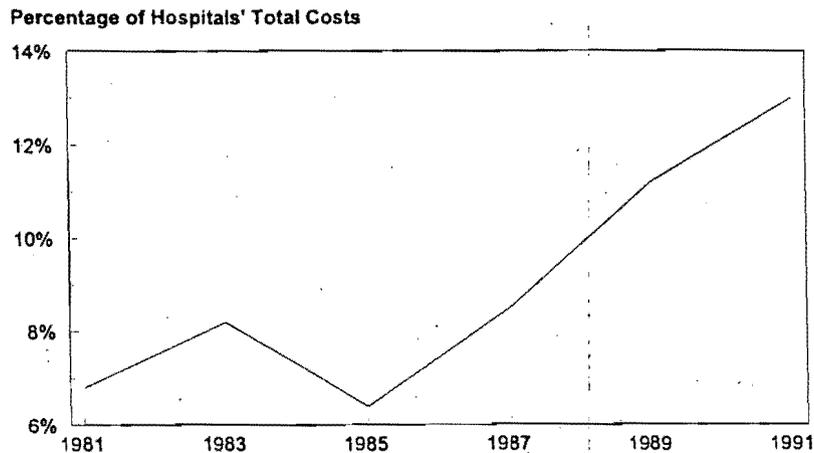
Nine out of ten Americans with private health insurance receive insurance through employers. Those who lose their jobs for an extended period of time may well lose their health insurance.

In addition, the uninsured place a large direct burden on those who do have insurance -- through higher taxes and through higher private insurance premiums. The effects of a large uninsured population go well beyond the individuals without coverage. The uninsured do receive health care -- often in emergency rooms, at very high costs. Hospitals and doctors raise the fees they charge those who have private insurance in order to cover the bill for the inefficient, high-cost services received by the uninsured.

The lack of private health insurance for some raises taxes for all. Some say the obvious solution is to cut, or "cap," federal health care spending. But cutting Medicare and Medicaid puts pressure on doctors and hospitals to raise the fees they charge those with private insurance. As the government pays less, everyone else pays more.

According to the Congressional Budget Office, unreimbursed costs for hospitals alone totaled over \$28 billion in 1991. As a result, private payers are charged substantially more by hospitals than the actual cost of their services.

**Hospitals' Unreimbursed Costs, 1981-1991**



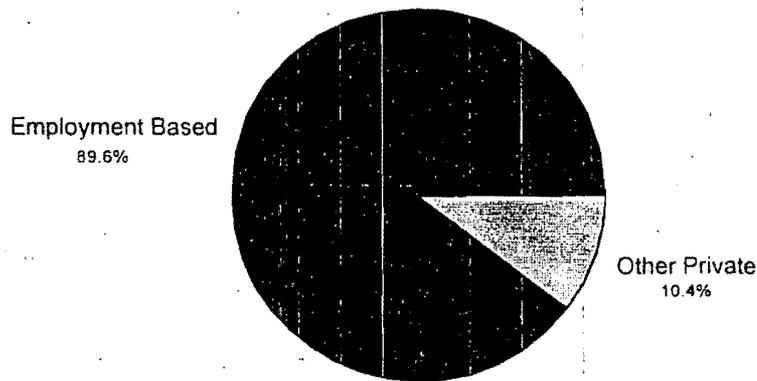
**Myth #6:** *An employer mandate is not necessary to fix the health care system, or to decrease the number of uninsured.*

**Reality:** The United States has an employment-based health care system. The major cause of increasing numbers of uninsured is employers dropping coverage.

According to the March 1993 Current Population Survey, nine out of ten of the nonelderly who purchase private insurance obtain it through the workplace.

Recent increases in the number of uninsured can be attributed to a decline in the number of employers who offer coverage. The share of the nonelderly population with employment-based coverage declined from 66.8 percent in 1988 to 62.5 percent in 1992. This fall was partly offset by a rise in the number of nonelderly Americans with publicly-financed health insurance -- from 12.4 percent to 15.1 percent. Even with this boost in publicly-financed coverage, the share of the non-elderly who are uninsured grew from 15.9 percent of the population in 1988 to 17.4 percent in 1992.

### Source of Private Health Insurance, 1992



## **Conclusion**

For millions of Americans with health insurance, the fear of losing their health coverage is a constant source of insecurity: over 38 million Americans were uninsured at some point in time in 1992.

Universal coverage is a universal issue. It is not simply about the unemployed, the poor, and or the young and healthy. Hard-working Americans are disadvantaged by today's health care system, and have the most to gain by reform that includes universal coverage. Today, the statistics show that the poor and elderly are covered by government programs, while millions of working Americans and their families are uninsured. Universal coverage is essential to strengthen the link between work and security.

It makes sense to build on the employer-based system. Most people today with private insurance obtain it through their employer -- it is a system that works for the vast majority of Americans. With universal coverage, small business will pay the same rates for the same coverage as do large businesses, and those who purchase insurance will no longer pay for those who do not.

## NOTES

Unless otherwise indicated, all numbers come from the March 1993 Census Population Survey. All CPS numbers refer to the non-elderly population (less than 65 years of age).

1. *Whither the Health Care Crises? Misinterpretations of Chronically Uninsured Estimates*, Timothy McBride, University of Missouri-St. Louis, April 1994.

# Alabama

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Sonny Callahan	102	80	79.0
2	Terry Everett	97	78	79.7
3	Glen Browder	102	81	79.0
4	Tom Bevill	101	80	79.4
5	Bud Cramer	91	73	80.2
6	Spencer Bachus	85	68	80.6
7	Earl F. Hilliard	116	90	77.5
<i>Total</i>		694	550	79.3

# Alaska

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Don Young	84	76	90.5

# Arizona

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Sam Coppersmith	86	80	93.3
2	Ed Pastor	129	113	87.3
3	Bob Stump	78	71	90.6
4	Jon Kyl	77	72	93.3
5	Jim Kolbe	84	75	90.1
6	Karan English	87	77	88.6
<i>Total</i>		479	416	86.8

# Arkansas

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Blanche M. Lambert	126	109	86.1
2	Ray Thornton	114	100	87.6
3	Tim Hutchinson	118	104	87.6
4	Jay Dickey	120	104	86.1
<i>Total</i>		5,937	5,052	85.1

# Colorado

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Patricia Schroeder	80	66	81.6
2	David E. Skaggs	63	53	85.3
3	Scott McInnis	79	65	82.1
4	Wayne Allard	76	64	83.3
5	Joel Hefley	58	48	82.3
6	Dan Schaefer	55	48	86.0
<i>Total</i>		412	343	83.3

# Connecticut

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Barbara B. Kennelly	46	37	80.0
2	Sam Gejdenson	41	33	80.4
3	Rosa L. DeLauro	44	36	80.4
4	Christopher Shays	43	35	80.2
5	Gary A. Franks	40	33	81.6
6	Nancy L. Johnson	39	32	82.3
<i>Total</i>		255	206	80.8

- **WELL, I DON'T THINK WE'LL PRODUCE ANY HEADLINES TODAY. THE HEADLINE WILL BE IN A FEW WEEKS: "CONGRESS PASSES HEALTH CARE REFORM." BUT BETWEEN NOW AND THEN, YOU'LL BE FLOODED WITH COMPLEX -- AND CONTRADICTORY -- INFORMATION. SO, WE WANT A CANDID DISCUSSION.**
- **TODAY'S AGENDA IS THIS: IN THE FIRST HALF HOUR, DR. TYSON WILL DISCUSS INSURANCE REFORM ... DR. RIVLIN,**

COST CONTAINMENT ... I'LL SHARE  
INFORMATION DEVELOPED BY TREASURY ON  
THE DEMOGRAPHICS OR CHARACTERISTICS  
OF THE UNINSURED ... AND BOB RUBIN  
WILL REVIEW WORKFORCE ISSUES.  
THEN WE'LL OPEN IT UP FOR QUESTIONS  
AND COMMENTS.

- LET ME SAY ONE THING BEFORE LAURA  
STARTS. MOST OF YOU KNOW WHEN I WAS  
IN THE SENATE, ALONG WITH CHAIRMAN  
ROSTENKOWSKI, I AUTHORED AN

**INCREMENTAL BILL -- TO CREATE VOLUNTARY ALLIANCES; ADDRESS INSURANCE ISSUES LIKE CHERRY PICKING AND PORTABILITY; ADD PREVENTIVE BENEFITS TO MEDICARE; AND MAKE PREMIUMS FULLY DEDUCTIBLE FOR THE SELF-INSURED. MY BILL PASSED THE SENATE -- TWICE -- BUT IT DIDN'T MAKE IT INTO LAW. NOT BECAUSE OF SUBSTANCE, BUT BECAUSE OF POLITICS.**

- I WROTE AN INCREMENTAL BILL, BECAUSE I FELT IT WAS THE BEST WE COULD GET THROUGH -- AT THE TIME. PRESIDENT CLINTON FEELS -- AND I CONCUR -- WE CAN DO BETTER NOW. THE TIME IS RIGHT, AND WE HAVE A PRESIDENT WHO IS FULLY COMMITTED. IT'S DIFFERENT ON THE REPUBLICAN SIDE, TOO. WHEN IN YOUR WILDEST DREAMS DID YOU THINK BOB DOLE WOULD PROPOSE A BILL CALLING FOR \$100 BILLION IN SUBSIDIES?

INTRODUCE LAURA  
INTRODUCE ALICE

- I WANT TO DISCUSS THE CHARACTERISTICS OF THE UNINSURED. WITH THE HELP OF THREE CHARTS, I'LL GO OVER THREE MYTHS, AND THE REALITIES.

SLIDE 1

- THERE'S A MYTH THAT UNINSURED ARE UNEMPLOYED. THE REALITY IS, THEY'RE WORKING AMERICANS. THE VAST MAJORITY

-- ALMOST 85 PERCENT -- ARE IN WORKING FAMILIES.

- THIS CHART SHOWS THE JOB STATUS OF THE UNINSURED. 52 PERCENT WORK FULL YEAR, FULL-TIME ... 7 PERCENT, FULL YEAR, PART-TIME ... 25 PERCENT PART-YEAR ... WHICH LEAVES ONLY 16 PERCENT NOT WORKING.
- AMERICANS YOU'D EXPECT TO BE UNINSURED -- THE POOR, THE ELDERLY OR THE DISABLED -- ALREADY HAVE COVERAGE

THROUGH MEDICAID, MEDICARE, AND OTHER PUBLIC PROGRAMS, SUCH AS VA. SO, THAT LEAVES MOSTLY MIDDLE-INCOME WORKING FAMILIES AS THE ONES WITHOUT INSURANCE.

- AND THESE UNINSURED ARE NOT POOR. THREE-FOURTHS HAVE MODERATE INCOMES -- ABOVE THE POVERTY THRESHOLD. ONE IN THREE IS A MEMBER OF A FAMILY MAKING MORE THAN \$30,000 A YEAR.

**SLIDE 2:**

- **THE SECOND MYTH IS THAT THE UNINSURED ARE ALL YOUNG, HEALTHY PEOPLE WHO CHOOSE NOT TO BUY INSURANCE. THE REALITY IS, 44 PERCENT ARE OVER THE AGE OF 30.**
- **YOU CAN SEE FROM THE CHART THAT ONE QUARTER ARE CHILDREN. THAT'S CAUSED BY A COMBINATION OF LOW INCOMES AND HIGH INSURANCE PREMIUMS. BUT LOOK AT THE 18 TO 24 YEAR OLDS AND THE 25 TO**

29 YEAR OLDS. TOGETHER, THEY COME TO ONLY 30 PERCENT.

- THIS SAYS TO ME, THAT MOST PEOPLE WHO ARE UNINSURED EITHER HAVE AN EMPLOYER WHO DOESN'T PROVIDE COVERAGE, OR THE WORKER CANNOT AFFORD TO BUY IT WITHOUT SOME HELP WITH THE COST OF THE PREMIUM.
- AND FOR MOST OF THE UNINSURED, BEING WITHOUT INSURANCE, IS A LONG TERM, NOT A SHORT-TERM PROBLEM.

**THE UNIVERSITY OF MISSOURI CALCULATES THAT NEARLY 75 PERCENT OF UNINSURED WILL REMAIN UNINSURED FOR AT LEAST A YEAR.**

**SLIDE 3**

- **THE THIRD MYTH: THERE ARE THOSE WHO THINK THAT IF "I HAVE INSURANCE -- THE UNINSURED DO NOT AFFECT ME." THE REALITY IS THEY AFFECT YOU -- A LOT.**

- **INSURANCE COSTS ARE HIGHER ...  
TAXES ARE HIGHER BECAUSE OF HIGHER  
FEDERAL HEALTH COSTS ...  
AND AMERICANS WHO LOSE THEIR JOBS MAY  
WELL JOIN THE UNINSURED.**
- **YOU CAN SEE FROM THE CHART, IN 1981,  
ABOUT 7 PERCENT OF A HOSPITAL'S COSTS  
WERE UNREIMBURSED COSTS. IN 1991  
(THOSE ARE THE MOST RECENT NUMBERS WE  
HAVE), IT'S 13 PERCENT. CAN YOU  
IMAGINE IF 13 PERCENT OF YOUR READERS**

**DON'T PAY THEIR SUBSCRIPTION. IF 13 PERCENT OF YOUR ADVERTISERS DON'T PAY UP. YOU WON'T BE IN BUSINESS LONG, OR YOU MAKE UP THE LOSSES BY CHARGING OTHER CUSTOMERS MORE.**

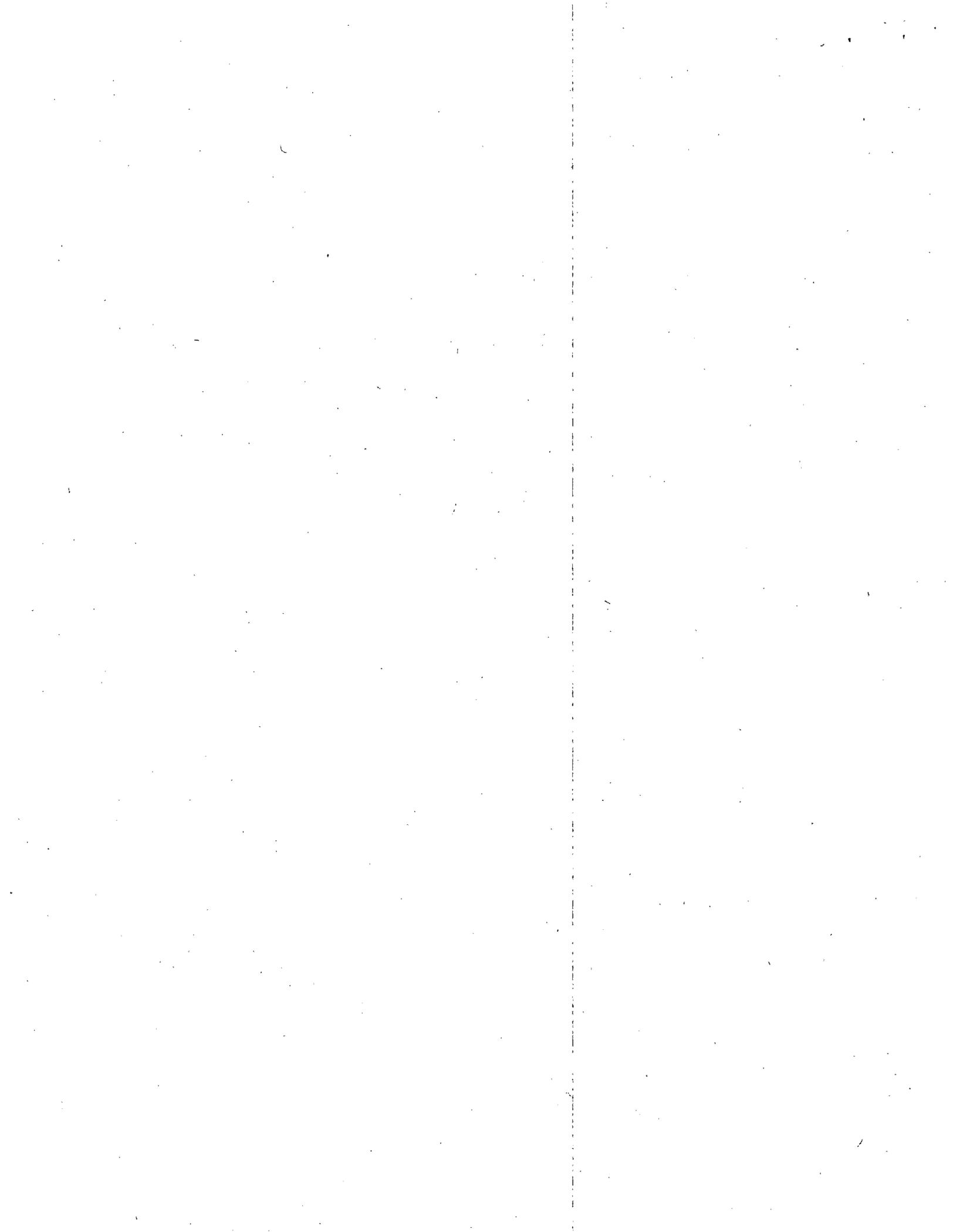
- **ACCORDING TO THE CONGRESSIONAL BUDGET OFFICE, UNREIMBURSED COSTS FOR HOSPITALS ALONE TOTALED MORE THAN \$28 BILLION IN 1991. AS A RESULT, PRIVATELY INSURED PERSONS PAY**

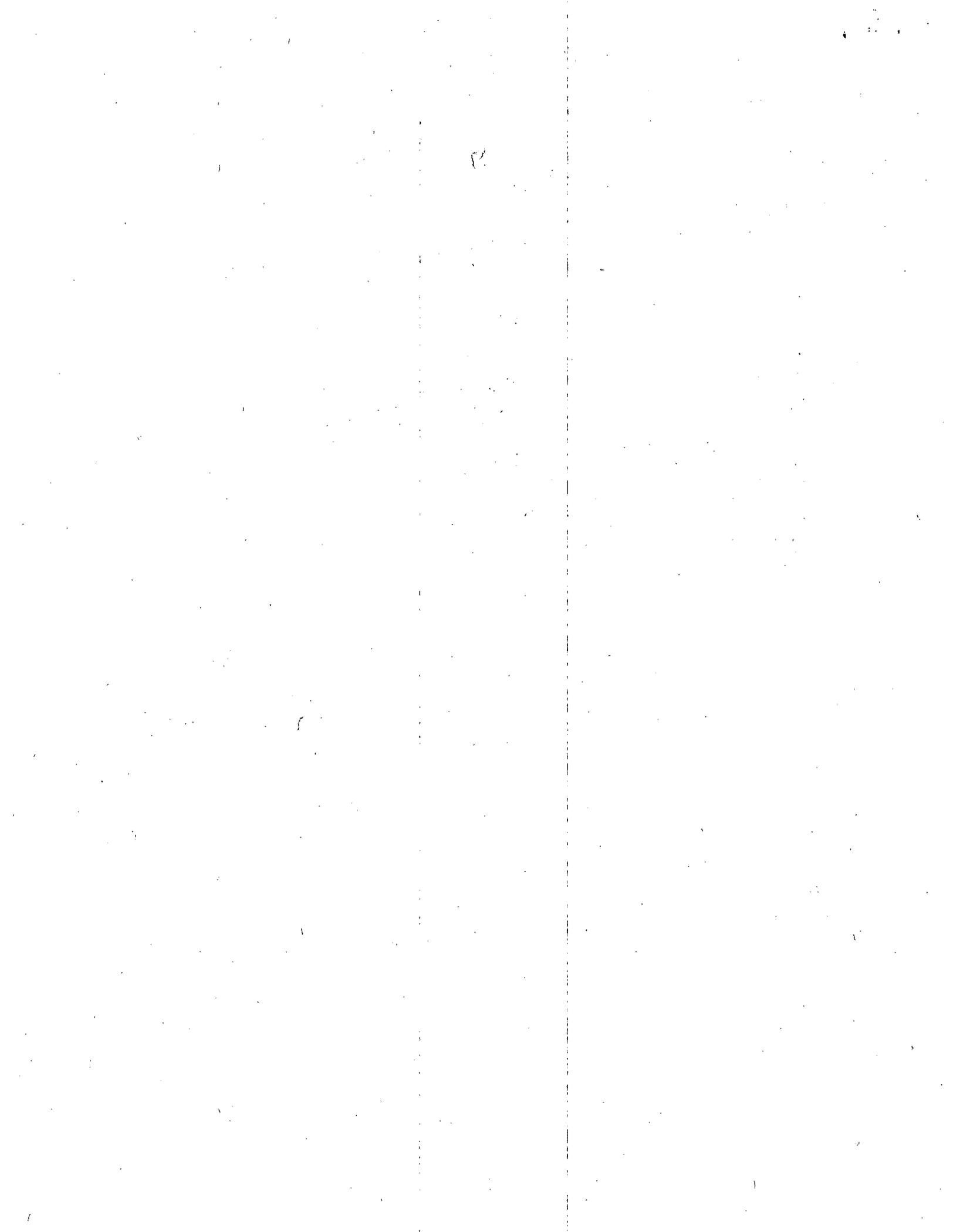
**SUBSTANTIALLY MORE TO HOSPITALS THAN THE ACTUAL COST OF THEIR SERVICES.**

- **WHEN THE GOVERNMENT PAYS LESS, PRIVATE PATIENTS PAY MORE. THE HOSPITALS AND OTHER PROVIDERS SHIFT COSTS TO PERSONS WITH PRIVATE INSURANCE.**
- **LET ME CONCLUDE BY SAYING UNIVERSAL COVERAGE IS ESSENTIAL -- TO PROTECT THOSE WHO HAVE NO INSURANCE, THOSE WHO MIGHT LOSE IT, OR THOSE WHO PAY**

HIGHER PREMIUMS THAN THEY WOULD IF EVERYONE WAS COVERED. IT MAKES SENSE TO BUILD ON THE EMPLOYER-BASED SYSTEM, SINCE MOST PEOPLE TODAY OBTAIN THEIR INSURANCE THROUGH THEIR EMPLOYER. AND WE NEED TO MAKE SURE HEALTH CARE IS AFFORDABLE TO BOTH EMPLOYERS AND EMPLOYEES.

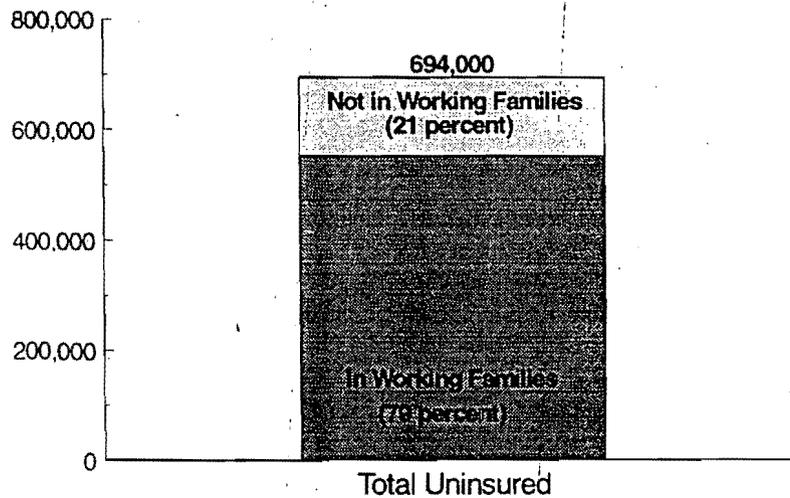
- AS THE PRESIDENT AND THE FIRST LADY SAY: UNIVERSAL COVERAGE IS ABOUT MIDDLE-INCOME WORKERS AND THEIR





# 694,000 PEOPLE IN ALABAMA DO NOT HAVE HEALTH INSURANCE, INCLUDING 542,000 IN WORKING FAMILIES

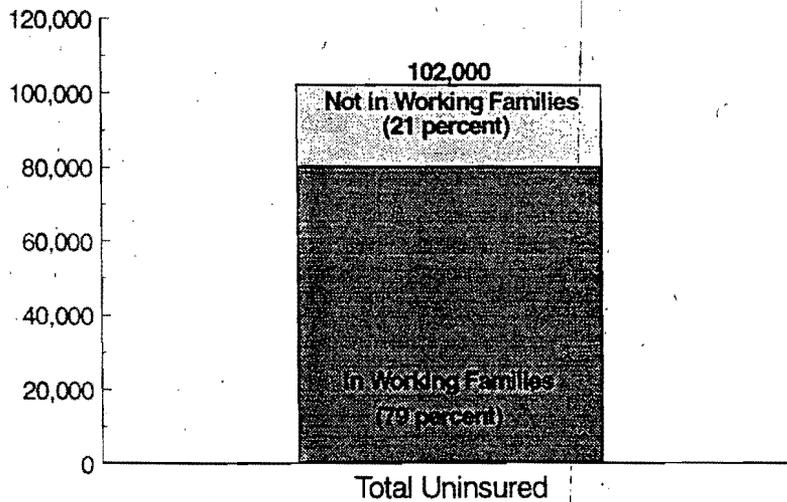
Number of Uninsured in Alabama



- The uninsured are exposed to major health risks and financial insecurity.
- People *with* insurance in Alabama pay higher premiums to cover the costs of caring for the uninsured.
- Without universal coverage, thousands of hard working people in Alabama will remain at risk of losing their health insurance.
- 542,000 (79 percent) of the 694,000 uninsured in Alabama are in working families.

**102,000 PEOPLE IN ALABAMA'S FIRST DISTRICT  
DO NOT HAVE HEALTH INSURANCE,  
INCLUDING 80,000 IN WORKING FAMILIES  
(Representative Sonny Callahan)**

**Number of Uninsured in Alabama's 1st District**



- The uninsured are exposed to major health risks and financial insecurity.
- People *with* insurance in Alabama's 1st District pay higher premiums to cover the costs of caring for the uninsured.
- Without universal coverage, thousands of hard working people in Alabama's 1st District will remain at risk of losing their health insurance.
- 80,000 (79 percent) of the 102,000 uninsured in Alabama's 1st District are in working families

## DISTRIBUTION OF UNINSURED

### Question:

Your data suggest that the uninsured are not equally distributed across States. Does that mean that a health reform bill that achieves "universal coverage" will be more beneficial to residents of certain States?

### Answer:

Your observation is right, residents of States with large numbers of uninsured stand to benefit substantially from universal coverage...but it is not correct to assume that persons who live in States with small percentages of uninsured won't also benefit. Let me explain.

In order to protect against loss of insurance as workers and their families move across State lines, it is important to extend insurance to every family. Moreover, many individuals and families in States with relatively smaller numbers of uninsured do not have adequate coverage. A comprehensive standard benefit package will both assure portability and upgrade coverage for millions.

Office of Economic Policy  
July 18, 1994

## COSTS TO SMALL BUSINESSES

### Question:

It strikes me that there is a "flip" side, if you will, to your argument that certain States with large numbers of uninsured will benefit most from universal coverage. Doesn't that also mean that small businesses in those States -- where many working uninsured are concentrated -- will have to bear a disproportionately large financial burden under the employer mandate?

### Answer:

Well, it is certainly true that under the President's plan, all businesses -- including small firms -- are expected to help pay for the cost of providing employer based coverage. And to the extent that they did not already do so, these businesses would have to make a contribution. But, it is very important to point out that small, low wage firms would be heavily subsidized through a system of discounted premiums. Moreover, small, medium and large firms that do offer insurance in those States would benefit significantly in that they are currently carrying a very substantial cost-shift burden [paying for the cost of caring for the uninsured]. Since small firms suffer most under the current system, these firms would be especially well-served by a better distribution of the cost of providing care.

Like the President, the committees dealing with this issue have acknowledged the need for a well-structured system of subsidies, and while the actual configuration of the subsidy is still evolving, I feel sure that at the end of the day we will be able to come together on a plan for helping individuals, families and firms make this change.

Office of Economic Policy  
July 18, 1994

## RELIABILITY OF DATA

### Question:

How good is this data once it is broken down into substate regions like Congressional districts? For example, is it fair to assume that communities with large numbers of uninsured do not provide adequate coverage through public health clinics -- services available to families but not captured in the insured data?

### Answer:

You're right, data is always better when it is aggregated -- that is, when you're dealing with data sets this large, you tend to be more accurate at the macro level. However, I am confident that the methodology used to arrive at the Congressional district breakdown is sound...and I don't think you'll find any better breakdown than what the Treasury staff has assembled.

Office of Economic Policy  
July 18, 1994

## SOURCE OF DATA USED

### Question:

Is there anything new here, Mr. Secretary? My impression is that the data you have included in this report is well known and already widely available. What should we look for here?

### Answer:

You are right, much of the health coverage data has been produced for years by various agencies, organizations and university based researchers. But given the complexity and texture of this debate, we thought you would appreciate having the most recent information about the uninsured assembled in one place. In addition, what is new here is the breakdown of information by Congressional district.

Office of Economic Policy  
July 18, 1994

## CONGRESSIONAL SUPPORT BY REGION

### Question:

Looking at the distribution of the uninsured by State, Mr. Secretary, it occurs to me that the final debate in Congress -- assuming you can get past the rhetoric of the last few weeks and months -- is likely to break down by region rather than by party. That is, Members from the southern and western States may either support universal coverage because there is such a great need for it among their constituents -- or oppose it because the burden on the businesses in those States is excessive.

Likewise, Members from the northeast, far west and midwest may either support universal coverage because it secures benefits that workers already have -- or oppose universal coverage because it is not such a serious problem in their States yet residents of those regions will have to bear a large portion of the cost of the subsidies. Am I right?

### Answer:

I think your point about the non-partisan nature of this debate is well taken. Both Democrats and Republicans represent districts and States where there are serious gaps in coverage, and even if coverage appears to be reasonable, there is the insecurity associated with losing your health coverage if you change or lose you job. For different reasons -- to secure existing benefits, to control costs, to extend benefits, to obtain subsidies -- we will all benefit from enacting a comprehensive health reform bill.

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## UNIVERSAL COVERAGE AND MANDATES

Question: If we can get close to universal coverage without mandates doesn't that make more economic sense than a system that even the Chair of the CEA admits may cost 600,000 jobs?

Answer:

- o First, you can't get close to universal coverage without a mandate of some kind or without going to a single payer system. Neither the Dole plan, nor the Senate Finance plan, nor the Cooper plan achieve the coverage targets they claim to achieve. Let's examine exactly what CBO said about Cooper.
- o On the one hand, CBO said that Cooper's bill could achieve 91 percent coverage if **the subsidies were fully funded**; but CBO also said that Cooper's bill underfunded the subsidies by \$30 billion a year and that its' mechanism for providers to simply absorb a subsidy shortfall is untenable.
- o Similarly, Lewin based its conclusion that Cooper would get to 91 percent coverage on this faulty assumption. CBO found that the Cooper plan has a \$30 billion a year financing hole in this plan, which will increase the deficit and leave 20 to 25 million people -- most of whom will be middle class -- uninsured.

## DEFINE UNIVERSAL COVERAGE

Question: The President has made it clear that he will veto a bill that doesn't achieve universal coverage but he has never defined the term "universal coverage." What would be an unacceptable time frame to get to universal coverage?

Answer: Universal coverage means that every citizen will have affordable comprehensive health benefits. Of course there will be people who fall through the cracks, but everyone will be able to obtain health care without fear of being bankrupted. The President deliberately made the time line flexible for achieving universal coverage and has always said that he would be willing to work with Congress on defining an acceptable phase in time. However, that date must be clear, and it must be in the foreseeable future.

## DEFINE UNIVERSIAL COVERAGE-FOLLOW UP

Question: By all indications the date for universal coverage is going to be well into the future, and certainly not before 1998. Doesn't that leave you with many of the problems of an incremental transition against which you are campaigning so heavily now? If the health care coverage and cost crisis is now, isn't a bill with a slow phase-in unacceptable?

Answer: Yes, the coverage and cost problem in health care are real, and we believe they need to be addressed in a comprehensive and timely way. At the same time, we are talking about an enormous industry that today constitutes one seventh of the economy. We're not about to rush a new system into place. The important thing is to be clear with consumers, providers and payers about the fact that we will achieve universal coverage within a reasonable length of time.

## TRIGGERS

Question: Would a more market-oriented bill based on managed competition with a hard to meet the President's bottom line goal? What about a soft trigger in which a commission would make recommendations to Congress if coverage targets weren't achieved?

Answer: I would first remind you that the President's proposal is built around market forces as the chief mechanism for controlling costs, with a backup of limits on how fast premiums can rise. It would be premature to speculate about what Senator Mitchell and Congressman Gephardt will prepare to their respective chambers. I can only reiterate what the President has said all along. He will only sign a bill that achieves universal coverage, but that he wants to work with Congress in developing a compromise bill on how to get there. The administration would certainly consider a bill with triggers, but only if we are confident that it can achieve universal coverage and significant cost control.

## STATE FLEXIBILITY OPTION

Question: How far is the Administration will to go with allowing States maximum flexibility to design their own health care systems? There are rumors that the Administration is considering allowing States to design completely new reform system -- beyond the single payer option specified in the Health Security Act. Would the Federal government merely make block grants to States for subsidies? Wouldn't this maximum flexibility policy put already stretched State budgets even more at risk? What is the Administration's position on the California ballot initiative to go to a single payer system?

Answer: ERISA is the Federal law that covers pensions, health plans and other employee benefits. ERISA was enacted in 1974. I helped push the bill through the Senate Finance Committee. I was there when the President signed the bill in the Rose Garden, 20 years ago this Labor Day. The provision in ERISA preempting State laws governing benefits has done some good over the years in protecting multistate employers from having to deal with 50 different State laws.

But the balance here is allowing the people closest to the ground -- those back home in the states, counties and cities -- to have some flexibility to adapt their health system to meet their needs, while at the same time providing enough national uniformity to make sure that health plans don't have to deal with 50 different State laws and thousands of local laws. Every issue must be looked at with an eye toward finding the best mix of national uniformity and local flexibility. We are continuing to work with the business community and the State and local governments to get the right balance.

## DEFENDING THE MANDATE

Question: All of your arguments for universal coverage are really arguments for a mandate on businesses and individuals to purchase insurance. You yourself once argued as a senator for a more incremental reform -- one that wouldn't achieve universal coverage but would make the purchase of health insurance more affordable and accessible. Could you envision a scenario in which the President would sign a bill with no mandates? In other words, could there be a bill that achieves universal coverage without any mandates?

Answer: We in the Administration believe the best way to achieve universal coverage is through a system of shared responsibility between employers and individuals. I think we've seen some examples of problems with passing incremental reforms in the absence of universal coverage; in New York State last year when small group reform was enacted, young, healthy people stayed out of the system, leading to higher premiums for everyone else in the small group community rate pool. We are concerned that the incremental reforms now being debated will not achieve the coverage levels they claim (91 to 94 percent) and if enacted they could worsen the situation by increasing cost of purchasing insurance which could cause some individuals and families to forgo coverage. In other words, there is potential for increasing the number of uninsured.

## SUBSIDY STRUCTURE

Question: Your chief complaint against the incremental plans is that the plan subsidies are insufficient and would cause perverse economic incentives for businesses. But the President's plan faces many of these same issues; the cap on Federal spending for subsidies leaves subsidies availability for eligible recipients in doubt. Also, firms have a large incentive to rearrange themselves to maximize subsidies under the HSA. How should a Mitchell/Gephardt bill deal with these questions?

Answer: With regard to the availability of government subsidies for businesses and individuals, I think it's clear that incremental reforms could cost the government much more than a system of universal coverage, since these nonuniversal reforms present employers with such a powerful incentive to drop coverage thereby increasing the amount government would have to devote to individual subsidies. Secondly, we are working with Majority leaders Mitchell and Gephardt on the issue of target subsidies; as you know many of us have thought for some time that individual-based subsidies involve fewer economic distortions than firm-based subsidies and I think there is interest in congress in that type of structure. But the first decision you need to make is whether you are going to go to a system of universal coverage or not. Everything else flows from that.