



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

THE DIRECTOR

November 7, 1995

MEMORANDUM FOR LEON PANETTA

From: Alice M. Rivlin  
Director

*AR*

Subject: 1996 Medicare Part B Premium Timing Issue

This memorandum describes decisions the Administration should consider prior to November 15 regarding Medicare Part B premiums and seeks your immediate guidance.

Under current law (OBRA 93), Part B premiums will drop on January 1, 1996, and beneficiaries' Social Security checks will grow by both the amount of the premium drop and the 1996 COLA. If a 1996 Part B premium increase (including an "increase" that extends the 1995 premium) is enacted as part of reconciliation, the Social Security Administrator will have to notify 36 million Part B beneficiaries that their Social Security payments will be reduced because their premium has risen.

Moreover, if the premium increase is enacted after November 15, the Social Security Administration will not have sufficient time to change the checks that will go out on January 1, 1996, and Part B beneficiaries will be overpaid because their checks will reflect the lower OBRA 93 premium. SSA will then have to deduct from beneficiaries' Social Security checks the amount of the overpayment.

**Background**

During the first week of each month, the Social Security Administration deducts the Medicare Part B premium from almost all Medicare beneficiaries' Social Security checks. A decrease in the premium means a larger Social Security payment and vice versa. In 1996, there will be about 36 million people enrolled in Medicare Part B.

The absolute dollar value of the 1995 Medicare Part B premium was set in law by OBRA 1990. This dollar value (\$46.10 per month) is equal to 31.5% of program costs in 1995. OBRA 1993 mandated that the premium in 1996-1998 should be equal to 25% of program costs. For 1996, this formula yields a premium of \$42.50 per month. Thus, under current law, the premium would decrease on January 1, 1996.

House and Senate Medicare legislation assumes that a Part B premium increase will take effect January 1, 1996. SSA has informed OMB that **it will be impossible to implement an increase in the Part B premium by January 1, 1996 if the increase is enacted after November 15, 1995.** If an increase is enacted after November 15, and the effective date

(January 1, 1996) is not changed, the Administration -- not Congress -- will be compelled to implement a downward adjustment to over 30 million Social Security checks during 1996.

*Even if current law for the premium is not changed but 1996 Part B spending reductions are enacted after November 15, the 1996 premium could still change.* The precise dollar amount of the premium would change because it is based on a percentage of program costs, which would decrease with spending cuts. Thus, it could be necessary to go back to beneficiaries and adjust the premium in any case.

## Options

- (1) **Do nothing and allow the Part B premium to fall, consistent with OBRA 93.** One option is to allow the lower, 25% Part B premium (\$42.50) to be deducted from January Social Security checks (thus increasing Social Security payments). This option is consistent with the Part B premium proposal in the President's June budget plan. It would also make Congressional proposals to increase the premium in 1996 appear larger because they would be compared to a lower premium. This might force Congress to decrease savings from beneficiaries or delay implementation of the premium increase.

One disadvantage of doing nothing is that, if Congress and the President agree after November 15 to increase the Part B premium in 1996, the Administration will be required to issue a notice implementing an increase in the Part B premium and a reduction in beneficiaries' Social Security checks in 1996. If the effective date of the premium increase is January 1, the Administration also could have to issue a notice of overpayment for January-April for all beneficiaries in mid-1996.

- (2) **Maintain the premium at \$46.10 per month.** An alternative is to maintain the premium at the 1995 dollar level of \$46.10 per month -- equal to about 28% of Part B program costs, even assuming up to \$1.5 billion in Part B program savings in 1996. The House Medicare bill has 1996 Part B program savings of about \$1.6 billion (CBO scoring).<sup>1</sup>

Extending the 1995 premium into 1996 can be described as a neutral position, since it prevents any changes from taking place until Congress and the Administration complete work on a reconciliation bill that is acceptable to the President.

A possible legislative vehicle available before November 15 is a debt ceiling extension or the next continuing resolution (CR). One rationale is that the 1995 premium, along with discretionary spending authority, is being continued for the short-term until Congress and the President agree on a 1996 budget.

Please let us know how you would like to proceed.

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<sup>1</sup>Note: This percentage is a preliminary staff estimate using OMB Medicare baseline, i.e., the baseline used for official Part B premium determinations. CBO estimates would differ somewhat.

November 11, 1995

MEMORANDUM TO THE PRESIDENT

From: Gene Sperling, Chris Jennings, Nancy-Ann Min

Subject: Medicare 31.5% Part B Premium Proposal

**CURRENT STATUS:** In the Republican reconciliation plan, around \$50 billion is raised over seven years through setting the Medicare premium at 31.5% of Part B program costs. The Republican leadership correctly understands that if this reconciliation proposal does not become law by mid-November, they will not be able to program the computers in time to implement this increase for January 1, 1996. The Republican leadership therefore fears that if they cannot pass this aspect of their reconciliation bill soon, a lower premium will be put in place for the beginning of 1996 and Republicans will face the politically difficult task of raising premiums by \$11 a month in the middle of the year. The Clinton balanced budget plan calls for a 25% Part B premium contribution and we have opposed any attempt to allow the Republicans to pass their increase in reconciliation -- and certainly by throwing it in a continuing resolution.

**SUMMARY: REPUBLICAN 31.5% PROPOSAL:** The Republicans argue that their proposal to impose a 31.5% Part B premium contribution simply extends current policy, since the \$46.10 that is in place for 1995 amounts to 31.5% of Part B program costs. Yet, the 31.5% would be a clear increase above current law -- and indeed far higher than any percentage since at least 1981. As discussed below, the fact that the *current Part B Premium amounts to 31.5% is a historical accident, and does not reflect the policy choice of any Congress to have Medicare Part B premiums at a 31.5% level.*

Indeed, the 1990 Congress set the \$46.10 amount for 1995 because they feared that soaring medical costs and manipulation of the health care baseline by a Republican OMB would lead the 25% contribution level to be too high. As it turned out, this attempt to protect Medicare beneficiaries backfired. When health care cost grew less than projected in 1990, the \$46.10 amount that was set into law caused recipients to pay more than 25% --- as the \$46.10 monthly premium ended up amounting to 31.5% of program costs.

WRG  
D.J.  
G.S.  
-  
Sperling Plan

Yet, starting in January 1, 1996, the Part B premium under both current law and the Clinton balanced budget proposal reverts to 25%. Because the \$46.10 monthly premium for 1995 accidentally amounted to a level higher than 25%, the reversion to 25% leads premiums for 1996 to actually drop for this one year from \$46.10 to \$42.50. As the Republican level would change current law by raising it to 31.5%, it would make premiums \$53.50 -- \$11 above current law per month, or \$132 a year and \$264 per couple.

**BACKGROUND AND HISTORY ON PART B PREMIUM CONTRIBUTIONS:** Over the last two decades, one of the primary policy goals for Democratic lawmakers has been to prevent Medicare premiums from increasing so much that they reduced the real, inflation-adjusted purchasing power of Social Security benefits. As you know, Social Security benefits have a cost-of-living-adjustment (COLA) to protect against inflation.

As Medicare premiums are deducted right out of the Social Security checks, if Medicare premiums rise more than the CPI, Medicare premium increases can have the effect of reducing the real value of Social Security benefits.

When Medicare first began, premiums were set as high as 50% of program costs. Yet, with high rates of medical inflation, premium increases grew too high and in 1972, Congress abandoned the 50% level, and instead linked premiums to the CPI. In 1981, President Reagan and Congress temporarily adjusted the underlying law to return to a specific percentage of Part B program costs -- only this time it was to a 25% level. Changing to a 25% contribution level did allow for increased revenues for reducing the deficit. Because of that, Administrations and Congresses have been able to contribute to deficit reduction simply by extending the 25% level -- since without such extenders it would revert back to being linked to the CPI, which raises less revenues for the general fund than a 25% contribution level. During the 1980s, Reagan or Congressional Republicans did try to raise the premium percentage to over 30% on several occasions, but each time it was defeated.

In 1990, however, when Democrats were constructing the 5-year budget deal with President Bush, they feared that Republican OMB officials might seek to raise premiums by manipulating the health care baseline. Therefore, Democratic lawmakers temporarily abandoned the 25% percentage level and decided it was safer to lock in specific dollar amounts for each of the five years in the 1990 agreement. For 1995, the amount selected was \$46.10 and as mentioned above, this turned out to be higher than projected -- 31.5%. *Yet, it is crucial to note that "31.5%" was never legislated by any Congress, and that intent of the legislation was in reaction to fears that a 25% level would be too hard on beneficiaries.*

In 1993, when we were putting together OBRA 1993, the Democrats did not fear that the Clinton OMB would manipulate the baseline to raise Medicare premiums -- and as they had seen that using set amounts had not worked -- they returned to a 25% level for the years in our plan that went beyond the 1990 agreement. Therefore, there were set dollar amount from 1991-1995, and a return to the 25% ratio for the remaining three years of OBRA 1993 -- 1996, 1997 and 1998. After that -- unless there are extenders -- the law returns to linking Part B premiums to increases in the CPI.

WILLIAM COI  
CENTRAL  
ALSO, SUBJECT

What the Clinton balanced budget plan does is extend this 25% for the entire period of the balanced budget plan. Even though we are extending the traditional 25% premium policy, this "extender" actually gives us some Part B savings after 1998 because without our 25% provision, the law would revert back to only increasing premiums by the CPI in 1999.

In sum, despite the Republicans efforts to suggest that having a 31.5% premium contribution is not raising premiums -- it just isn't so. The fact that the premium for 1995 amounted to 31.5% was an accident. Indeed, while there may have been times in the 1970s where set premium amounts were higher than 25%, the Republican proposal would be legislating the highest set percentage for Medicare premiums since 1972 and would affect all seniors regardless of incomes.

cc: Leon Panetta  
Erskine Bowles  
Alice Rivlin  
Laura Tyson  
Carol Rasco  
George Stephanopoulos  
Pat Griffin  
Jen Klein

Premium Cap File  
Calltransmed

Topic: Glide Path For National Health Spending

Proposal: Shift from annual budget targets to multi-year "glide path" budgeting

Specifics: Rather than set & enforce budget targets for each year, keep the same end point but allow some year-to-year variations. Example (Clinton plan #s): Keep 5.2%, 4.7%, 4.1%, 3.5%, 3.5% as "glide path", but firm control total would be cumulative 22.8% increase in spending over 1996-2000 (%s are multiplicative, not strictly additive - so total growth is more than the 21% sum of the annual averages)...

First "check point" would be the 3rd year...for any state more than about 3% over the "glide path" at that point corrective action would be required to get back toward glide path, i.e. more than 3% over the cumulative 14.7% total of the glide path. A 1.5% deviance allowed in year 4. Budget total fully enforced in year 5...  
Optional interventions would be authorized starting in the first year, if premium bids were above targets.

Rationale: Hitting exact yearly spending totals is extremely difficult even for the federal budget, which has been moving toward multi-year budgeting and spending controls.

As a practical matter, health plans (as well as states and the federal government) will have difficulty in managing the health system's spending year-to-year, particularly during the initial 2 year transition period when 65 million + persons are being added to private insurance rolls, benefit packages are being standardized, premiums are shifting from experience rating w/ underwriting to community rating or modified experience rating, individuals are switching plans, etc. A plan would be bidding a 2nd year premium still having only partial 1st year information on who its enrollees are and what they will cost. Ability to estimate costs should improve thereafter.

Imposing immediate price controls/rollbacks for failure to hit every annual target precisely, particularly in the first 2-3 years, risks excessive and unnecessary intervention in the market.

This approach effectively controls total federal spending for the 5-year implementation period to the same amounts that are CBO-scoreable under annual controls

Topic: Mid-course Corrections To Stay On Glide Path - Health Alliances

Proposal: Provide market-oriented options for mid-course corrections in health spending, targeted at overly-expensive plans, so that mandatory price controls/rollbacks across-the-board are not needed.

Specifics: Health alliances should be given authority - if premium bids exceed glide path - to apply one or more incentives for high cost plans to reduce expenses, including:

- establishing upper limit on premium that can be charged for the standard benefit package; high-cost plans will either have to reduce their premiums to this amount or drop out of alliance;

option: allow plans to increase deductibles (but not change any benefits) to meet premium cap... allows high-cost plans to remain in alliance & gives individuals opportunity to choose them - research shows that high deductible is a competitive disadvantage, so plan still has greater market pressures for economy

- freezing enrollment in high-cost plans (an effective action CalPers applied to Kaiser); high-cost plan will have to moderate costs if they want more growth;
- allowing general negotiating authority with threat of being able to bar plans from the alliance... alliance would thus have same discretion as large employer benefits office and purchasing cooperatives, able to use group purchasing clout to get best deals for members.

Rationale: These options allow alliances a broader array of effective tools than the Clinton plan makes available. In particular, they reflect the view that excessive plan premiums may be best dealt with by strengthening competitive pressures on the high-charging plans to keep within spending targets

Topic: Initial Budget Issues

Proposal: Strengthen provisions against being "over the glide path" so far in year 1 & 2 that getting back to it starting in year 3 is too difficult - particularly from "windfall" profits that come from new coverage of the uninsured - but without initial price control requirements

Specifics: Each alliance would issue a "minimum expected savings" notice to prospective plan bidders and employers prior to each year which show much premiums should be reduced due to providers reducing their "cost shifts" for the uninsured who will now have coverage, administrative paperwork reductions, etc.

The alliance actions to reduce spending, in addition to the pro-competitive options outlined above, could also include specific actions to deal with provider "windfalls" that come from failures to offset additional revenues from the previously uninsured with price cuts for most payers. If a state found that spending was over the glide path, partly for this reason, it could impose a provider tax, which would be rebated to providers that submitted an independent auditors report to show that such offsets had occurred; funds from providers that could not offer such proof would be split between federal and state governments and individual tax rebates, to offset additional expenses.

Rationale: If annual budget controls, enforced through potential price roll-backs, are not required, there is at least a possibility that 1st year bids may be significantly over the glide path. An alliance and state should have a number of options for dealing with this situation, as outlined in other papers; these options provide specific preventive actions and recapture authority to deal with the largest "must have" savings to achieve the restrained private sector premium targets.

Topic: Mid-course Corrections To Stay On Glide Path - States

Proposal: Each state would be responsible for analyzing its own health care spending and for developing a series of options for decision-makers about how to stay on the glide-path, if such actions are necessary. These reports would be available for determining corrective action starting with the 3rd year "check point"

Specifics: Each state would establish a State Health Board (or commission) to assess state health spending compared to nationally-set targets and appropriate actions if a state were over its "glide path". The Board would function much like CBO, with its scorekeeping and annual "reducing the deficit options" report to Congress

The analyses would analyze price levels, use, reasons for spending increases and comparisons with other national and regional data to determine where state spending and/or inflation were excessive, the causes, and options for appropriate corrective action.

The state boards would specifically be asked to assess reasons for poor market performance and to recommend actions to strengthen markets, as well as for government regulatory action where market initiatives would not be successful

Rationale: A state's health spending could exceed the federal glide-path for several reasons, including anti-trust violations and price-fixing, monopoly providers, unmanaged competition among insurers, lazy insurers, lack of consensus on medical treatments, self-dealing providers, etc. Premium caps on the insurers can get at only some of these problems. The treatment should fit the diagnosis.. or, to vary the metaphor, only the bad guys should be sent to the penalty box...

Stephen Zuckerman and Jack Hadley

# Clinton's Cost Controls Can Work

Controlling medical care spending is "Job One" for the Clinton administration's health care reform plan. System savings from successful cost control will help pay for extending insurance to the 37 million Americans who don't have it, for making sure that those who have it can't lose it and for guaranteeing that every insurance plan includes a comprehensive benefit package.

Not surprisingly, critics from both the left and right are concentrating their firepower on the administration's cost-control plan. The criticisms can be roughly divided into two camps. One is that the plan's cost-control features won't work. The other, oddly enough, is that they will work too well and lead to massive disruption in the provider system and the rationing of care.

What is the administration's cost control plan? Although often ridiculed as being off, by and for policy wonks, the basic strategy is quite simple. It has two lines of attack. The first is to promote competition among insurance plans under a cap on the average premium in an area. The second is to limit the amount of new money flowing into the system by capping the rate at which insurance premiums are allowed to increase.

The Clinton proposal requires that all insurance plans offer a comprehensive package of benefits and charge the same premium to all comers, regardless of age, health history or employment situation. According to the theory of managed competition, with the product standardized and insurance companies less able to compete by rejecting or avoiding high risks, competition will have to take the form of price and quality competition. Insurance plans will attract customers and prosper by providing value for money.

In spite of the promise of managed competition, it largely remains a theory. To put teeth into it, the Clinton plan will impose a financial penalty on any insurance plan that tries to increase its premium more than the cap allows. There is little doubt that if faced with constrained revenues, insurance plans will limit their expenses. Each plan will decide the best way to do this, including constraining the overuse of services and limiting what they pay doctors, hospitals and other health care providers. But they will have every incentive to do it in a way that doesn't drive away subscribers. One critic characterized this approach as "getting the insurance plans to do the government's dirty work." However, it seems far preferable that insurance companies that are responsible to their subscribers make these decisions than having the federal government involved in detailed price negotiations and review procedures with individual hospitals and physicians. As another critic put it, "That's like bombing from 30,000 feet. You can't see whom you kill."

In reality, the administration's cost-containment goal is modest. Its original estimate is that annual savings would be \$136 billion in the year 2000. That's a lot of money to anyone. But let's put it into perspective. At the time this estimate was made, the Congressional Budget Office projected that health care would absorb 18.9 percent of GDP by the year 2000. The Clinton plan would bring that down to 17.3 percent. We currently spend 14.3 percent of GDP on health care, while no other industrialized



country spends more than 10 percent. Thus, the Clinton plan's "draconian" cost-containment combination of more competition and caps on premium growth permits about a 3 percent increase in the share of GDP going to health. This plan does not try to shrink health spending relative to where we are now. No health care jobs will be lost, though fewer new jobs may be added in the future.

How will the system respond to these constraints? The specter of sick patients being unable to receive care is completely unfettered. The U.S. health system is fraught with inefficiencies and excesses that have no measurable health benefits. The constraints on spending growth will, for example, force more triage to reduce the estimated 15-30 percent of diagnostic tests and surgeries that may be unnecessary. Private insurers will no longer be willing to pay providers prices that are 30-40 percent above Medicare, nor should they. Providers will be able to survive with lower prices for private patients, because universal coverage will mean an end to uncompensated care and low prices for Medicaid beneficiaries.

Studies of the present system have shown that hospital costs are 10-15 percent higher than they would be if all facilities produced services more efficiently, and this excludes savings that would accrue from not producing unnecessary services. Imposing financial pressure through caps on premiums means some hospitals will scale back their investments in buildings and equipment—which are often underutilized—and reorganize their staffs.

Our own current research on a nationwide sample of almost 1,450 hospitals suggests that they respond to financial pressure primarily by controlling costs. The 25 percent of hospitals with the lowest profits in 1987 experienced cost increases of 13.3 percent between 1987 and 1989 compared

with an average of 27.6 percent for hospitals with the highest profits. In contrast, for both groups of hospitals, total revenues grew at virtually the same rate, about 21 percent over the three years. 30-day post-admission mortality rates for Medicare patients improved slightly, and the shares of hospital patients covered by Medicare and Medicaid increased by about 3 percent.

Patients will also need to change. They may need to accept a less-intensive approach to diagnosis and treatment as currently practiced in the best-quality HMOs. And they may also need to consider whether a high-cost health plan is worth the extra money. If it is not, consumers will be able to choose a less costly health plan. People may not like these changes simply because change can be uncomfortable. However, Americans will no longer fear losing their coverage if they become very sick or lose their jobs.

How fast would spending growth begin to subside? If the speed with which hospitals have responded to Medicare's prospective payment system, other rate-setting systems and lowered-profits is a guide, the answer is almost immediately. When providers are paid less, they move quickly to cut their expenses and organize service delivery more efficiently. When Medicare phased in its prospective payment system between 1982 and 1984, hospitals that faced the greatest potential financial loss held their expense growth to one-third that of hospitals facing prospects of financial gain, 10.2 percent compared with 10.2 percent. Hospital-California that faced strong competitive pressure as well as prospective losses from PPS actually cut their costs by 4.3 percent between 1983 and 1984. The annual increase in the volume of so-called "overpriced procedures" provided to Medicare beneficiaries by physicians fell from 9.3 percent in 1986-87 to 2.4 percent in 1988-89 in response to a 2.4 percent cut in average fees. Given this evidence and congressional action within the next year, the system should be able to adjust by the year 2000 without major adverse consequences.

The Clinton proposal aims to alter incentives—a combination of regulatory and market forces. Some critics would rather see much greater reliance on changes in the tax treatment of health insurance premiums as the way to change incentives. Despite its intellectual appeal to some, there is little evidence to show that this approach will succeed. On the other hand, even though systems of regulated spending and price controls have good track records of controlling costs, they do not have widespread political support. Most people view such systems as administratively burdensome, inflexible and likely to lead to rationing. The Clinton proposal relies on competition among plans, but limits the amount of tax-subsidized dollars that can flow into the system. It requires the development of a potentially regulatory framework for limiting total spending. This compromise. But, its acceptability and effectiveness may be greater than either pure alternative.

Stephen Zuckerman is a senior research associate at the Urban Institute. Jack Hadley is co-director of the Center for Health Policy Studies at Georgetown University School of Medicine.

Communicating File

## TALKING POINTS ON ECONOMIST LETTER ON PRICE CONTROLS

DRAFT

*In an effort reminiscent of the scare tactics used in the health insurance industry's television campaign, William Niskanen, former member of Reagan's Council of Economic Advisers, now at the Cato Institute, and John Lott of Wharton released a letter signed by economists criticizing "price controls" in the Health Security Act. This letter is inaccurate and misleading; the President's plan doesn't have price controls. Instead, the Health Security Act relies on private sector competition to control costs, with a back-up limit on how fast the average American's premiums can increase. As leading health economists will attest, the letter, which, it should be remembered, criticizes only one aspect of the plan, does not accurately reflect the content or effects of the spending restraints in the President's plan.*

### **PREMIUM CAPS ARE NOT PRICE CONTROLS**

- Price controls call for government micro-management of every health care service, drug technology, and product. The President considered, but specifically rejected, a plan imposing price controls on health care. The President's primary strategy for cost containment is private sector competition -- creating the right economic incentives to bring costs in line and encourage health plans to compete on price and quality.
- The premium caps are a reinforcement measure to build discipline and certainty into our health care system. If employers are to be told they have the responsibility to contribute to coverage, they deserve the guarantee that their premiums won't rise unchecked and that the federal government will not spend without accountability.
- The Congressional Budget Office (CBO) released a report in September of this year which stated a number of necessary ingredients to increase the effectiveness of premium caps in controlling health care costs without adverse effects, such as instituting a standardized benefits package and mandating guaranteed renewal of insurance policies. The Health Security Act includes every one of CBO's suggestions for improving the effectiveness of limits on premium increases. [CBO "Controlling the Rate of Growth of Private Health Insurance Premiums" September, 1993]
- Government won't make decisions on specific prices; health plans will have to decide themselves how to become more efficient in a way that won't drive consumers to another plan. As Stephen Zuckerman and Jack Hadley, two leading health policy analysts wrote, "it seems far preferable that insurance companies that are responsible to their subscribers make

these decisions than having the federal government involved in detailed price negotiations and review procedures with individual hospitals and physicians." [Washington Post "Clinton's Cost Controls Can Work" 11/7/93]

### **LETTER FLAWED AND MISLEADING**

The letter contains numerous flaws and distortions -- which is probably why the names of the country's leading health economists are conspicuously absent from the list of signers. Here are just a few of the distortions and inaccuracies:

**Rhetoric:** "Price controls produce shortages, black markets, and reduced quality. This has been the universal experience in the four thousand years that governments have tried to artificially hold down prices using regulations."

**Reality:** We agree, but our plan has no price controls. A good analogy is regulation of public utilities, such as electricity and water, which have been hailed by economists as a market-oriented, effective regulation. You don't see electric and gas companies running out of money or indiscriminately cutting off service to consumers.

**Rhetoric:** "Your plan...imposes price limitations on new and existing drugs."

**Reality:** The President's plan does not set limits on all new and existing drugs. What limits are in the plan apply largely to the Medicare program -- limits proposed, supported and implemented by past Republican and Democratic administrations alike.

**Rhetoric:** "Your plan...caps annual spending on health care."

**Reality:** This statement is simply inaccurate. While the plan caps premium expenditures, it doesn't contain any provision to determine or enforce the nation's total amount of spending for health care. Every individual will have the option of following his or her doctor into a traditional fee-for-service plan

**Rhetoric:** "Caps, fee schedules, and other regulations may appear to reduce medical spending, but such gains are illusory."

**Reality:** The Reagan and Bush Administrations proposed numerous caps in the Medicare and Medicaid programs without adverse effects (and spending on these programs still grew astronomically). Would Mrs. Lott and Niskanen eliminate all of these controls? If so, who would they have pay the higher prices?

**Rhetoric:** "Your plan sets the fees charged by doctors."

**Reality:** Wrong. Most doctors (all but those in the traditional fee-for-service plan) will be paid by health plans under arrangements made by those doctors and health plans -- not by bureaucrats.

**Rhetoric:** "The result [of government regulation of gasoline]...forced people to waste hours waiting in lines..."

**Reality:** The analogy to oil regulation is both false and absurd. Oil is a limited good, most of which is imported. Unlike both oil and health, medical services are virtually unlimited. The more we're willing to pay for, the more of it can be produced. Unfortunately, while wasteful, inappropriate hospital admissions and other services costs lots of dollars, they don't result in better health -- just higher costs.

**Rhetoric:** "We will end up with...reduced innovation."

**Reality:** First, the Clinton plan specifically sets aside significant funding for academic health centers. Second, there are no spending limits on academic health centers, research institutions, think tanks, etc.

**Rhetoric:** "We will end up with...expensive new bureaucracies."

**Reality:** The last thing the President wants is big government bureaucracies, and that is exactly why he rejected a government-run plan. The Health Security Act calls for the minimal amount of new government needed to ensure that the market is operating to guarantee real choice, real quality and real competition. We expect most alliances will be run by groups of local businesses and consumers.

**Rhetoric:** "Threat of price controls on medicines has already decreased research and development at drug companies, which will lead to reduced discoveries and the loss of life in the future."

**Reality:** There is no evidence of decreased research and development since the President's plan was proposed. The threat of comprehensive reform may have caused some insurance companies and drug manufacturers to limit their profits and has caused hospitals to become more efficient.

### **PRICE CONTROLS PROPOSED UNDER GOP**

- It is ironic that Mr. Niskanen would lead an attack on the Clinton plan for price controls on health care, since Republican administrations have a long tradition of wage and price controls dating back to the Nixon administration. Under Reagan and Bush alone, at least 63 specific caps or freezes in the Medicare and Medicaid programs were enacted for

hospital fees, physician services, and states. In the absence of comprehensive reform, however, these cuts were simply shifted to businesses and consumers. [Department of Health and Human Services]

### ***DO THE PREMIUM CAPS WORK TOO WELL OR NOT WELL ENOUGH?***

- Many critics of the plan, including a number of the economists who signed the Lott-Niskanen letter, have criticized the Clinton plan's financing in recent months. But if they are attacking the premium caps, they must believe these controls work and the plan's financing works. If they don't work, then they won't cause any of the negative effects the letter claims they will cause. Which is it going to be? These critics need to get their stories straight.

### ***SERIOUS REFORM PLANS CONTAIN SIMILAR MEASURES***

- Several health care plans proposed in recent years -- from conservative Republicans such as Senator Kassebaum and Representative Michel to centrist Democrats such as Senator Kerry and Representative McCurdy to single payer advocates such as Senator Wellstone and Representative Stark -- contain cost control measures to restrain the growth of national health care spending.

***Michel*** (H.R. 3080) Under the Michel proposal, premium rates would be regulated by business class and limits would be placed on the variation of rates within a class of business. In addition, the rate of increase would be limited for small businesses.

***Kassebaum-Glickman*** (S. 325/H.R. 834 (Danforth, McCurdy co-sponsors) Costs would be controlled by placing binding annual limits on the maximum allowable rate of increase in "BasiCare" premiums.

***Stark*** (H.R. 200) A national health expenditure budget of the aggregate amount of private spending would be set annually. Premium rates would also be regulated, generally by using Medicare methods.

***McDermott-Wellstone*** An "American Health Security Board" would specify the total spending by the Federal government and states for covered services.

***Kerry*** (S. 1446) A Commission would control costs through a global budget set state by state, based on a national per capita cost calculation.

***Rostenkowski*** (H.R. 3205) A national limit would cap all expenditures except Medicare.

**Jeffords (S. 3331)** A national board would establish "MediCORE" budgets which would estimate and enforce total annual national expenditures.

**Bingaman (S. 3300)** This proposal would set national budgets for health care, calculated with data from states and a computation of national per capita costs.

**Daschle (S. 2523)** National public sector health spending, which would be managed at the state level. Hospitals and clinics negotiate with states to determine payment rates.

### **INTERNATIONAL COMPARISONS**

Nearly every other industrial country in the world has adopted some form of cost control mechanism for health care spending -- without resorting to rationed care or decreased quality. According to the General Accounting Office, "other industrialized countries have had more success than the United States in controlling the growth of health care spending without adversely affecting coverage or broad measures of health status." [GAO "Health Care Spending Control: The Experience of France, Germany and Japan" November, 1991]

### **PROMINENT HEALTH ECONOMISTS DISPUTE LETTER'S CONTENTS**

The following nationally renowned health economists, some of whom have been publicly critical of our plan, recognize the letter as misleading and distorted. They are available for comment at the attached phone numbers.

**Henry Aaron** Director of Economic Studies, The Brookings Institution 202/797-6121

**Charles Schultz** Brookings Institution, former member of the Council of Economic Advisers 202/797-6121

**Eric Reinhardt** Princeton University 609/258-4781.

**Lawrence Klein** University of Pennsylvania (Nobel laureate, 1980).

**Stuart Altman** Brandeis College. 617/737-3800.

**Joseph Newhouse** (has Cutler contacted? number?)

**Alan Blinder** Member, Council of Economic Advisers 202/395-5036

## Feldstein Criticism

Q: Dr. Feldstein has written that you have vastly underestimated the impact of this program on the deficit. How do you respond?

A: First, let me say that we will get the Medicare and Medicaid savings that Dr. Feldstein claims will be impossible. Broader employer coverage and system-wide reduction of cost growth make these savings possible.

In Dr. Feldstein's article, he also alleges that broader insurance coverage will raise utilization of care about 5 percent more than we think it will. He assumes that the currently uninsured will greatly increase their use of medical care. In fact, however, the Health Security plan encourages savings over spending. Even if Feldstein were right, however, there would be little direct impact on the government. Most of the cost of medical care under the Health Security plan is still spread over the employer based system.

Dr. Feldstein also argues that the Health Security plan's requirement that employers provide health insurance to their employees will reduce wages and cut tax revenues to the Treasury. Quite irrelevantly, he calculates how much revenue the Treasury would lose if no firms provided health insurance now and all were subjected to a new 7.9 percent payroll tax to provide such coverage. In fact, however, most people are already covered by employer provided insurance. Many of them have more expensive coverage than the Health Security plan requires. Firms whose costs were reduced by the Health Security plan will pay higher wages than they do at present, providing more work incentives.

ACCESS # 930714-0113.  
HEADLINE A Workable Alternative

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\* By Martin Feldstein

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SOURCE WALL STREET JOURNAL (J), PAGE A14

\* There is a growing political consensus that something should be done to extend coverage to the uninsured, to protect those who fear a loss of insurance, and to control the rapid rise in health care costs. Doing so does not require a radical change in our health care system. The broad goals of increasing protection and limiting health costs could be achieved by three changes to our current system.

\* First, require employer-provided health insurance plans to allow employees to continue coverage at their own expense when they change jobs ("portability") and eliminate exclusions and waiting periods for pre-existing conditions. Extend the same benefits to dependents, surviving spouses and divorced spouses. Any policy that did not have these features would lose the current favorable tax treatment of being regarded as an employer cost but not included in employee income. These changes would eliminate the principle concern of the 85% of the population who now have health insurance.

Second, use targeted programs to extend coverage to the 15% who are now uninsured. For example, the unemployed could be covered by using a fraction of unemployment benefits to pay for coverage. Colleges and universities that receive federal funds could be required to provide insurance or health services to students. Targeted programs could also deal with most others who are currently uninsured. These programs involve costs and taxlike distortions. But since they deal with only 15% of the population, they involve much less interference than programs like the White House plan, which would change the insurance of every American and raise marginal tax rates sharply.

\* Third, to help contain costs and make health care responsive to patients' preferences, change the tax rules that currently weaken cost sensitivity. Although many employers now use managed care to improve the cost-effectiveness of their health benefit spending, their net savings to shareholders and employees are reduced by the tax rule that health insurance outlays are deductible as a business expense without any limit and are not included in employees' taxable incomes.

This special tax treatment also makes employees prefer very comprehensive health insurance with small deductibles and co-insurance. Any arrangement that limits the value of the tax-free health insurance benefits that employers can provide would encourage corporate shopping for better managed care plans and would encourage individuals to select health insurance with greater deductibles and co-insurance and therefore to be more cost sensitive when they and their doctors choose among treatment options.

(See related article: "Board of Contributors: What's Wrong With the Clinton Health Plan" -- WSJ July 14, 1993)

End of Story Reached

ACCESS # 930507-0126.  
HEADLINE Tax Rates and Human Behavior

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\* By Martin Feldstein

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The Clinton administration continues to ignore the harmful effects of high marginal tax rates. The White House now talks of a new 7% payroll tax to substitute for employer premiums for health insurance. In fact, the new payroll tax would have to be at least 9% just to replace existing premiums. An additional tax equal to 6% of payroll would be needed to pay for the administration's plan to extend coverage to the uninsured and "underinsured."

The net effect of the new Clinton taxes would be to raise the marginal tax rate of typical employees by more than 15 percentage points. The White House appears unaware that taxes do more than transfer money from individuals to the government. High marginal tax rates also distort incentives, and those distortions waste valuable human and physical resources.

The proposed new taxes would come on top of marginal tax rates that are already remarkably high for ordinary working people. A single person who earns \$25,000 or a married person in a couple that earns \$40,000 already faces a 50% marginal tax rate -- a 28% federal income tax rate, a 15% employer-employee Social Security payroll tax rate, and a state income tax typically about 7%. The new taxes being considered would raise the marginal tax rate for these individuals to more than 65%!

An employer who now pays \$20 in wages and payroll taxes for an additional employee hour delivers only \$10 of extra spendable income to an individual whose total marginal tax rate is 50%. Adding a new 15% tax would mean that the \$20 would deliver only \$7 of additional spendable income to the employee. Any economy in which a \$20-an-hour employer cost gives only \$7 an hour of spendable income to the employee is headed for trouble.

Under the Clinton plan to replace existing employer premiums with a payroll tax, the tax payments would be directed by the employer to a health insurance provider. Proponents argue that this would simplify the insurance system and make it easier to deal with part-timers.

Some claim that the change from premiums to a payroll tax doesn't really matter because "it's just another way of paying for the same costs." This misses the important point that a payroll tax -- unlike the existing premiums -- would reduce the spendable income that results from each incremental hour of work.

A 9% payroll tax on top of the existing 50% marginal tax rate would cut the spendable income that results from an incremental hour of work by 18% of what it is today. This is true regardless of how the payroll tax is formally divided between employers and employees.

The sharp decline in the reward for working the additional hour would induce employers and employees to reduce taxable wages in favor of untaxed fringe benefits, shorter hours and longer vacations. This means a wasteful misuse of resources, a lower tax base, and therefore the need for an even higher payroll tax rate to

raise the same amount of revenue!

Even if substituting a payroll tax for the current premiums were administratively desirable, the distortions from the extra payroll tax would be so large that this idea should be shelved and forgotten.

The Clinton plan to provide health insurance to those who are currently uninsured or "underinsured" is so lavish that the government's own experts estimate that it will cost between \$100 billion and \$150 billion a year. That's equivalent to between \$2,700 and \$4,100 per uninsured man, woman and child. To finance it would take a tax increase equal to an additional 6% payroll tax. If the Clinton planners recognized the adverse effects of high marginal tax rates, they would scale back their plan and use employer mandates, not taxes, to broaden coverage.

The Clinton administration's willingness to consider increasing marginal rates for middle- and lower-income employees, as well as a 35% rise in the marginal rate of wealthy taxpayers, reflects a fundamentally incorrect view of how taxes affect individual behavior. The policy officials who advocate such taxes and the staffs that estimate their revenue impact assume that individual behavior is not affected in any substantial way by changes in marginal tax rates. That false assumption implies that higher tax rates produce correspondingly higher tax revenue and suggests that wasteful distortions of taxpayer behavior are not a problem.

During the past 20 years a substantial body of research by economists has made it clear that this "no response" or "small response" view is wrong. Statistical evidence has convinced the overwhelming majority of the economics profession that individuals respond very substantially to the incentives created by tax rules. Much of this research is directly relevant to understanding the impact of President Clinton's proposed tax hikes.

Economists agree that the behavior of married women is particularly sensitive to tax rates, an important fact since nearly 60% of them are working. Most studies imply that raising married women's marginal rates from 50% to 65% would reduce their hours worked by the equivalent of one day a week through more part-time work and a decrease in labor force participation. Yet the Treasury and congressional staffs ignore such employment reductions when they calculate the revenue effects of proposed tax changes. And the policy advocates ignore the distortions in behavior and the fall in national income when they propose massive tax rate hikes.

Statistical research by economists also shows that individuals who face the highest tax rates load their portfolios with untaxed municipal bonds and low-dividend stocks instead of more highly taxed bonds and that the incentive to do so would be much greater with a 40% federal tax on investment income than with the current 32% tax.

Fifteen years ago the staffs of the Treasury and Congress denied that the capital gains tax influenced investors' decisions about realizing capital gains. The mass of evidence that has accumulated since then has forced them to recognize that taxes do have a very powerful effect on the realization of gains. In analyzing President Bush's proposal to lower capital gains rates, the congressional staff estimated that the increased willingness of taxpayers to realize gains would offset more than 80% of the revenue that would

be lost if there were no impact on behavior.

Marginal tax rates also have a powerful effect on tax deductions. Although no one makes charitable contributions just to save taxes, a large volume of research shows that the amount of charitable giving is increased substantially by tax deductibility. Each 10% fall in the net after-tax cost of giving raises the amount given by more than 10% and reduces taxable incomes by an equal amount. Economic studies also confirm that home ownership and mortgage deductions are quite sensitive to higher marginal tax rates.

These substantial effects of marginal tax rates on earnings, on portfolio income, and on tax deductions for charitable contributions and mortgage interest, imply that higher marginal tax rates distort incentives and that those distortions waste valuable human and physical resources. They also imply that high marginal tax rates reduce taxable income and therefore generate less revenue.

These effects are particularly important for assessing the Clinton proposal to raise marginal tax rates on high-income individuals. Because of the way that proposal was designed, there would be a substantial distortion to incentives with little revenue gain. If individuals reduce their taxable income by just 10% of adjusted gross income in response to the sharp jump in marginal rates, the Treasury would collect only about one-fourth the revenue that would be collected if there were no behavioral response.

Although the Treasury and congressional staffs claim that they take some economic response into account in their revenue estimates of the Clinton plan, they refuse to say how much. They do admit that they completely ignore the change in employment and hours and any other changes that affect real income. My own estimates with Daniel Feenberg at the National Bureau of Economic Research imply that the government revenue estimators ignore almost all of the taxpayers' likely response. The members of Congress should demand to know what their revenue estimators are assuming before they enact a massive and damaging increase in marginal tax rates.

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Mr. Feldstein, former chairman of the president's Council of Economic Advisers, is a professor of economics at Harvard.

End of Story Reached

ACCESS # 930818-0044.

HEADLINE Board of Contributors:  
What's Wrong With the Clinton Health Plan

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\* By Martin Feldstein

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DATE 07/14/93

SOURCE WALL STREET JOURNAL (J), PAGE A12

\* Health care finance is likely to be the most substantial legislative battle of the Clinton presidency. The plan being completed by the White House staff would raise marginal tax rates by more than 12 percentage points for most taxpayers and make it more difficult to slow the growth of health care spending. Fortunately, such a radical increase in taxes is not needed to extend comprehensive insurance to the currently uninsured and to protect others against the termination of their insurance through unemployment, early retirement or the loss of a spouse.

The proposal that will soon be on President Clinton's desk looks something like this:

The government will design a standard insurance package, specifying a broad range of covered services and the amount of out-of-pocket deductibles and co-insurance that patients will pay. Medicare will continue to provide the coverage for those over age 65.

Current health insurance premiums will be replaced by a tax equal to 10% of family income up to a maximum of \$5,000 at a family income of \$50,000. Because of the limited taxes paid by lower-income families, a substantial shortfall would remain to be financed. Although no decisions have been made about how to finance this gap, the likely annual cost of at least \$50 billion is equivalent to a further one-tenth rise in all personal income tax rates.

The effect of all this would be to raise marginal tax rates dramatically for families with incomes under \$50,000. With the new taxes in place, a family with \$40,000 of income would face a combined marginal tax rate of more than 60%: the new 10% health insurance tax, the current 15% employer/employee Social Security tax, the 28% federal income tax rate (raised to at least 31% to finance the projected health insurance shortfall), a typical state income tax rate of 6%, plus state and local sales taxes.

In an attempt to disguise the true nature of the health insurance tax, the White House plan would describe it as a "payroll premium" to be paid by employers, with a complex adjustment process to deal with two-earner families and with nonpayroll income. But a tax is a tax. For families with incomes under \$50,000, the payroll premium would require the family to pay an additional 10 cents out of every additional dollar of income.

\* The payroll premium tax would not go to Washington but would be paid to state-level Health Insurance Purchasing Cooperatives (HIPCs) that, in turn, would contract with health care providers -- health maintenance organizations, managed care plans run by insurance companies, hospital-based care systems, etc. -- to offer the package of benefits designed by the government. In principle, all plans would be open to everyone without regard to pre-existing conditions.

In my judgment, this radical reform plan is bad in four

significant ways.

-- It raises marginal tax rates on the 70% of families with incomes below \$50,000 by at least 12 percentage points: a 10% health insurance tax and higher income taxes to finance the \$50 billion shortfall. Families with incomes over \$50,000 would pay the \$5,000 health tax plus additional income taxes.

\* -- It does not strengthen incentives to limit costs and to produce health care efficiently. Since patients would pay little or nothing out-of-pocket at the time of care, they and their doctors would have no incentive to seek lower-cost sources of care. Major employers that now use preferred provider plans to negotiate lower costs from hospitals and physicians would no longer have any incentive to do so if their costs are set by the 10% payroll tax.  
\* The future discipline on health care spending would have to be increased government regulations, with an inevitable decline in the quality of care and personal service.

\* -- It provides no mechanism for patients and their doctors to express their true preferences about spending on health care.  
\* Personal health care now exceeds one-fifth of all consumer spending, with an even larger fraction for lower income families. Many households might prefer to spend more on housing, food and other things and less on health care. But with comprehensive insurance designed by Washington bureaucrats, households have no way of influencing how they allocate their incomes between health care and other things.

-- It would substantially increase future budget deficits. The government revenue calculations assume that the health insurance taxes would not alter taxpayer behavior. But raising the marginal tax rate to 62% from 49% on middle-income taxpayers -- a 25% reduction in the net-of-tax share kept by taxpayers from each additional dollar of taxable income -- would reduce work effort and cause shifts from taxable compensation to nontaxable fringe benefits. If this 25% reduction caused a fall of even 5% in the taxable incomes of affected taxpayers, the government would lose more than \$50 billion a year in income and payroll taxes.

The government's failure to take this into account means that future deficits would be "surprisingly" large by an equal amount. But recognizing it explicitly would reduce political support for the health plan by requiring even higher tax rates. Future budget deficits would also be enlarged by cost overruns when the massive cost savings that White House officials attribute to "managed care" do not materialize.

\* My own preferred approach to health care reform, described briefly in the box accompanying this article (see related article: "A Workable Alternative" -- WSJ July 14, 1993), would be very different. But I also want to suggest an alternative plan that is much closer to the style and spirit of the current White House plan and therefore more likely to appeal to President Clinton and his advisers. This alternative, dubbed the A-plan (for Alternative), avoids the four serious defects of the current White House proposal.

\* The A-plan provides health insurance for the entire population in a way that limits the maximum health care costs to the same fraction of each family's income as the White House plan. Yet it avoids the large increases in marginal tax rates and the enlarged budget

\* deficit. It also helps to control costs and to make health care responsive to the preferences of patients and their physicians. If President Clinton likes the current White House plan, he should like the A-plan even more.

Under the A-plan, the government would specify the same range of covered services as under the White House plan. Employers and employees would pay 10% of income (up to a \$5,000 maximum) to a HIPC, just as under the White House plan. The government would make up the cost shortfall from general revenue.

Up to that point, the A-plan is essentially identical to the current White House proposal. But there the similarity ends. The critical difference is that under the A-plan the family would receive a Low Claim Refund at the end of the year equal to the difference between their medical bills and the amount that they and their employer paid to the HIPC. Thus a family with \$40,000 of income and \$1,200 of medical bills would receive a Low Claim Refund of \$2,800.

The Low Claim Refund has two distinct and important advantages.

First, the Low Claim Refund effectively eliminates the dramatic 10 percentage point increase in marginal tax rates. A family with \$40,000 of income that earns an additional \$100 would pay \$10 more in taxes but would receive \$10 more in their Low Claim Refund. Only if the family's health spending exceeded \$4,000 would an increased tax payment not produce an equal increase in the Low Claim Refund. Since only 40% of families with incomes under \$50,000 have health costs that exceed 10% of their incomes, 60% of those families would receive rebates and would therefore not face the additional 10% payroll tax on higher earnings.

\* For most families, the Low Claim Refund would make the total cost of health care lower than the White House plan. To offset this difference would require a larger subsidy to the HIPCs from general revenue. Preliminary analysis that I and my colleagues have done at the National Bureau of Economic Research indicates that this additional subsidy could be financed with a 4% payroll tax even if total family health costs were the same with the Low Claim Refund of plan A as they are with traditional insurance. In short, the Low Claim Refund cuts the 10% extra marginal tax rate to less than 4% for almost all families.

Second, the Low Claim Refund would make patients and their doctors more sensitive to the costs of care. Since an extra dollar of hospital or doctor charges would reduce the family's refund by a dollar, the patient would have a strong incentive to seek the most cost-effective care. With more than 60% of families eligible to receive refunds, the improved cost consciousness would be very substantial. With patients and doctors having a greater incentive to be cost-conscious, there would be less need for government regulation to control costs. With lower total costs, the tax rates required to finance the plan would be lower. Without Bureaucracy Moreover, patients making decisions between more health spending and greater Low Claim Refunds would help to shape the style and quantity of care instead of relying on the political/bureaucratic process to determine total health spending.

In practice, each family would also choose an insurance policy or other prepayment option from the HIPC to pay for health spending in

excess of 10% of family income. To give them an incentive to choose cost-effective options, families would receive rebates for low premium options and would pay extra for high premium options.

There are many matters of detail about the A-plan that could be modified. But the fundamental difference between it and what appears to be the current White House plan is the Low Claim Refund. It would permit limiting the net health spending for each family to no more than the White House plan but without the adverse tax and budget effects and with more favorable effects on the cost and responsiveness of health care spending.

\* When President Clinton decides during the next few weeks what plan to send to Congress, he should recognize that there are options that achieve his goal without higher taxes and that increase rather than diminish market pressures to contain health care costs.

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Mr. Feldstein, former chairman of the president's Council of Economic Advisers, is a professor of economics at Harvard.

(See related letter: "Letters to the Editor: Clinton Plan, fo a Healthier America" -- WSJ Aug. 18, 1993)

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End of Story Reached

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HEADLINE Board of Contributors:  
The Health Plan's Financing Gap

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\* By Martin Feldstein

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SOURCE WALL STREET JOURNAL (J), PAGE A18

Financing the Clinton health plan would require substantially more tax revenue than the administration admits. Unless there is rationing and government controls on the use of medical care, the expanded health insurance benefits would cost much more than the plan projects. And the changes in the behavior of firms and individual taxpayers caused by the plan would reduce total government revenue by at least \$50 billion a year (at 1997 levels).

There are two primary reasons that the actual insurance costs would exceed administration projections: Medicare and Medicaid savings would be smaller than projected and the public's utilization of medical services would be greater.

The Clinton plan claims that caps on Medicare and Medicaid spending would cut the recent double-digit rates of spending growth to only 4% a year within five years. As a result, Medicare and Medicaid spending would then be 20% below the amount that is now projected without the Clinton plan.

No details are given about the reductions in care that would be needed to achieve these massive spending cuts. They cannot be achieved (as Medicare savings have in the past) by shifting costs to other patients, since the Clinton health plan would be paying the bills for those other patients as well. Nor can a 20% cut in outlays be achieved by reducing waste, fraud and abuse. It would require substantial reductions in the actual volume of services given to the aged and the poor. It's not surprising that members of the Democratic leadership in Congress have already made it clear that they will oppose such cuts in health care spending.

Even a 10% reduction in Medicare and Medicaid outlays would be a remarkable and unprecedented achievement. It is as large a cut in these politically sensitive programs as can credibly be imagined. It would nevertheless leave a financing gap equal to half of the plan's projected 20% decline in Medicare-Medicaid outlays. At 1997 levels of Medicare and Medicaid spending, that's equal to \$35 billion a year.

The actual costs of the Clinton plan would also exceed the administration's projections because utilization would increase by more than the administration assumes. The plan increases insurance coverage substantially: covering the 37 million who now lack formal insurance, raising everyone's insurance to the standard of the Fortune 500 companies, covering all pre-existing conditions, and including some care for mental health and substance abuse.

An increase in insurance coverage inevitably increases the utilization and provision of medical services. The government actuaries recognize that but substantially underestimate the likely magnitude of the increase. This underestimation occurs because the actuaries base their estimates of utilization under the Clinton plan

on experiments at the RAND Corp. in the 1970s in which samples of individuals were induced to swap their regular health insurance policies for new RAND policies that had different deductibles and co-insurance rates.

The RAND analysts found that individuals with more comprehensive insurance used more health services. But changing the insurance policies for a sample of isolated individuals in this way does not alter the prevailing standard of care in a community. The RAND study thus measures the extent to which individuals with more insurance increase their demand for care but it tells us nothing about how the prevailing standard of care would change if everyone had the comprehensive insurance proposed in the Clinton plan.

It is of course difficult to judge how much the increased insurance provided by the Clinton plan would change the prevailing standard of care and therefore by how much more it would raise the volume and intensity of medical care than the reactions predicted by the RAND experience. But the effect of providing universal comprehensive insurance is likely to be very substantial. A very conservative estimate would be that total personal health spending would be increased by at least 5%, a 1997 increase of \$35 billion.

Combining the administration's overoptimism about Medicare-Medicaid savings and its understatement of increased utilization implies at least \$70 billion a year of extra program costs. This is not intended as a precise estimate, but as an indication of the minimum amount by which the administration's current estimates understate the true financing costs.

The only way to avoid these increased costs would be to impose a system of controls and rationing that denies patients the care that they and their doctors want. Perhaps that is what is meant by "global budgets" for private care. If that is the essence of the Clinton plan, it deserves to be the focus of our national debate.

The administration's estimates also essentially ignore the impact of the plan on existing government revenue. Consider first how the "payroll premium" tax would shrink taxable wages and salaries and thereby reduce all forms of income and payroll tax revenue.

Under the Clinton plan, employers would pay premiums of \$2,240 a year for employees in two-parent families (and corresponding amounts for other types of employees), subject to a maximum payment of 7.9% of the firm's total payroll.

It is this limit of 7.9% of payroll that converts the "payroll premium" from a mandatory insurance premium into a 7.9% payroll tax that generally discourages work and encourages individuals to take compensation in nonpayroll form. If a firm that is subject to the 7.9% cap adds a new employee who is paid \$20,000, the employer must pay an additional "payroll premium" tax of 7.9%, or \$1,580. If the firm increases the pay of any employee by \$1,000, it must pay an additional "payroll premium" tax of \$79. In other words, the payroll premium is a 7.9% additional tax on incremental wages (except for those firms at which 7.9% of total payroll exceeds the total mandated premiums.)

The immediate effect of imposing the payroll premium tax would be to discourage hiring, to increase layoffs and to reduce profits in firms that now pay less than 7.9% of payroll for health insurance. The reduction in profits would not be permanent because capital

plan. Unless voters want to pay increased taxes of at least \$120 billion a year, Congress should be working on alternative lower-cost ways of dealing with our health care problems.

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Mr. Feldstein, former chairman of the president's Council of Economic Advisers, is a professor of economics at Harvard.

End of Story Reached

ACCESS # 931110-0009.  
HEADLINE Clinton's Hidden Health Tax

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\* By Martin Feldstein

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SOURCE WALL STREET JOURNAL (J), PAGE A20

A recent Wall Street Journal/NBC News poll found that more people now think that they will be hurt by the Clinton health plan than think they will be helped by it. This sharp decline in the plan's popularity since the president's September speech to Congress has probably occurred because people don't like the idea that they might no longer be able to use their current doctors and would face limited choices about medical care in the future.

The number of people who reject the Clinton plan is likely to rise even higher when the public begins to focus on the major tax increase that the president has proposed to finance it.

\* Mr. Clinton has been careful to avoid any reference to a tax. He talks instead about requiring employers to pay for the health care of their employees.

But while the president can try to avoid the big T word, everyone knows that a government requirement to pay money is a tax. And even though employers would be the ones required to write the biggest checks, economists of all political views agree that such employment-based taxes are ultimately paid by the employees in the form of lower real wages.

Specifically, the Clinton plan would require each employee to pay a "premium" to the state "health alliance" that the government would establish. Premiums would vary, with larger premiums for married employees than for single individuals. Mr. Clinton would also require firms to pay premiums that are four times what their employees pay (subject to a limit that would keep the total premiums of any firm under 7.9% of its total payroll).

For a typical married employee, the required personal premium would be \$872 a year. For any couple that does not pay that much now, the requirement in President Clinton's plan would be a new tax.

For firms that already spend as much on each employee as the Clinton plan requires (e.g., \$2,479 for each married employee with children), there is nothing extra to pay. But if the required premium is more than the firm now pays, there is no avoiding the fact that the extra payment is a tax. For the many firms that now provide no insurance, the entire premium would be a tax. Similarly, for the many employees who now take no insurance because they are covered by their spouses' plans, the entire premium would be a tax. And for those employees for whom the firm now pays less than the required premium, the increased payment would be a tax.

\* Hitting employers with a new tax like the Clinton mandatory premium that is based on the number of employees or the total value of payroll would have three immediate effects, with the relative importance of each effect differing from firm to firm. First, the higher cost of employees would cause some firms to fire some employees, especially those for whom the extra cost is large relative to their current wage. These would be primarily lower wage employees. Second, the higher health care costs would temporarily

erode profits. And third, some employees might take pay cuts or forgo pay increases to protect their jobs.

But although the short-term responses to the new tax would be different combinations of these three reactions in different firms, over a somewhat longer term the net effect would simply be lower wages. Just as health insurance premiums in the past have slowed the growth of wages, higher taxes to finance health premiums in the future would slow the growth of wages even more.

Nothing else is possible. The market can provide jobs for all those who are now working only if the cost of employment to firms is no higher than it would be without the required health premiums. That means that the sum of the new wage and the required health tax for each employee must not exceed what the firm now pays in wage and fringe benefits. Those who initially lose their jobs because of the higher mandated health premiums would put downward pressure on wages until this occurs.

The key point in all of this is that the true cost of the taxes -- including the part that is labeled a "required employer premium" -- would be borne by employees in the form of lower wages.

The reduction in individuals' gross earnings could be quite substantial. For two-earner families with children, the Clinton plan would require that the premiums paid by the husband and wife plus the amounts that their employers must contribute would be more than \$5,800. It would be a rare family for which this would not mean a substantial tax increase.

The recent disclosure that 40% of Americans would pay higher out-of-pocket premiums under the Clinton plan than they do now is therefore just the tip of the iceberg. In the end, we would also pay for the much more substantial increased employer premiums by having to accept lower net-of-tax wages.

Not calling this tax a tax is more than just politically helpful spin control designed to make it easier to enact the Clinton plan. The president's approach is much more significant. It would keep the tax out of the budget and would therefore not require congressional action to raise the tax in the future. As the cost of health care rises, employees and employers would automatically be forced to increase their "premium" payments.

The 7.9% cap on the share of wages that a firm can pay means that, in any firm subject to the cap, the employer premium is equivalent to a 7.9% payroll tax. A majority of employees would find themselves working for such firms under the Clinton plan. When any employee in such a firm earns an additional \$100, the firm's total payroll goes up by \$100 and the firm must therefore pay an additional \$7.90 to the health alliance. This tax on additional earnings reduces the reward for working more hours, for taking more responsibility, or for doing more arduous work. The Clinton health tax would not only reduce take-home pay but would also distort incentives.

The 7.9% cap converts the mandatory premium into a full-fledged payroll tax on employees at every earnings level. Even an employee whose current health benefit happens to cost his or her employer 7.9% of the employee's income would nevertheless face a new 7.9% tax on any increase in the individual's earnings.

The administration's failure to discuss the true nature of the

\* tax increase makes it impossible to have informed public debate about Mr. Clinton's proposals for changing our health care system. But even more seriously, proposing that a major new tax not be called a tax is a first step toward a new form of fiscal irresponsibility in which future tax increases would occur automatically without legislative action.

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Mr. Feldstein, former chairman of the president's Council of Economic Advisers, is a professor of economics at Harvard.

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ACCESS # 930818-0072.

HEADLINE Letters to the Editor:

Clinton Plan, for a Healthier America

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DATE 08/18/93

SOURCE WALL STREET JOURNAL (J), PAGE A11

\* Martin Feldstein's July 14 editorial page piece "What's Wrong With the Clinton Health Plan" is just that -- wrong. The president would never sponsor, nor would Congress ever vote for, a health plan that would raise marginal tax rates by 12% for most Americans.

\* Mr. Feldstein's portrayal of the president's plan is fundamentally flawed. His doom and gloom predictions of what health reform will mean for families and the economy -- higher taxes, higher deficits, inefficient health care delivery and restricted doctor-patient decision-making -- will be the inevitable results if we don't reform health care, not if we do.

\* Mr. Feldstein suggests the Clinton plan will include a 10% tax on family income and will raise income taxes 3%. The president has never suggested a 10% tax on family income and has stated repeatedly there will be no income-tax hike.

\* Mr. Feldstein suggests most families -- those with incomes of \$50,000 or less -- would pay more under payroll-based financing. He would have done well to read the June 1 Wall Street Journal article that evaluated a similar financing approach and came to the opposite conclusion: families with incomes of \$50,000 or below will pay less.

\* The driving theory behind market-oriented health care reform is that when providers are forced to compete on cost and quality, the health care industry will be driven toward greater efficiency and more cost-effective uses of resources. In today's health care system, the more tests and procedures doctors and hospitals do, the more they get paid. Under the Clinton plan, health plans would be paid a set amount per enrollee, forcing them to manage health care delivery more efficiently and effectively, and encouraging cost-effective primary and preventive care to avoid having treatable illnesses turn into costly emergencies. The Clinton plan brings the force of the marketplace to health care, giving consumers greater choices and forcing plans to compete for the first time on cost and quality.

\* Failing to reform the health care system will definitely result in an increased budget deficit. Exploding medical costs and their effect on Medicare and Medicaid spending have made it increasingly difficult to lower the deficit. The only way to cut Medicare and Medicaid spending is to put them under an enforceable budget. The only way to cap those programs without driving business and family health care costs out of sight through cost shifting is to bring private sector spending under a budget as well, capping the overall growth in all health care spending. That is precisely what Mr. Clinton proposes to do.

\* The so-called "A-plan" Mr. Feldstein proposes is essentially a tax on the sick. Under the plan, all Americans pay the 10% payroll tax he derides, and an additional 4% payroll tax to finance subsidies. He proposes that those who don't need health care get money back, while those who do need health care would pay 14% of

their income. Think about that: a 14% payroll tax on a middle class family that has a son who breaks his arm and a daughter who needs her tonsils out. A 14% tax on a small-business owner who gets in a car accident. A 14% tax on a secretary with liver disease, or a couple with a baby. And that's before the significant co-payments and deductibles he recommends to bring cost-consciousness to health care.

\* The president's plan will guarantee health care security,  
\* comprehensive benefits, and high quality health care at a price all Americans can afford.

Sen. Tom Daschle, (D., S.D.)

Sen. J.D. Rockefeller IV, (D., W.Va.)

Washington

End of Story Reached

ACCESS # 931117-0097.  
HEADLINE Clinton's Conservative Health Plan

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By Alice M. Rivlin

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\* The Clinton administration's plan for fixing what ails the American health care system is bold and comprehensive, but hardly radical. Indeed, it is conservative in at least three of the senses of that term.

\* First, it reforms the system with minimal disruption to the basic mode of paying for health care that Americans are used to -- employer-based insurance. Second, it relies primarily on market incentives, not government regulation, to control escalating health care costs. Third, it can be financed -- without smoke and mirrors -- primarily by reallocating resources already devoted to health care and does not require large tax increases.

\* Almost everyone agrees that if we are to have the productive, competitive, flexible economy that we all want, we cannot allow the "health care tax" to continue rising. We are already using 14% of our gross domestic product to pay for health care. Every time we let this "tax" drift up another percentage point, we are allocating an additional \$50 billion a year of the nation's precious resources to health care. Moreover, a high-growth economy requires that people be able to move into new jobs, but our current system locks people into jobs and onto welfare out of fear that they will lose their health insurance. Finally, hardly anyone would deny that the way we now pay for health care contributes to unnecessary cost increases and a wasteful use of health resources.

Now that there is such broad consensus that the current system is punishing the economy what is to be done?

\* The Clinton team rejected radical surgery such as a single-payer system or government-set health care prices in favor of restructuring the current system and building on its strengths. There are two types of evidence that such restructuring can work. First, health maintenance organizations and other groups of providers compensated on a per-capita basis have demonstrated that they can deliver good care for appreciably lower cost. These groups have incentives to emphasize prevention, to reduce unnecessary procedures, tests and hospitalizations, and to economize on the acquisition and use of expensive equipment. Second, big-business experience has shown that a large buyer can negotiate with competing health plans and get a much better deal than is available to individuals and small firms that lack market power.

The Clinton plan would encourage doctors and other providers to join health plans that would be paid per-capita premiums. It would give individuals and small employers access to the market power that big business has used so successfully by organizing purchasing cooperatives or health alliances to bargain with health plans for the best deal.

The Clinton plan would ensure everyone at least a standard set of health benefits -- benefits that would not be at risk if an individual changed jobs, became unemployed or got sick. All

businesses would have to provide health coverage, but subsidies would reduce the burden on small and low-wage firms. Employees would share in the cost, with a choice of plans and clear incentives to choose the most cost-effective options for meeting their health needs.

\* The Clinton approach reflects strong faith that consumer incentives, combined with buyer power and better information about quality and performance, can rein in escalating costs. That faith is strong, but not absolute. If health care premiums continue rising appreciably faster than other prices, "global budgets" would control the rate of increase of premiums. If the market incentives work -- and the Clinton team believes they will -- then the controls will not be necessary.

\* Most of the cost of health care for working people and their families would be shared, as at present, by employers and employees. The major new cost for the government would be the subsidies needed to make the insurance affordable to small firms and low-income individuals.

\* These subsidies, along with new benefits under Medicare for out-of-hospital prescription drugs and home health care for the severely disabled, and some other administrative costs, are expected to increase government health spending by roughly \$130 billion by the year 2000, when the program is fully up and running. Revenue increases -- principally from a healthy increase in the cigarette tax -- are expected to produce only about \$30 billion. The rest (roughly \$100 billion) will come from reallocating resources that would otherwise have gone into existing government programs.

These offsetting savings in other government programs are not, as some critics have alleged, vague caps or unrealistic hopes for reducing "waste, fraud and abuse." Rather, the administration is proposing specific changes in program rules that are feasible precisely because of the proposed reform of the private system.

For example, Medicare and Medicaid cover many working people. Under the new rules, the working elderly and the working poor would be covered by their employers instead. Both programs also make huge payments to hospitals to help them cover the cost of treating the uninsured. When everyone has insurance, these payments will be sharply reduced.

Increases in reimbursement rates for private providers would also be slowed -- a change made more feasible because reimbursement for all providers will be rising less rapidly. In addition, upper-income people would pay a large share of the heavily subsidized premium for physician care under Medicare. These specific changes in the Medicare and Medicaid rules would reduce the cost of the two programs by more than \$100 billion in the year 2000. The cost of other government health programs -- for veterans, federal employees and military dependents -- will also grow less rapidly as some of their patients move into health alliances.

Under current policies, federal health expenditures are expected to be about \$680 billion in 2000 -- about \$465 billion of which will be for Medicare and the federal share of Medicaid alone. The administration is not proposing to reduce federal health spending -- only to reduce the annual rate of growth from about 10% to about 5% by 2000 as the new system phases in.

\* In a Sept. 29 article on this page, Martin Feldstein argued that political opposition will make large reductions in the growth of Medicare and Medicaid impossible. In the absence of health care reform, he would be right. Broadened employer coverage and system-wide reduction of cost growth, however, make these savings feasible, while the new prescription drug and home health benefits under Medicare make the package attractive to the elderly.

Mr. Feldstein also argued that the Clinton plan's requirement that employers provide health insurance to their employees will reduce wages and cut tax revenues to the Treasury. Quite irrelevantly, he calculates how much revenue the Treasury would lose if no firms provided health insurance now and all were subjected to a new 7.9% payroll tax to provide such coverage. In fact, however, most people are already covered by employer-provided insurance, many with more generous coverage than the Clinton plan requires. Firms whose costs are reduced by the plan will initially have higher profits and ultimately probably pay higher wages than they do at present.

In either case, Treasury revenues will increase. Employers not now providing health insurance will have to pay more, but the impact on them will be reduced by subsidies. Very small firms will have their cost increase capped at 3.5% of payroll. A more accurate reading of the plan would have led Mr. Feldstein to the conclusion that total wages and Treasury revenue are likely to go up if the plan is enacted.

\* There is plenty of uncertainty about the future cost of health care, but two current facts cannot be denied. One, the U.S. already has an elaborate health care system that leaves millions of people uncovered and whose costs are rising rapidly. Two, government already pays more than 40% of America's health bill.

\* The question now is whether, without scrapping the entire system, we can introduce incentives that will make health care delivery more efficient, and whether we can reallocate some of the resources now tied up in costly government programs to making insurance affordable for the currently uninsured.

The architects of the Clinton plan believe that we can, and that we owe it to the American people to try.

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Ms. Rivlin is deputy director of the Office of Management and Budget.

(See related letter: "Letters to the Editor: Clinton's Radical Health Plan" -- WSJ Nov. 17, 1993)

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would move to other uses where it can earn a higher return. After a few years, the reduced demand for labor would cause wage rates to decline by the 7.9%.

Experience shows that a tax on marginal wage and salary income reduces working hours, encourages the substitution of fringe benefits for wages, and shrinks taxable compensation in other ways. Calculations with the National Bureau of Economic Research TAXSIM Model imply that a new universal 7.9% payroll tax would cause changes in behavior that reduce total 1997 wages by about \$115 billion and cut the federal government's tax revenue by \$49 billion -- \$24 billion less in personal income tax payments, \$16 billion less in employer-employee Social Security tax payments and \$9 billion less in payroll premium payments. If only two-thirds of employees were in firms subject to the 7.9% cap, these amounts would be reduced by one-third.

The Clinton health plan would reduce government revenue in other ways as well. Providing health insurance to everyone would encourage more early retirement, less employment among second earners who now work to obtain insurance, and more shifts to the underground economy. All of these changes would reduce income and payroll tax revenue. The plan's complex system of subsidies and premium caps for small firms and for firms with low average wages would also encourage the outsourcing of jobs in ways that reduce payroll premium revenue.

The combination of all these changes would probably reduce tax revenues by at least \$50 billion a year. Adding to that the \$70 billion of extra costs implied by excess Medicare-Medicaid spending and by increased utilization implies a total annual financing shortfall at 1997 levels of over \$120 billion.

Closing a \$120 billion annual financing gap would require a massive increase in tax rates. In 1997, \$120 billion would be 18% of currently projected personal income tax revenue. But an across-the-board 18% increase in all personal income tax rates wouldn't raise an extra \$120 billion because higher marginal rates cause reductions in working hours, changes in the form of compensation to nontaxable fringe benefits, and shifts to less onerous but lower paid work.

Calculations using the TAXSIM Model imply that raising an extra \$120 billion in 1997 would require increasing marginal tax rates by at least 24% even if those higher tax rates only reduced taxable income and wages by as little as 2%. A taxpayer who is now paying a 15% marginal tax rate would face a rate of 18.6%. A taxpayer at the current top 39.6% personal rate would see that rise to 49% or higher.

The Clinton plan promises attractive features to a wide range of interest groups to get their support. Senior citizens would get free prescriptions. Big business would be able to shed responsibility for the health costs of early retirees and would have health costs limited to 7.9% of payroll. Small business would get subsidized insurance. Most employees, and especially lower wage workers, would get substantial improvements in their insurance coverage. All of this financed by increasing annual per-capita cigarette taxes by \$60!

The American public needs to know the true total cost of the

Premium Cap File: Trigger

For Roger Altman

For Chris Jennings

Let's talk today. 

**DRAFT: NOT FOR DISTRIBUTION**

## **POTENTIAL CONCERNS WITH A TRIGGER MECHANISM**

### **INCREASE COSTS**

In the absence of universal coverage, desirable insurance reform will increase the cost of insurance premiums.

- Market reforms (guaranteed issue, renewal, limits on pre-existing conditions, etc.) will generally help those with serious medical conditions; but they will not, in and of themselves, reduce costs.
- For example, outlawing pre-existing conditions will lead to adverse selection, creating incentives for healthy individuals to forgo purchasing coverage until needing services.

These problems of adverse selection will make community rating difficult and increase premiums. The only way to avoid this increase would be to allow insurers to impose pre-existing conditions on those individuals -- which will be politically unpopular.

- Coverage, then, will be too expensive or inaccessible for those needing services.

### **UNIVERSAL COVERAGE DELAYED**

Most trigger proposals represent postponement of difficult decisions: studies reveal that market reforms alone will not dramatically reduce the numbers of the uninsured. Only a mandate or extremely generous subsidies will do that.

- The Robert Wood Johnson Foundation supported demonstration projects in 13 states that used market mechanisms such as premium subsidies, pooled purchasing and providers subsidies to make health insurance more available have had limited success in extending insurance to the uninsured. (Alpha Center, Senate Finance Committee Testimony, 2/1/94)

Managed competition advocates, such as the Jackson Hole Group, have historically argued that competition will work best when all are covered. Most trigger proposals provide for a permissible number of uninsured.

- Since many will still be moving in and out of insurance, there will be fewer incentives to manage care and more energy will be devoted to avoiding the cost-shift from the uninsured.
- Without universal coverage cost-shifting will continue, and it will be harder to press providers for reductions.
- Also without universal coverage, uncompensated care will continue. Uncompensated care costs will disproportionately affect providers and health plans, which then distort competition.

#### **POTENTIAL GAMING BY BUSINESSES**

Even with a policy provision to prevent downsizing by firms above 100 to avoid the mandate, it will be extremely difficult and expensive to enforce.

- Unsuccessful enforcement will increase federal subsidies and premiums for families and employers.

If subsidies are offered to low-income individuals and there is no mandate, employers of low-income individuals will have an incentive to drop that coverage and let the government subsidize the employees.

#### **UNFAIR, DIFFERENTIAL IMPACT ON STATES**

- Using the percentage of the uninsured as a trigger will lead to unfair treatment of states, especially those who have made efforts to cover their residents and now have relatively low percentage of the uninsured in their states.

#### **INADEQUATE PROTECTION FOR THE POOR**

The safety net could be endangered.

- If health plans are really competing aggressively, they will fight harder to avoid extra costs, including the cost-shift from the uninsured.
- Providers, pressed by plans and competition for reductions, will be even less willing to care for the poor.

**EMPLOYERS CURRENTLY PROVIDING COVERAGE CONTINUE TO CARRY UNFAIR SHARE OF THE BURDEN**

- Businesses currently providing health insurance to their employees will continue to be punished -- they will continue to pay higher rates to compensate for those employers who do not provide coverage.

**LOSE ARDENT SUPPORTERS OF HEALTH CARE REFORM**

- Core constituency groups, e.g. consumer and union groups, may find this approach unacceptable.

## POSSIBLE REVERSE TRIGGER APPROACHES

### Goals

- To avoid windfall payments to providers or insurers related to uncompensated care and Medicaid.
- To provide an opportunity for competitive forces to achieve cost containment goals.
- To minimize federal budgetary risk.

### Determining "Competitive" and "Non-Competitive" Areas

- Prior to the beginning of the first year of reform, health plans provide community-rated premium bids for the guaranteed package of benefits.
- Based on these premium bids, geographic areas (e.g. alliance areas, or community rating areas) are classified as "competitive areas" or "non-competitive areas."
  - ▶ "Competitive areas" are those areas where the health plan premium bids demonstrate the area's ability to avoid windfall payments to providers or insurers through competitive forces alone.

Specifically, a competitive area is one where the weighted average premium bid (based on projected enrollment) is less than the pre-established premium target for the area (or possibly within a small corridor above the target).

- ▶ "Non-competitive areas" are those areas where the health plan premium bids *do not* demonstrate the area's ability to avoid windfall payments to providers or insurers through competitive forces alone.

Specifically, a non-competitive area is one where the weighted average premium bid (based on projected enrollment) is *greater* than the pre-established premium target for the area (or possibly greater than the target plus a small corridor).

### "Reverse Trigger"

- **Non-competitive areas.** A "reverse trigger" mechanism applies in non-competitive

areas. In these areas, a back-up mechanism is necessary to avoid windfall payments. In these areas, premium caps would apply beginning in the first year of reform. Caps would sunset after three years (a "reverse trigger"), when a "retrospective trigger" mechanism would apply (see below).<sup>1</sup>

- **Competitive areas.** Premium caps do not apply at all in competitive areas. Since competitive areas demonstrated ability to avoid windfall payments, caps are not necessary in these areas. However, a "retrospective trigger" mechanism applies after the first year of reform to ensure appropriate growth in federal subsidy payments (see below).

### "Retrospective Trigger"

- A "retrospective trigger" mechanism applies in competitive areas, and in non-competitive areas after the three year sunset of premium caps.
- The retrospective trigger would not seek to constrain premium increases. Its only goal is to ensure that federal payments for subsidies grow at an appropriate rate.
- There are a number of ways to structure a retrospective trigger. One approach is as follows:
  - ▶ If the average premium in an area exceeds the premium target for that area, it means that federal payments for subsidies are also higher. The excess federal subsidy payments are recouped in the following year.
  - ▶ In the following year, the federal government reduces the subsidy payments to the area (e.g. to the alliance, the state, or the "clearinghouse") by any excess payments from the previous year due to higher than targeted premium levels.
  - ▶ The reduced federal payments for subsidies are compensated for by reducing overall payments to health plans.

The reduced payments to plans could be targeted at: (1) High cost plans (i.e. a payment reduction equal to a percentage of the difference between a plan's prior year premium and the premium target for that year); (2) High growth plans (i.e. a payment reduction equal to a percentage of the

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<sup>1</sup>There are alternative ways of describing premium caps that may be more consistent with the approach described here. For example, the mechanism could be described as a bidding process where plans whose bids are excessive are accepted only if they lower their bids.

difference between a plan's premium *increase* and the targeted increase for the area); or (3) Some combination of the two.

- ▶ For health plans subject to payment reductions, payments to providers would, in turn, be reduced through a process similar to the Health Security Act.
  - ▶ Under this approach, employers and families pay based on unconstrained premium bids. However, federal subsidy payments to an area (and, ultimately, to plans) are based on constrained levels.
  - ▶ A state could be permitted (at its option) to make up the higher subsidy costs instead of triggering health plan payment reductions.
- A retrospective trigger mechanism could be somewhat disruptive if very large payment reductions are necessary. This could be addressed by automatically activating premium caps in an area if large payment reductions are necessary under the retrospective trigger.

Premium Cap FY4

## Concerns Raised About Premium Caps and Suggested Responses

1. Data: We don't have good information on health expenditures, per resident, by state, much less by alliance area. Even if we can construct a national premium target that is 'right', alliance level targets will inevitably be too high in some places and too low (relative to current spending), in others. In areas where the premium target is too low, we should expect that all (or most) health plans will initially bid above the target, and political pressure will be created to raise the cap. If the cap is not raised, then there may be substantial and undesired disruption in the provider community (hospitals forced to lay off large numbers of people, physicians forced to lay off personnel and/or accept extremely large income cuts), certainly leading to vocal protest, and, potentially, jeopardizing access to beneficial care.

Suggested response: We have good information on hospital expenditures, by location of provider, and relatively good information on 'border crossings' to convert this into data on per capita expenditures by location of residence. We have reasonably good information on physician expenditures by location of provider, and can use Medicare and private data bases to estimate border-crossings and convert this into expenditures by location of residence.

Further, health expenditures will increase substantially with the enactment of universal coverage. This increased revenue will provide some slack if estimation errors are made. Even if the premium caps are 'too low' in some areas, it is still likely that total provider revenues will be substantially higher than they would have been in the absence of reform. This increase in provider revenues will provide a cushion against mistakes, and make it unlikely that providers will be forced to lay off employees.

2. Timing: the caps are imposed starting on January 1, 1996, well before many medical markets will be functioning competitively. This makes it unrealistic to expect the caps to be met. (Under the HSA, market reforms and universal coverage are projected to being on January 1, 1998 for 60% of the population.)

Suggested response: Given the expectation of a competitive marketplace, providers and health plans have already begun reorganizing the delivery system for quality and economy. This movement will continue and accelerate after health reform is enacted.

3. The caps will encourage health plans/insurers to bid high, since they know that if they bid low and make a mistake, they will not be able to recover in subsequent years by raising

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premiums. It is likely that all plans will bid at the level of the premium cap, and there will be no price competition. Health plans/insurers will face large amounts of uncertainty from multiple sources:

60 million new people will be covered by private health insurance (Medicaid and uninsured); plans have no historical experience in their own claims data to project expenditures for these populations;

community rating, a new (and as yet unspecified) risk adjustment system, and elimination of pre-existing condition exclusions increases health plan risk;

for fee-for-service plans, provider payments will be governed by the negotiated alliance wide fee schedule rather than the arrangements plans have been using historically;

provider practice patterns may change as a result of requirements for direct billing and the ban on balance billing;

provider networks will change as a result of essential community provider provisions and centers of excellence provisions;

One result of this uncertainty is that plans may be prone to bid conservatively with or without premium caps. The existence of premium caps, which virtually guarantees plans that they cannot recover from bids that are too low, will cause all plans to be priced right at the premium cap. In the absence of premium caps, some plans might be willing to price lower in an attempt to capture market share, knowing that if they make a mistake, they would be able to recover over time.

Suggested response: With or without premium caps, many plans are likely to bid conservatively. Without premium caps, conservative bids will result in additional windfall to plans, that may be competed away over time. With premium caps, plans will be constrained, on average, to the premium target, which will pre-empt windfalls resulting from conservative bidding strategies.

It may well be that all plans will bid up to the cap initially as a response to uncertainty, but then lower their bids over time (or request premium increases that are smaller than allowed) as uncertainty is reduced and they figure out whether they are better off gaining market share by lowering their relative price.

(An additional potential response would be to modify the premium cap formula to allow plans that are lower than average to increase more quickly than plans that are above average. At the extreme, this would allow 'de novo' bidding each year. Such a modification would encourage lower bids, since plans would not need to be so worried about being stuck in a losing position. The cost of such a modification is that high

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priced plans would no longer even be guaranteed inflation, but could be forced to reduce their price.)

4. Equity: Caps based on formulas tied to current spending will freeze in excessive expenditures in high cost areas and dramatically penalize areas where significant efficiencies have already been achieved. State-by-state limits overlook regional markets. In many states, large numbers of people move across state lines for care.

Suggested response: The equalization commission proposed in the HSA will recommend methods for reducing interstate variation in premium targets. The movement of people across state lines for care does not limit the ability to set per capita premium targets for people based on their place of residence.

5. Rationing: Caps based on 'arbitrary' formulas may restrain aggregate health expenditures below the level that is needed to assure adoption of new and beneficial technologies, and force rationing of beneficial care.

Suggested response: The level of premium caps that has been proposed is consistent with the growth of health expenditures from approximately 14% of GDP currently to approximately 16.5% in the year 2000. Most of Western Europe is at 9% or below. While there can be no ironclad guarantee, 16.5% of our income for health care in the year 2000 should be sufficient to buy us all the medical care that is likely to improve our health (and then some!).

6. We have proposed a system in which competing fee-for-service and PPO plans could have widely different fee schedules; if some plans are assessed to bring them into compliance with premium caps while others are not, then the plans that have been assessed will pay lower rates to providers than the plans not assessed. This may cause some providers to refuse to accept patients from assessed plans, especially since providers are prohibited from balance billing. But since patients and consumers will not even know which providers will accept patients from plans that have been assessed, it will be difficult to have good information, when choosing a plan, whether a particular FFS or PPO plan really gives one access to all the providers in the community.

Suggested response: If a fee-for-service plan is subject to a significant assessment in order to comply with the premium caps but other fee-for-service plans are not subject to assessments, the assessed plan will almost certainly quickly exit the market. Few consumers will be willing to pay more for one FFS plan for a standard benefit package when other FFS plans with the same benefits package are available at a lower price.

Answer on PPOs, and/or HMOs offering POS products?

Estimated 25% Part B Monthly Premium  
with President's Balanced Budget Plan Part B Savings

	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
Gross 25% Premium	\$43.70	\$48.20	\$53.20	\$59.10	\$67.20	\$74.30	\$82.80
-Offset for Part B Savers	-0.20	-0.90	-1.50	-2.20	-2.90	-3.70	-4.50
Net 25% Premium	\$43.50	\$45.20	\$51.70	\$56.90	\$64.30	\$70.60	\$78.30

Gross premiums are CBO estimates. Offsets for Part B savers based on Administration estimates.

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*Part B Premium*

**The Medicare Premium Differences**  
**Comparing the President's Balanced Budget Plan to the Republican Plan**

<u>Year</u>	<u>Republicans</u>	<u>President</u>	<u>Difference per Couple</u>
1996	\$53.70	\$42.50	\$22.40
1997	\$57.00	\$47.00	\$20.00
1998	\$59.30	\$51.00	\$16.60
1999	\$64.10	\$56.00	\$16.20
2000	\$73.10	\$63.00	\$20.20
2001	\$80.10	\$69.00	\$22.20
2002	\$88.90	\$77.00	\$23.80

<u>Difference in premiums in 2002</u>	<b>\$11.90</b>	<u>Premium difference 1996-2002</u>	<b>\$848.40</b>
<u>Difference per couple in 2002</u>	<b>\$23.80</b>	<u>Difference per couple 1996 -2002</u>	<b>\$1696.80</b>

<u>Year</u>	<u>Republicans***</u>	<u>President****</u>	<u>Difference per couple</u>
1996	\$51.40	\$42.50	\$17.80
1997	\$54.90	\$45.50	\$18.80
1998	\$58.60	\$49.50	\$18.20
1999	\$62.80	\$53.40	\$18.8
2000	\$70.70	\$59.50	\$11.20
2001	\$77.20	\$64.60	\$25.20
2002	\$84.60	\$70.40	\$28.40

<u>Difference in Premiums in 2002</u>	<b>\$14.20</b>	<u>Difference in Premiums 1996-2002</u>	<b>\$897.60</b>
<u>Difference per couple in 2002</u>	<b>\$28.20</b>	<u>Difference per couple 1996-2002</u>	<b>\$1795.20</b>

\* Republicans: November 1995 premiums scored off of CBO baseline (\$270 billion cut).

\*\* President: HCFA projection of premium assuming \$124 billion cut off of CBO November baseline.

\*\*\*Republicans: December 1995 CBO Baseline Adjustment (\$227 billion).

\*\*\*\*President: \$97 billion savings in Medicare as scored by CBO: January/February.

Clinton Administration to Announce Hike

in Medicare Premiums Later this Month

~~Part B~~ Part B  
Premium 1997  
File

-New Fee to be Approx. \$176 Monthly-  
Seniors Will Pay \$44, Taxpayers to Pay \$132

Taxpayer Share of Premium up 32% Since 1995

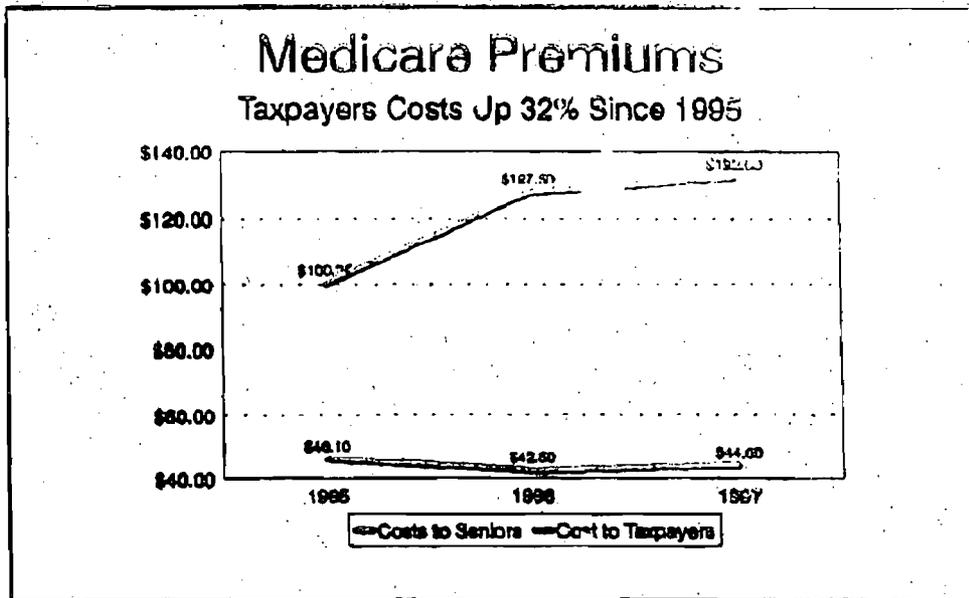
Washington - The Clinton Administration later this month will announce an increase in the Medicare Part B premium paid by seniors and a larger hike in the share of the premium paid for by taxpayers, Bill Archer, Chairman of the Ways and Means Committee said today.

The new premium, effective January 1, 1997, will be approximately \$176 a month, up from today's \$170 total monthly fee, Archer said, basing his estimate on a projection from the Congressional Budget Office. The share that senior citizens will be required to pay will be roughly \$44.00 monthly, up from the current fee of \$42.50. The balance of the premium, \$132, will be paid for by the taxpayers. The *Los Angeles Times* this morning reported that the senior citizens portion of the fee will be \$43.80 in 1997.

In 1995, the total monthly premium was \$146.35, with taxpayers paying \$100.25. As a result of this month's announcement, the taxpayer share of the premium will be increased 32% to \$132. The taxpayer increase will result in higher deficit spending. In 1995, Medicare Part B spending was \$69.6 billion, with \$50.8 billion financed through the deficit.

"The way to save Medicare is to help both our senior citizens and the next generation," Archer said. "We can and we must find a bi-partisan way to do both. But we must be very careful not to take any action that jeopardizes our nation's future by exploding the deficit, making it harder for the next generation to be successful."

In 1995, seniors paid 31.5% of the cost of the total premium and taxpayers, through the deficit, financed the remaining 69.5%. In 1996, the senior citizen share was reduced to 25%, increasing the taxpayer portion to 75%.



### **Medicare Part B Premium and Part A Deductible**

*How much is the Medicare Part B premium going up and why?*

The monthly Part B premium is rising just 3 percent -- an increase of \$1.30 a month from \$42.50 to \$43.80. The Part B premium covers the cost of doctor visits and other outpatient care. It is set by law at 25 percent of Part B program costs. The 3 percent rise will help pay for expected increases in the number, complexity, and cost of services provided as well as scheduled increases in Medicare fees to doctors and other health care providers.

*How does this Part B premium increase compare to the Dole-Gingrich Medicare plan that President Clinton vetoed?*

Under the Dole-Gingrich Medicare plan, the Part B premium would have been \$13.20 more a month for every beneficiary -- that's 30 percent higher than the amount the premium is now scheduled to be. The Dole-Gingrich plan would require Medicare beneficiaries to pay 31.5 percent of Part B program costs through their monthly premiums. The President's balanced budget plan would keep premiums at 25 percent of Part B costs.

*How does this increase compare with increases in past years?*

It is the smallest increase since 1990. (The Part B premium decreased in 1996 due to a change in the law that brought the premium back down to 25 percent of Part B costs). This year's modest increase reflects the success of the Administration's efforts to slow the growth of Medicare spending. Program growth declined to 10.8 percent in FY1995, down from 11.4 percent in FY1994.

*Wasn't the premium supposed to increase by 9 percent? Are you holding down premiums for political reasons?*

No. The 1997 premium is being reduced to reflect slower-than-expected growth in Medicare spending in 1996. Part B costs in 1996 are expected to be 6.1 percent lower than was predicted when the 1996 premium was set. We are returning those savings to the beneficiaries in the form of lower premiums.

*How much is the Part A deductible going up and why?*

The Part A deductible also is increasing by 3 percent -- from \$736 to \$760. The Part A deductible is charged for the first day of hospital care in each spell of illness. It is the only payment made for the first 60 days of inpatient care provided to a beneficiary. By law the Part A deductible is set by a formula that accounts for increasing costs and complexity of hospital services.