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Testers

One Plan - One Strategy

Timing - → (Real —

↳ Security

= Concern:

* Cost -

* Catastrophes

* Timing Coverage

Too Complicated —

+ Will continue to be

* Something needs to be done

* Quality -

Cleaning

Security

* Control Costs

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Reg Plan

→ Security
Control Costs
Coverage
Better care than getting [illegible]

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March 1, 1994

TO: SENATOR DOLE

FROM: DARREN DICK

CC: DAN STANLEY
SHEILA BURKE

SUBJECT: VETERANS HEALTH CARE REFORM

As you know, veterans make up one of the traditional core constituencies for Republicans. However, on the issue of health care reform, Republicans are losing this group. While the major veterans service organizations (e.g., American Legion, VFW, DAV, PVA) have refrained from endorsing the entire Clinton reform proposal, they embrace its approach to veterans health care because it is the only plan to comprehensively address veterans health care. For example, the American Legion has stated that the Clinton proposal contains 70-80% of its proposal for Veterans Health Administration reform. Additionally, the National Commander of the Legion has stated that he tells veterans that only Clinton has addressed the concerns of veterans.

You may want to raise this issue at this weekend's GOP health care retreat. Republicans could reclaim their constituency by publicly stating that they are aware of the concerns of veterans and will keep them in mind as health care reform legislation is drafted. It could also be helpful to outline some of the problems and questions surrounding the Administration's proposal (some listed below).

THE CLINTON PLAN

Under the Clinton proposal each Veterans Administration Medical Center would be an alliance. Veterans would be able to choose between the VA plan (the Clinton basic benefits package) and plans from other alliances. Service-connected veterans choosing the VA plan would not be required to pay co-payments. The Administration proposal also would allow VA hospitals to contract with third parties to provide services for other plans.

PROBLEMS WITH THE CLINTON PLAN

* The VA, as currently constituted and with its emphasis on in-patient care, will have trouble competing with other alliances.

* The Administration does not seem to have adequately planned for the expense of up-grading VA facilities and services in order for VA to compete with other alliances.

* Planned Reductions in Force for the Department of Veterans Affairs will probably hinder the VA's ability to compete in the health care market.

* If the VA cannot attract enough veterans, will it be kept open? The veterans groups want it to be. However, CBO estimates that VA will lose 25% of its patients if the President's plan is enacted.

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Health Care Reform Legislation

Sponsor	Bill Number	# of Cosponsors
Senator Chafee	S.1770	19
Senator Lott	S.1533	12
Senator Gramm	S.1796	10
Senator Gramm	S.1807	10
Senator Nickles	S.1743	24
Senator Moynihan	S.1775	0
Senator Kennedy	S.1779	0
Senator Breaux	S.1579	3
Congressman McDermott	H.R.1200	90
Congressman Cooper	H.R.3222	58
Congressman Michel	H.R.3080	143
Congressman Gephardt	H.R.3600	102

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BUILDING BLOCKS

GOALS

1. Defeat Clinton
    - Offer Republican alternatives
    - Filibuster
    - Offer Amendments
    - Negotiate bi-partisan Congressional Compromise

2. Control Costs
    - Government Regulations: Price controls/global budgets/premium caps/Clinton alliances/national board
    - All Payor (monopoly)
    - Competition
    - Antitrust Reform
    - Malpractice Reform
    - Paperwork Simplification
    - Increase Individual Responsibility
        - Cost Sharing
        - Life Style
        - Tax Disincentives
    - Insurance Reforms
    - Medical Savings Accounts
    - Consumer Value Information
    - Voluntary Purchasing Groups/Co-ops

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3. Increase access to health insurance
   - Tax code changes/equity
   - Subsidies/vouchers/credits
   - Mandate employers to offer (not pay)
   - Insurance Reforms

4. Reform Medicaid
   - Swap
   - Buy-in of Medicaid to private insurance (of low income to medicaid)
   - Caps
   - Managed Care

5. Reform Medicare
   - Means test A/B
   - Opt to retain private coverage at time of eligibility
   - Raise risk contract participation
   - Require managed care participation
   - Prescription drugs

6. Full Financing
   - DSH
   - Limitation on tax deductibility and exclusion
   - Medicare/Medicaid cuts
   - Cigarette tax
   - Other sin taxes

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7. Universality
   - Individual Mandate
   - Employer Mandate
   - No mandates/market forces

8. Guarantee Choice of Providers/Insurance
   - IRA's/MSA options
   - Mandate on employers to offer multiple plans
   - Preemption of state mandates
   - Point of service requirement
   - Status quo

9. State Flexibility
   - ERISA waivers
   - Preemption of mandated benefits
   - Opt out of Federal system

10. Maintain Quality
    - Report Cards
    - Outcomes research
    - No price controls or global budgets

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AGENDA

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SENATE REPUBLICAN
HEALTH CARE TASK FORCE RETREAT
MARCH 3 - 4, 1994
AT THE INNS OF ANNAPOLIS

THURSDAY, MARCH 3

3:00pm	Bus departs from Hart Horseshoe for Annapolis
4:00pm	Bus arrives Calvert Inn
4:00-4:30pm	Registration and Room Assignment
4:30-4:40pm	Chairman Welcome Outline of program Distribution and overview of questions that will help guide substantive and strategy discussions
4:40-6:30pm	Analysis/Comparison of Republican Reform proposals Presentation of side-by-side and Member discussion: Led by Stan Jones and Rod DeArment
6:30-7:00pm	Break -- Refreshments
7:00-7:30pm	Dinner Buffet
7:30-8:30pm	What the public is saying about health care reform Presentation: Bob Blendon Response: Bob Teeter Response: Karlyn Bowman
8:15-8:40pm	Break
8:40-9:40pm	Members only discussion

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FRIDAY, MARCH 4

6:30 am	Continental Breakfast available
8:15-9:30am	Over breakfast and Coffee -- Constituent discussion: NFIB, Chamber, Hospitals, representatives of Individual small and large businesses, HIAA, etc. (Members only)
9:30-9:45am	Break
9:45-12:00pm	Building Blocks of Reform: Eliciting Member responses to questions Led by Stan Jones and Rod DeArment
12:00-12:15pm	Break -- Lunch Buffet
12:15-2:00pm	Final Strategy Discussion: What should Republicans do?: (Members only)
2:10pm	Bus Departs from Calvert Inn

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ATTENDEES

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ATTENDANCE LIST
As Of March 2, 1994

SENATORS

John H. Chafee
Robert Dole
Pete Domenici
Dave Durenberger
Orrin Hatch
Robert and Joyce ~~Mrs.~~ Bennett
Christopher Bond
Conrad Burns
Dan and Mrs. Coats
Thad Cochran
William Cohen
Paul Coverdell--
(FRIDAY ONLY)
Slade Gorton
Phil Gramm--
(MISS DINNER-WILL SPEND NIGHT)
Charles Grassley
Judd Gregg
James Jeffords--
(THURSDAY ONLY)
Dirk Kempthorne--
(FRIDAY ONLY)
Trent Lott--
(LEAVING NOON-FRI.)
Richard Lugar
Connie Mack
John McCain--
(LEAVING NOON-FRI.)
Mitch McConnell--
(DINNER AND THURSDAY EVENTS BUT WILL NOT SPEND NIGHT)
Frank and Nancy ~~Mrs.~~ Murkowski
Don Nickles
William Roth
Alan Simpson
Arlen Specter
Ted Stevens

SENATORS (CONT.)

Malcolm Wallop--
(FRIDAY ONLY)
Kay Bailey Hutchison
Robert Smith
John Warner--
(FRIDAY ONLY)
Hank Brown--
(THURSDAY ONLY)
Strom Thurmond--
(THURSDAY ONLY)

(35)

REPRESENTATIVES

William Thomas
Thomas Bliley
Nancy Johnson
Newt Gingrich
Dennis Hastert
Cliff Stearns
(5)

GOVERNORS

Carroll Campbell, SC
Mike Leavitt, UT
Stephen Merrill, NH

(3)

RNC

Haley Barbour

(1)

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The Duberstein Group

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SIMPLE SIDE BY SIDE

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DRAFT

OVERVIEW OF REPUBLICAN HEALTH REFORM PLANS

	CHAFEE	GRAMM	LOTT	NICKLES
UNIVERSAL COVERAGE	Individual mandate	NO	NO	Individual mandate
LOW INCOME SUBSIDIES	YES	YES	YES	YES
LIMITATIONS ON FEDERAL $ FOR ENTITLEMENTS	YES	YES	YES	YES
INSURANCE REFORMS	YES	YES	YES	YES
UNIFORM BENEFITS	YES	NO	NO	NO
PURCHASING GROUP PROVISIONS	YES	YES	YES	NO
TAX CODE: Medical Savings Accounts	YES	YES	YES	YES
Increase deduct. for self-employed	YES	YES	YES	YES
Tax cap	YES	NO	NO	Limited credits
Long Term Care Insurance tax clarification	YES	YES	YES	YES
DIRECT COST CONTROLS	NONE	NONE	NONE	NONE
ANTI-FRAUD AND ABUSE PROVISIONS	YES	NO	YES	YES
ADMIN. SIM-PLIFICATION	YES	YES	YES	YES
CONSUMER VALUE INFORMATION	YES	NO	YES	YES
LIABILITY REFORM	YES	YES	YES	YES
MEDICAL EDUCATION PROVISIONS	YES	NO	NO	NO
MEDICAID Capitation	YES	YES	NO	YES
Eliminate DSH	YES	NO	NO	YES

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	CHAFEE	GRAMM	LOTT	NICKLES
MEDICARE Private Option	YES	YES	NO	Study
Provider Cuts	YES	NO	NO	YES
Means test	YES	NO	YES	NO
QUALITY STANDARDS	YES	YES	YES	YES
RURAL/INNER CITY PROVISIONS	YES	NO	YES	YES
HEALTH PLAN REQUIREMENTS	YES	YES	YES	YES

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HEALTH CARE REFORM: A SIDE–BY–SIDE ANALYSIS

Plan Feature	Comp. Family Health Access & Sav. Act Sen. Phil Gramm et al.	Consumer Choice Health Security Act Sen. Don Nickles et al.	American Health Security Act Rep. Jim McDermott et al.	Responsible National Health Insurance AEI Press, 1992
Mandate/ Universality	No mandate. Individuals choosing not to be insured will (after 1 year) lose eligibility for preexisting conditions subsidy explained below. Individual will be payer of first resort for moneys owed. All applicable federal and state laws concerning the collection of unpaid debt will apply.	Mandates individuals to purchase minimal medical coverage for medically necessary "acute medical care." Individuals failing to purchase coverage would be ineligible for the tax credit explained below and would lose personal exemption for health insurance.	Establishes a single–payer system covering all U.S. citizens and lawfully admitted aliens. Others may be covered at discretion of the newly established national board or under a state program.	Mandates individuals to purchase coverage against catastrophic medical expenses. Required coverage varies with income. Coverage could be purchased individually, through an employer, or through another social institution. Tax credits or vouchers will be provided based on income.
Purchasing Cooperatives	Removes antitrust barriers to ease joint ventures in the provision of services and removes other regulatory restrictions on the formation of voluntary purchasing cooperatives.	No provision.	No provision.	No provision. However, does encourage states to solicit bids for fallback insurance that would provide the required coverage for those who do not obtain other insurance.
Benefits Package	For employers to continue the tax deduction on health insurance they must offer three plans: a continuation of current insurance, an HMO or PPO, and a catastrophic plan with a deductible of $3,000 with the establishment of an MSA.	Minimum requirement for "acute medical care" including: physician services, inpatient, outpatient, and emergency services, appropriate alternatives to hospitalization, and prescription drugs. Deductible limits do apply for standard coverage and for establishment of an MSA.	Complete coverage (no deductible, copayment, or other charge) of inpatient, outpatient, primary and preventative services, nursing, home health, LTC, vision, dental, prescription drug, mental health, and most other noncosmetic "frill" services.	Mandatory core level of benefits will be determined by Congress. Suggested beginning point is services covered by a low–cost, managed care plan with significant market share. Permitted copayments rise with income, but the core package is mandatory for all.
Global Budgets	No provision.	No provision.	National budget established annually, based on prior year expenditures plus growth in GDP. Board will allocate funds to states based on per capita average, adjusted for cost and health status in the state. Adjustments must be budget neutral. States must submit budgets to board, allocate funds, and spend less than 3% on admin. charges. State programs will receive federal funds equal to 86% of their weighted average pop. based share of national budget. The states are responsible for the balance.	No provision.
Prescription Drugs	No provision.	Included in the minimum benefits package.	Board will establish list of approved drugs based on advice of committee, and will negotiate maximum prices with manufacturers. States will pay for drugs based on these prices and will set separate dispensing fees for pharmacies.	See benefits package.
Preexisting Conditions	Individuals with preexisting conditions will be expected to pay 150% of average catastrophic premium for persons in same age and area. Gov. will pay excess (above 150%) if entire cost exceeds 7.5% of income. Insurers will bid to cover high risk pool.	Guarantees issue, renewal, and limits exclusions based on preexisting conditions. Also limits underwriting.	All current U.S. citizens and legal immigrants will be covered. Coverage will be provided as of birth or date of legal immigration.	Initial purchase is mandatory. Fallback insurance is offered to high risks, with credits given to individuals above 150% of average rate. Renewability is guaranteed for 3 years with adjustments allowed only for increases in average risk.
Community Rating	No provision.	Insurance plans will not be allowed to experience rate, and will be limited to an "adjusted community rate" (allowing adj. for geography, age, and gender).	Not applicable.	No provision. However, does suggest modified community rating as one option to avoid adverse selection.

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HEALTH CARE REFORM: A SIDE–BY–SIDE ANALYSIS

Plan Feature	Comp. Family Health Access & Sav. Act Sen. Phil Gramm et al.	Consumer Choice Health Security Act Sen. Don Nickles et al.	American Health Security Act Rep. Jim McDermott et al.	Responsible National Health Insurance AEI Press, 1992
Tax Treatment	Converts tax deduction for the self–employed into a tax exclusion, gradually equaling the national average employer contribution. A similar exclusion will be provided for those not receiving employer provided coverage. Contributions to MSAs are fully tax deductible.	Replaces current tax exclusion with a refundable tax credit. Credit is based on a sliding scale determined by an individual's ratio of health expenses to income. Credit ranges from 25% to 75% percent of cost.	Will expand withholding tax and employer match. Employers will be required to pay an 8.4% payroll tax, while employees will pay a 2.1% payroll tax (ratio set at 4/1). Small business (<75 employees with avg. wage <$24,000) tax capped at 4%.	Would convert tax exclusion into tax credit to assist the poor and those with high–risk ratings. Tax system would be used to enforce mandate by taxing those failing to purchase insurance at a rate equal to their premium rate, net any credit.
Admin. Changes (claims proc. & reporting)	All federal and state agencies involved in the funding and delivery of care will use standard forms, and must reduce paperwork by 75% in 5 yrs. Standard form will be developed for private concerns that receive public money.	The Secretary of HHS would be authorized to require all health care providers to submit claims in accordance with national standards. Secretary will also study electronic claims processing and other administrative savings.	Development of uniform electronic database, establishment of national ID, and uniform claim and payment forms.	No provision.
Program Financing	Medicare savings ($61.5B), Medicaid savings ($112.5B), and other offsets ($15.7B).	Primary financing will be provided by the conversion of the tax exclusion and caps on Medicare and Medicaid. Other savings will come from eliminations and reductions in Medicare programs.	Will be financed through withholding tax and employer match, cigarette tax, and a tax on handguns and ammunition.	Will be financed through the conversion of the tax exclusion.
Medicaid	Makes per capita payment to the states to allow them to enroll patients in HMOs or MSAs. Creates a sliding credit for families ineligible for Medicaid with incomes between 100% and 200% of poverty level for purchase of catastrophic insurance.	Medicaid would continue, but disproportionate share program would be converted into state grants to promote health insurance, disease prevention, and health promotion for population just above Medicaid eligibility.	Medicaid is superseded upon enactment, but must pay for services completed before enactment (Jan. 1, 1995).	Would replace Medicaid with the system of credits and vouchers listed above.
Medicare	Individual can continue current policy or receive capitated payment as long as individual enrolls in private insurance. 50% of savings can be taken as cash. Increased MSA deposits will reduce role of Medicare.	No provision.	Medicare is superseded upon enactment, but must pay for services completed before enactment (Jan. 1, 1995).	Medicare could be folded into RNHI, with low income elderly recieving credits, or it could be left as is, or elderly could be given the choice between the two systems. RNHI could also be phased in as current workers retire.
Malpractice	Plaintiff pays "frivolous" court costs. Liability limited to actual damages. Contracts can be used to limit liability in return for lower fees. Noneconomic damages limited to $250,000. Contingency fees limited to 25%. Limits collateral source payments and allows for periodic payment. Statute of limitations reduced to 2 years from discovery and 4 years from occurrence. No punitive damages against FDA–approved drugs or technology.	Provides guidelines for federal and state arbitration, limits noneconomic damages to $250,000, provides periodic payments for rewards over $100,000, and limits the liability of defendants for noneconomic and punitive damages to their percentage of fault (as determined by trier of fact). Also limits collateral source payments.	No provision. However, a quality council will collect data from outcomes research and will develop practice guidelines and adopt guidelines to identify outliers whose practice suggests quality deficiencies. Each state will develop independent quality reviews.	No provision.
Long–Term Care (LTC)	Allows individuals opting for capitated payment under Medicare to use other 50% of savings toward LTC costs.	Permits permanent life insurance, 401(k), and IRA savings to pay for longer care and be excluded from taxable income.	Nursing and home health services, home and community–based LTC services, hospice care, and prescription drugs are covered. LTC services provided to anyone needing assistance with 2 activities of daily living	No provision.
Retiree Benefit	No provision.	No provision.	Individuals will be covered for entire life.	No provision.
Medical Savings Account (MSA)	MSAs will be available to those electing the catastrophic plan with a $3,000 deductible. Contributions to MSAs receive same tax treatment as premium payments. Unspent funds can be withdrawn and treated as income.	Allows for the establishement of MSAs and provides same tax credits listed above for deposit. One MSA per household with annual deposits limited to $3,000 plus $500 per dependent.	No provision.	No provision.

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SUMMARY: CHAFEE/ DOLE

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HEALTH EQUITY AND ACCESS REFORM TODAY
ONE-PAGE SUMMARY

WHAT ARE THE GOALS OF OUR PLAN ?

Universal health insurance coverage
Restraint of runaway health care costs
Preservation of quality, choice, and jobs

HOW DOES IT WORK?

Universal access will be achieved through the following reforms:

Standard benefit package, clarified by National Benefits Commission
Tax deduction only for standard package
Equity in the tax code -- all Americans will receive the deduction
Insurance market reform -- eliminate risk selection
Voluntary Health Insurance Purchasing Cooperatives for individuals and small businesses
Federal vouchers for those who still cannot afford coverage, but are Medicaid or Medicare ineligible. All Americans will be covered by the year 2000
Individual mandate to acquire health insurance coverage

Additional savings will be achieved through the following reforms:

Administrative streamlining
Medical liability reform
Antitrust reform
Medicaid restructuring

Other reforms:

Greater emphasis on preventive care
Improved access for those in medically underserved regions
State flexibility to experiment with innovative forms of health care reform

HOW IS THE PROPOSAL FINANCED?

Immediate funding will come from specific cuts in Medicaid and Medicare program.

Additional funding from savings realized from reforms in this bill, as certified annually by CBO.

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CHAFEE/BOLE

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SUMMARY

THE HEALTH EQUITY AND ACCESS REFORM ACT (HEART)
(S. 1770, H. R. 3704)

General Approach:

The Health Equity and Access Reform Act of 1993 (HEART) is the product of three years of study of the nation's health care system by the Senate Republican Health Care Task Force. The Task Force concluded that 1) the U. S. health system works and 2) it does not need radical revision, but does need comprehensive reform.

The objectives of the HEART proposal are to: 1) ensure coverage of affordable health insurance for all Americans; 2) bring down the increase in health care costs; and 3) preserve the choice and quality that distinguishes the American health care system.

HEART guarantees universal coverage by the year 2005 by: 1) making health coverage more affordable through reform of the insurance industry, 2) helping low-income Americans purchase coverage through a Federal voucher program and 3) requiring individuals to purchase health insurance coverage. The bill relies on changes in the tax treatment of health insurance to encourage individual responsibility and consumer awareness of price and quality. HEART also contains administrative simplifications, antitrust reforms, medical malpractice reforms, fraud and abuse prevention and quality assurance initiatives. It is financed on a "pay as you save" principle and is deficit neutral.

Access To Coverage:

- All **individuals** (citizens and legal aliens) will be required to purchase insurance by the year 2005 through their employer or through a voluntary health insurance purchasing cooperative. The mandate is phased in based on an individual's ability to purchase the standard plan and is tied to the realization of savings in current government health programs (primarily Medicare and Medicaid). Individuals refusing to purchase coverage would be liable for a penalty equal to the average annual premium of the local area plus 20% when entering the system, e.g., through emergency rooms.

- Beginning in 1997, **non-Medicaid eligibles** with incomes below 90% of the Federal Poverty Level (FPL) ($12,902/family of four) will be given vouchers to buy insurance through purchasing groups. Voucher assistance will expand annually from 90% of the FPL in 1994 up to 240% of the FPL by the year 2005. The vouchers will be financed as savings become available from reductions in the rate of growth in Medicare and Medicaid.

- **Individuals, small businesses, the self-employed and the unemployed** would have access to health insurance through voluntary purchasing groups. **Small employers (< 100)** must offer, but are not required to pay for, a standard benefit package or alternative catastrophic insurance state-certified as a Qualified Health Plan (QHP). Employees of small businesses may choose not to join any of the employer-offered plans but, instead, may purchase coverage from another QHP.

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- **Large employers** (>100) must offer both a standard and catastrophic benefit package to all employees. The large employer may form a purchasing group with other employers, purchase coverage from a QHP, or self-insure as long as the employer's plan is Federally-certified and offers the standard benefit package and complies with insurance reforms, malpractice reforms, solvency requirements, reporting requirements and consumer protections.

- **Medicare beneficiaries and Medicaid recipients** will have access to care through the existing programs but will have the option to enroll in managed care plans.

Structural Reforms to the Health Care Delivery System:

- States would divide the state into one or more geographic areas called **Health Care Coverage Area** (HCCAs) in which one or more purchasing groups may compete for members. A HCCA must include at least 250,000 residents. A HCCA may also be formed to cover more than one state. It is not required that a purchasing cooperative be established in every HCCA; a single not-for-profit organization may be a purchasing cooperative for more than one HCCA and/or cross state boundaries.

- States would be required to establish voluntary **health insurance purchasing cooperatives** through which small businesses (<100), the self-employed and individuals can obtain coverage. The cooperatives will be state-chartered and operated as non-profit. They will collect premiums from employers and pay claims to qualified health plans. Each cooperative's Board of Directors is elected from the membership of employers, employees of small employers and individuals residing in the HCCA. Cooperatives cannot set payment rates to providers, assume financial risk or perform certification or enforcement functions.

- **Qualified Health Plans** (QHPs), certified by states as meeting Federal benefit and National Association of Insurance Commissioners (NAIC) insurance practice standards, must:

- design and implement enrollment processes;
- meet premium collection and collection criteria;
- guarantee eligibility to all applicants;
- prohibit discrimination based on illness or pre-existing conditions;
- guarantee renewal to all participants;
- base premiums on community rates and rating limitations of age, family size, and administrative costs);
- ensure delivery of services throughout the entire HCCA in which they are offered;
- offer a standard package or catastrophic/Medical Savings Account package or both;
- comply with administrative reforms;
- comply with medical malpractice reforms;
- meet quality assurance and financial solvency standards;
- comply with data collection and information sharing requirements;
- participate in State-based risk-adjustment programs;

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Evaluations. HEART also establishes a Medical Research Trust Fund to guarantee adequate funding for research.

Tax Code Changes:

All purchasers (employers, employees, individuals) of qualified health plans will receive favorable tax treatment for the cost of the coverage up to the "applicable dollar limit" (ADL), defined as the average cost of the lowest-priced one-half of certified plans in a HCCA. Deductibility of the plan for the employer is limited to the ADL cap; premiums in excess of the cap will be taxable to the employee as income. For self-employed individuals, 100% deductibility of a qualified health plan is extended permanently.

Role of the States:

States are given broad authority and flexibility to establish their own health care systems, except that a single payer system is specifically prohibited. Any state-specific health care system must be budget neutral to the Federal government, and offer coverage for an equivalent standard benefit package. States must assume the following responsibilities: establish HCCA areas; certify qualified health plans; establish operating procedures for voluntary purchasing cooperatives; establish risk-adjustment programs for each HCCA; develop binding arbitration processes for medical malpractice suits; specify enrollment periods for qualified health plans; and establish a state program for insurance reform and certify compliance with Federal guidelines. States are granted limited waivers to ERISA (see health insurance reform) and assured of simplified waiver procedures enabling enrollment of Medicaid and Medicare beneficiaries into managed care plans. HEART preempts state mandated benefit and anti-managed care laws.

Health Insurance Reform:

Purchasing groups for small employers (< 100) and large (self-insured) employers must comply with National Association of Insurance Commissioners (NAIC) standards for insurance reform (see Qualified Health Plans, p. 3). ERISA protections are modified in that self-insured employers must also meet HEART's requirements for benefit plan solvency, quality assurance, data collection, and mediation of malpractice claims.

Medicare:

Medicare is retained as current law. However, HEART directs the HHS Secretary to develop a legislative proposal within 1 year to " provide for an appropriate methodology... to make payments to qualified health plans for the enrollment of Medicare beneficiaries". The bill also contains provisions providing opportunity for Medicare beneficiaries to enroll in qualified health plans and/or remain enrolled in a qualified health plan upon becoming Medicare-eligible. The annual rate of growth in Medicare expenditures is reduced from 12% to 7% by 2005.

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Medicaid:

Medicaid is retained as current law. State maintenance of effort for coverage of eligible populations in 1994 is required. The bill limits the rate of growth in Medicaid to 6% annually over the years 1997 - 2000 and 5% annually for 2001 and beyond. Per-capita caps, based on historical costs, are placed on payments to states for acute care Medicaid services. With certain limitations (enrollment percentages), HEART allows states to move Medicaid recipients into managed care plans without going through the federal waiver process. Other changes to Medicaid include a phase-out of disproportionate share payments to hospitals (DSH) beginning in 1996 at a rate of a 20% reduction in payments annually.

Quality Assurance Reforms:

HEART establishes several new entities for the purposes of administrative simplifications and for the reporting, collecting, analyzing and distributing health care-related data. Among those are a Health Insurance Coverage Data Bank, the Health Care Data Exchange System, a National Health Informatics Commission, an Interagency Health Care Data Panel, and a Health Care Fraud and Abuse Data Collection program. These new organizations are given authority to develop regulations and procedures for the reporting of health care-related data from providers, employers, purchasing groups and qualified health plans. The data will translate into consumer information on provider performance and procedure outcome measures and practice guidelines for providers. Expanded criminal and civil penalties of medical fraud and abuse are established to deter fraudulent claim billing and eliminate waste. HEART also establishes strict privacy and confidentially standards.

Malpractice Reform:

To lower health care costs, HEART includes provisions requiring mediation and alternative dispute resolution in malpractice suits prior to usual litigation procedures. Non-economic damages are capped at $250,000 and attorney contingency fees are limited to 25% of the award. Malpractice reforms apply to product liability suits on drugs and devices, including investigational drugs that are part of an FDA-approved clinical trial and deemed "safe and effective". No punitive damages are permitted on FDA-approved products if they are used correctly.

Anti-Trust Reforms:

HEART provides for antitrust reforms, including "safe harbors" for medical providers to share expensive equipment. Hospital mergers are permitted under certain circumstances based on the number of beds and occupancy rates. HEART provides for expedited review of anti-trust waiver requests. A new HHS/Federal Trade Commission/Department of Justice Office of Health Care Competition Policy will establish competition guidelines for approved providers, health care plans and purchasing groups.

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Cost Containment Mechanisms:

HEART relies on capping the deductibility of health plans and on competition in the market place to rein in health care cost increases. There are no global budgets, budget targets, caps on premiums or caps on reimbursement rates to providers or on products.

Financing:

Savings are realized from: 1) means-testing Medicare Part B premiums (the 75% Federal share of the premium will be "recaptured" for individuals with incomes over $90,000, $115,000 for couples); 2) phasing out payments to hospitals for bad debt and uncompensated care (disproportionate share payments); 3) reductions in capital and 4) graduate medical education payments to hospitals; 5) increases in co-payments for laboratory services, home health care and outpatient hospital services for Medicare beneficiaries; 6) enrolling Medicaid recipients in managed care plans; and 7) capping Medicaid payments to states for acute care services.

It is assumed that savings in Medicare and Medicaid fully fund the low income voucher program. To protect against cost overruns, the HEART voucher program for the low-income proceeds only after OMB certifies the savings are occurring as scheduled. In the event the savings occur faster than anticipated, the phase-in will be accelerated; if there is a shortfall, the phase-in will be extended.

Chief Sponsors:

Senator John Chafee (R-RI) and Senator Bob Dole (R-KA)
[16 Senate co-sponsors, all Republicans, include Senators Bennett (UT), Bond (MO), Brown (CO), Danforth (MO), Domemenici (NM), Durenberger (MN), Faircloth (NC), Gorton (WA), Grassley (IA), Hatch (UT), Hatfield (OR), Lugar (IN), Simpson (WY), Specter, (PA), Stevens (AK) and Warner (VA)]

Rep. William Thomas (R-CA)
[3 co-sponsors as of 12/2/93, include Reps. Steve Gunderson (WI), Nancy Johnson (CT), and Joe Moakley (MA)]

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SUMMARY: GRAMM

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THE COMPREHENSIVE FAMILY HEALTH ACCESS AND SAVINGS ACT

by Senators Phil Gramm, John McCain, Dan Coats, Hank Brown, Paul Coverdell, Kay Bailey Hutchison, Bob Bennett, Jesse Helms, Trent Lott, and Lauch Faircloth

October 13, 1993

I. ENHANCE SECURITY FOR THOSE PRESENTLY INSURED BY MAKING PRIVATE INSURANCE PORTABLE AND PERMANENT:

Workers and families presently insured will be guaranteed continued medical insurance coverage by allowing those who leave jobs where insurance coverage was provided to continue their present coverage for an 18-month grace period (or until such individuals can qualify for other coverage) by paying the full premium directly. People who are no longer with their spouses but were previously covered under their spouses' plans or people who have recently become legally independent and are no longer covered by their families' plans will be allowed to continue their current health insurance arrangements for the same grace period by paying their pro rata share of the premium. In addition, all policies would be guaranteed renewable, and premiums could not be raised based on the occurrence of illness. Insurance companies would not be able to cancel a policy except when the policy holder fails to pay the premiums or when the insurance company ceases to sell health insurance in the policy holder's state.

II. EXPAND FAMILY HEALTH INSURANCE CHOICES TO PROMOTE COMPETITION AND CONTROL COSTS:

As under present law, employer contributions for the purchase of medical insurance coverage will be excluded from employee income; however, to continue this exclusion employers must offer employees at least the following three options:

A) Continuation of existing health insurance arrangements;
B) HMO coverage or any other health care arrangement -- such as a voluntary purchasing group, a preferred provider organization, or managed care -- where the employer pays the current employer-paid share of health insurance costs to the alternate plan chosen by the employee; and
C) Establishment of a Medical Savings Account program where the employer would contribute to the program the amount currently being spent by the employer on the employees's existing health insurance arrangement.

- A new Medical Savings Account program would be established through enabling legislation allowing current employer and employee contributions to go first toward the purchase of a $3,000 deductible catastrophic insurance policy, which would be chosen by the employee from among plans offered by private insurers and paid for by the employer and employee in the same ratio as conventional insurance is now purchased, with remaining amounts currently spent on conventional insurance coverage going into a Medical Savings Account. Such a catastrophic policy will cover expenses such as physician services, hospital care, diagnostic tests, and other major medical expenses once the policy holder meets the $3,000 annual deductible. Tax-free withdrawals from the Medical Savings Account could be made to pay for qualifying out-of-pocket medical expenses which apply toward the insurance policy's deductible. If the funds in the

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Medical Savings Account are not spent so that as new deposits are made, the sum grows beyond the $3,000 deductible, the employee can withdraw the excess and treat it as income.

The individual employee would contract with the HMO or Medical Savings Plan and pay those costs in excess of the employer's current contribution for the purchase of health insurance coverage. Employees will have a 2-month period each year (an "open season") to choose a new option for the following year. Should the cost of the HMO or Medical Savings Account program be less than the employer currently pays for conventional insurance, the employee can keep the difference.

Each employer shall determine whether the employer's contribution into the alternate plan shall be based on the **average cost** of providing coverage for its employees under the current plan or the **actual cost** per individual employee. Whichever method the employer selects shall apply to any employee leaving the employer's current plan and selecting an alternative plan. In addition, whichever method the employer chooses shall be used in determining the cost of coverage that employees leaving the employment of the company must pay to continue bridge coverage during the grace period or until other coverage can be obtained.

III. PROVIDE EQUAL TAX TREATMENT FOR THE SELF-EMPLOYED AND UNINSURED:

Self-employed workers, who currently are permitted to deduct 25 percent of their expenses for medical insurance coverage will now be allowed to **exclude** from income a percentage of their medical insurance coverage costs equal to the national average that employers contribute. Those individuals without employer-provided health insurance coverage will be accorded similar tax treatment. This percentage will be recalculated annually and will ensure that anyone without employer-based health insurance coverage will be treated equitably. The exclusion will be phased in over five years up from 25 percent to the national average for the employer's payment. The tax exclusion will apply to the purchase of conventional health insurance, HMO coverage, Medical Savings Account contributions, or any other prepaid medical plan.

IV. ALLOW SMALL BUSINESSES TO POOL THEIR HEALTH INSURANCE PURCHASES:

Regulatory and legal impediments that restrict the ability of small businesses and other organizations (churches, local civic clubs, etc.) to group together voluntarily to allow their employees or members to pool their health insurance purchases will be removed.

V. ASSIST INDIVIDUALS WITH PRE-EXISTING CONDITIONS IN PURCHASING HEALTH INSURANCE:

Individuals uninsured due to pre-existing conditions that preclude affordable insurance **cannot** be denied coverage but will be expected to pay premiums up to 150 percent of the average premium paid by those of the same age, sex, and geographic area. The federal government will pay that amount of the premium which exceeds 150 percent of the average, but only if the entire cost of the coverage exceeds 7.5 percent of the individual's or family's income. This assistance shall be given for the purchase of a high-deductible catastrophic policy and private insurers shall bid for the policy in a risk pool. Such a catastrophic policy will cover expenses such as physician services, hospital care, diagnostic tests, and other major medical expenses once the policy holder meets the $3,000 annual deductible. The subsidy for pre-existing conditions does not cover premiums that are higher due to current behavior that is risky or unhealthy.

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VI. ENCOURAGE RESPONSIBLE BEHAVIOR BY THE FINANCIALLY CAPABLE:
Financially capable individuals ***(those with incomes above 200 percent of the poverty level--$13,864 for individuals and $27,848 for a family of four)*** who choose not to purchase at least a catastrophic insurance policy that covers physician services, hospital care, diagnostic tests, and other major medical services with a deductible no higher than 20 percent of their adjusted gross income or $3,000, whichever is higher, will not be eligible to receive federal premium assistance based on any pre-existing condition after the first year of enactment of this legislation. In addition, such an individual who incurs medical expenses will be the "payer of first resort." Only after he has exhausted all his assets will the government or any institution receiving federal funds provide assistance. Any amounts not recovered from such an individual will be garnished from the individuals wages on a pro-rata basis for a seven-year period.

VII. PROVIDE ASSISTANCE TO LOW-INCOME WORKERS IN PURCHASING HEALTH INSURANCE:
85 percent of Americans currently have health insurance coverage. By providing equal tax treatment to those who purchase their own insurance coverage without employer-provided assistance, by having the federal government partially subsidize the cost of insurance coverage for high-risk individuals, by providing incentives for financially capable individuals to obtain health insurance coverage now, and by making all health insurance policies portable and guaranteed renewable, we will ensure that **most** of the remaining 15 percent will have health insurance coverage. In addition, this proposal will not displace Community Health Centers, the Indian Health Service, the VA Health system, or CHAMPUS.

To achieve **total** coverage, a credit will be available to families and individuals not eligible for Medicaid and having income below 100 percent of the poverty level. This will allow them to fully fund the cost of a catastrophic insurance policy covering physician services, hospital care, diagnostic test, and other major medical services with an annual deductible equal to the higher of 20 percent of adjusted gross income or $3,000 and a preventive package for immunizations, routine physicals, pap smears, mammograms, prostate exams, and other basic preventive care. This credit will be reduced as family income rises and will be eliminated at 200 percent of the poverty level. This credit will be phased in over five years.

Those receiving a partial credit who refuse to purchase at least a catastrophic policy will not be eligible to receive federal premium assistance based on any pre-existing condition after the first year of enactment of this legislation. In addition, if such an individual incurs medical expenses, he shall be the "payer of first resort." Only after he has exhausted all his assets will assistance be provided. Any amounts not recovered from such an individual will be garnished from the individuals wages on a pro-rata basis for a seven-year period.

VIII. REWARD PREVENTIVE MEDICINE AND HEALTHY LIFESTYLES:
Insurance companies may charge different rates based on the willingness of the insured family or individual to use preventive medicine, including vaccines and physical exams. Insurance companies can charge lower rates to those who restrict their use of health harming substances and live healthy lifestyles.

Individuals with moderate incomes who receive federal assistance will be required to pay more if they are overweight, smoke, drink excessively, or engage in other activities that are harmful to their

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health. These extra payments will be based on the differentials that develop in the private insurance market.

IX. REFORM MEDICAID AND EXPAND CHOICES IN MEDICARE:

A) Medicaid payments to states will be made on a per capita basis. That is, states will receive an annual payment, indexed for medical inflation, from the federal government equal to the average federal cost per Medicaid enrollee on a state-by-state basis. The payment will vary by major risk categories. States will then be allowed the flexibility to design their own systems which could:

1) continue the existing Medicaid coverage;
2) enroll recipients into a private Health Maintenance Organization or other health care arrangements; or
3) establish a Medical Savings Account plan to cover the recipient's medical expenses, where, except for qualified medical expenses, no amount can be withdrawn from the Medical Savings Account which takes the account below the annual catastrophic deductible amount.

Also, states would be permitted to develop other innovations and requirements, including use of copayments.

B) Those currently covered by Medicare could keep their present coverage or receive annual government assistance up to the expected cost of their annual Medicare coverage for the individual retiree to enroll in a private Health Maintenance Organization or other health care arrangement or buy a Medical Savings Account.

Those choosing to opt out of the current Medicare system who are able to purchase coverage for less than the expected cost of their current Medicare coverage will be permitted to keep one-half of the difference.

Upon becoming eligible for Medicare (currently at age 65), individuals would have one year to decide whether or not to stay in the current Medicare system. This decision is final.

Under the Medical Savings Account option, the expected Medicare annual expenditure would be paid on an annual basis and would be used to purchase the retiree's catastrophic coverage from a private vendor, with the remaining funds going into the retiree's personal Medical Savings Account. Additional Medical Savings Account contributions or out-of-pocket expenses could be made by the retiree or anyone else on the retiree's behalf. The Medical Savings Account would also be established and maintained with a private vendor.

X. ENHANCE EFFICIENCY THROUGH PAPERWORK REDUCTION:

A) Medicaid, Medicare, and all other federal entities involved in the funding or delivery of health care shall standardize their health care forms and must reduce their total health care paperwork burden by 50 percent within two years of enactment of this legislation. The paperwork burden must be reduced by another 50 percent over the following three years, achieving a total paperwork reduction of 75 percent over a 5-year period.

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B) State agencies involved in the funding or delivery of health care, like federal entities, shall standardize their health care forms. Also like federal entities, within five years of enactment, states must reduce their total health care paperwork burden by 75 percent in order to remain eligible for federal health assistance.

C) A private commission will be established to develop, within 12 months from enactment, standardized forms to be used by private health care providers and private insurers. In order to receive federal reimbursement, private health care providers and private insurers must use these standardized forms. This commission shall be comprised solely of private health care providers and private insurers.

XI. PROVIDE MEANINGFUL MEDICAL LIABILITY REFORM:

A) Similar to the system in the United Kingdom where the "loser pays" court costs, any claim of negligence not "substantially justified" or improperly advanced will result in an automatic judgement against the plaintiff rendering the plaintiff liable for the costs incurred by the health care provider in defending himself, including any losses as a result of being away from his practice defending himself.

B) The liability of any malpractice defendant will be limited to the proportion of damages attributable to such defendant's conduct.

C) A health care provider can negotiate limits on medical liability with the buyer of health care in return for lower fees.

D) Non-economic damages cannot exceed $250,000 adjusted annually for inflation.

E) Lawyer's contingency fees will be capped at 25 percent.

F) Malpractice awards will be reduced for any collateral source payments to which the claimant is entitled, and the claimant will be required to accept periodic payment as opposed to lump sum on awards in excess of $100,000 adjusted annually for inflation.

G) No malpractice action can be initiated more than two years from the date the alleged malpractice was discovered or should have been discovered, and no more than four years after the date of the occurrence.

H) No punitive damages will be awarded against manufacturers of a drug or medical device if such drug or medical device has been approved by the Food and Drug Administration as safe and effective.

XII. PROMOTE EFFICIENCY IN THE HEALTH CARE MARKET BY REMOVING ANTITRUST BARRIERS:

By limiting certain antitrust impediments that restrict cooperative efforts, communities and providers will be given an opportunity to coordinate the delivery of health care and enter into joint ventures that promote greater efficiencies, and expand access.

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XIII. PAYING FOR HEALTH CARE REFORMS:

COSTS:

The taxpayer costs of the three new health care benefits contained in this proposal -- the universal health insurance tax exclusion; the high-risk insurance pool subsidy; and the low-income worker tax credit for insurance purchase -- will be put into effect under the following conditions:

A) None of the benefits shall take effect until savings accrued by the reforms contained in this plan have actually occurred.

B) Phase-in priorities based on achieved savings shall be as follows:

1) high-risk insurance pool subsidy.
2) universal health insurance tax exclusion will be phased up in annual 10 percentage point increments to 75 percent.
3) low-income worker tax credit for insurance purchase will be phased in first for families in poverty, then singles in poverty, and lastly, for families and singles above the poverty level.

Phased-In Costs
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
High-Risk Pool		$4	$4.2	$4.2	$4.2	$4.2	$20.8
Health Insurance Exclusion		$6.2	$8.7	$11.4	$14.6	$18.2	$59.1
Low-Income Worker Tax Credit		$0	$4.3	$10.3	$19.6	$30.1	$64.3
TOTAL COSTS		$10.2	$17.2	$25.9	$38.4	$52.5	$144.2

SAVINGS:

A) MEDICAID

Medicaid savings are achieved in three ways. First, Medicaid spending is "capitated," meaning that states would receive an annual federal payment based on the number of Medicaid recipients

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and the risk classes they fall into. States would then be given the flexibility to institute the reforms outlined in section IX. The payment to states would grow each year by the increase in the medical price inflation index.

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Medicaid Savings from Capitation and State Flexibility	$7.4	$13.8	$19.8	$26.3	$33.5	n.a.*	$100.7

Second, with the introduction of price competition in health care through expanded consumer choice contained in sections II and IX, the current differential between the medical price inflation index and the consumer price index is projected to decrease by one-half over five years. The resulting Medicaid savings are as follows:

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Medicaid Savings from Lower Medical Inflation	--	$.3	$.9	$2.0	$3.8	n.a.*	$7

Third, with the introduction of a high-risk individual subsidy and a universal tax exclusion, many Medicaid recipients will be brought under private plans. The resulting savings are as follows:

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Transfer out of Medicaid to Private Insurance	--	$.6	$1.3	$1.4	$1.5	n.a.*	$4.8

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B) MEDICARE

The introduction of price competition in health care generated by the reforms in sections II and IX is assumed to cut the current difference between the rate of growth in Medicare and the medical price index in half over five years. Further, the cumulative effects of this package are assumed also to lower the medical price index over five years. With this change, we assume savings of only half of the Medicare savings assumed by the President:

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Medicare Savings	$3.5	$7.5	$11	$16.5	$23	n.a.*	$61.5

C) OTHER OFFSETS

With creation of the risk pool coverage and universal access to catastrophic health care coverage, the use of the present deduction of health care costs in excess of 7.5% of income will drop dramatically. This estimate assumes a total reduction of 50%.

Savings
(in billions of $)

	1994	1995	1996	1997	1998	1999	TOTAL
Less Use of Medical Deduction	$2.8	$2.9	$3.1	$3.3	$3.6	n.a.*	$15.7

TOTAL SAVINGS (in billions of $)

1994	1995	1996	1997	1998	1999	TOTAL
$13.7	$25.1	$36.1	$49.5	$65.3	n.a.*	$189.7

Deficit Reduction **$45.5 Billion**

* "n.a." refers to not applicable. Savings in the sixth year are not applicable because the first five years of achieved savings will be used to fund benefits paid in each of the following years.

Cost and savings estimates and assistance provided by the National Center for Policy Analysis using the NCPA/Fiscal Associates Health Care Model, static estimates.

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Gramm Sketches Another GOP Alternative

By Helen Dewar
Washington Post Staff Writer

Sen. Phil Gramm (Tex.) unveiled yet another Republican alternative to President Clinton's health care reform proposals, one Gramm said would rely almost entirely on market forces to cut costs and expand coverage.

As outlined by Gramm in a breakfast meeting with reporters, the plan would require employers to offer health care options to their workers, assure coverage of people with preexisting health conditions, continue coverage for workers who change jobs and provide some assistance for the working poor.

It bears little, if any, resemblance to Clinton's plan and differs significantly from an alternative outlined last week by a group of Senate Republicans led by Sen. John H. Chafee (R.I.).

In keeping government intervention to a minimum, it more parallels a plan proposed by House Republicans.

Gramm described the choice between Clinton's plan and his own as "collectivized medicine" versus "bringing price competition into the health care market." Gramm would provide no new benefits until savings were assured.

While it appears to have little chance of passage, Gramm's plan is likely to sharpen the debate by presenting a clear conservative alternative to what many see as a gradually evolving consensus between Clinton and Chafee, who has signed up 22 colleagues as cosponsors on his proposal. Gramm said he has not yet tried to get cosponsors for his proposal, although he said he is working with about 20 Republican senators on the plan.

The president will unveil his broad reform proposal to a joint session of Congress today at 9 p.m.

Gramm's proposal would require employers to offer workers at least three health care options, including continuation of current coverage, transfer to other plans including health maintenance organizations (HMOs) or creation of "medical savings accounts" on behalf of individual employees. The deposits in those accounts would come from money that employers would otherwise have paid for health insurance. Employees who chose such accounts would have to be provided a catastrophic-illness insurance policy.

Self-employed workers or those without employer-provided insurance would receive tax breaks equivalent to the national average of employer-paid benefits. Medicaid and Medicare would be continued but with the option of enrolling beneficiaries in HMOs or medical savings accounts. Pools would be set up to cover high-risk workers, with some government subsidy for poorer workers, and credits for catastrophic coverage would be provided for those not covered by other aspects of the bill.

Gramm, who is also chairman of the Republican senatorial campaign committee, said Clinton's plan, if adopted without change, would "bankrupt" the country and doom the Democrats. "People would be hunting Democrats with dogs by the end of the century," he said.

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S. 1743

CONSUMER CHOICE HEALTH SECURITY ACT

FACT SHEET

November 20, 1993

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

WHAT IT DOES

The Consumer Choice Plan

- Provides **the security of universal health care coverage for all Americans**, guaranteeing them access to insurance that is portable, and available regardless of pre-existing conditions. It would take effect on January 1, 1997.

- Provides individuals and families with a **maximum choice of health insurance plans** with a wide variety of benefits and costs, including the ability to keep the employer-sponsored benefits they have now. That's more choice than most Americans have now.

- Individuals and families are provided with the **resources to purchase the health insurance plan that best fits their needs** with tax credits in place of the current employee tax exclusion for health care expenses. People whose health expenses consume a larger percentage of their incomes would get a bigger tax credit.

- **Controls rising health care costs** by empowering consumers with choice and individual responsibility and infusing real competition between insurance companies for the consumer's health care dollar.

- Further reduces rising health care expenses with **real reform of medical malpractice laws**, including capping awards for noneconomic damages.

- **Creates Medical Savings Accounts**, or MSAs, which can be used to pay medical bills or to pay for extra benefits.

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

What it does NOT do

- The plan has **no new, job-killing mandates on employers** to provide and pay for health insurance for their employees. Employers must only give their employees the option of retaining their current benefits, or "cashing out" their benefits and joining another plan.

- The plan requires **no new taxes**.

- The Consumer Choice and Health Security Act **does not wipe out existing health insurance policies, unlike the Clinton plan, which would outlaw nearly every health insurance plan now in existence.** Under the Consumer Choice Act, people who are happy with their employer-sponsored coverage can keep it.

- The plan places **no price controls** or "premium caps" on insurance plans that could reduce the quality of coverage and even result in the rationing of health care.

- The plan creates **no new national health board or government bureaucracies**.

- **There is no government coercion to purchase benefits not wanted or needed**, beyond a minimum catastrophic insurance requirement.

HOW IT WORKS

Insurance Reforms to Guarantee Access

- The Consumer Choice and Health Security Act provides for guaranteed issue of health insurance policies. Insurers could not exclude coverage of any preexisting medical condition of any applicant who switches from one insurance plan to another or of any currently uninsured person who buys insurance.

- Insurers cannot cancel or refuse to renew coverage of a health insurance policy except for non-payment of premiums or fraud or misrepresentation. Insurers could not offer bonuses to brokers for selling insurance to "healthy" people or avoiding the sale of policies to

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people with preexisting conditions, or engaging in any other discriminatory sales practices.

- Health insurance underwriting would be limited, allowing insurers to vary premiums only on the basis of age, sex and geography. However, because of the importance of prevention and healthy lifestyles, the legislation would allow insurers to give incentive discounts to promote healthy behavior, prevent or delay the onset of illness, or provide for screening or early detection of illness.

- Certain state laws pertaining to mandated benefits and services, anti-managed care laws, and mandated cost-sharing would be preempted.

Tax Credits

- Individual tax credits would replace the current tax exclusion for company-sponsored health plans.

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

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

- At a minimum, for every $100 which is spent on health insurance premiums, or contributed to a Medical Savings Account (MSA), or spent on ANY out-of-pocket medical expenses, the individual or family would pay $25 less in taxes. The greater the ratio of health costs to income, the greater the tax benefits. Low-wage persons with higher percentage health costs would receive greater benefits. The tax credit would be as much as $75 per $100 spent on health care, and would be refundable as explained below.

- The credits are refundable, meaning that if the value of the credit is more than an individual's or family's tax liability, the government would pay the difference. Much like the treatment of the Earned Income Tax Credit (EITC), employers would reduce their tax

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liability and provide the tax credit as additional income in the employees' paycheck, so they could purchase insurance.

Family Security Benefit Requirements

- Society should not have to pay the price for irresponsible individuals who refuse to purchase insurance and then expect us to pick up the tab when they become seriously ill or injured. Every individual and family would be required to have minimum health insurance coverage to cover medically necessary "acute medical care," including:

  - Physician services
  - Inpatient, outpatient, and emergency hospital services and appropriate alternatives to hospitalization
  - Inpatient and outpatient prescription drugs
  - A maximum deductible amount of $1,000 for an individual and $2,000 for a family and an out-of-pocket limit of $5,000. These amounts would be indexed to inflation in future years.

- For Medical Savings Accounts, or MSAs, the Consumer Choice plan would provide the same basic 25% tax credit for deposits. Each household would be permitted to have one MSA and to make an annual deposit no greater than the sum of $3,000 plus $500 for each dependent. The funds in an MSA could be used to pay medical bills not covered by their insurance plans, and to pay health insurance premiums.

- Transitional Rules: In order to provide individuals and families with secure, portable benefits, insurers and employers who currently provide health insurance coverage would be required to offer policyholders the option of converting their existing coverage to an individual or family plan. Employers would also be required to add the value of the coverage they now offer to their workers' wages. Thus, workers could take their coverage with them when they changed jobs or could use the money to buy a different plan that better suited their needs.

Employer Provisions

- Individuals and families could still purchase health insurance through their employers. This would not be their only option, since they would be able to receive the same tax relief if they purchased coverage on their own or through other groups such as unions, churches, farm bureaus, business coalitions, professional associations, or through some other group — similar to the choices that more than 10 million Federal employees, retirees and their families have today.

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- To ensure that individuals and families are able to make regular premium payments on their health insurance, employers would be responsible for withholding premiums from their employees' paychecks and sending these premiums to the employees' chosen insurer. Employers would also be responsible for adjusting their workers' tax withholding to reflect the new tax credits. Thus, taxpayers would not need to wait until they filed their tax returns to claim back the new tax credits.

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

Financing the Consumer Choice Plan

- Because the Consumer Choice tax credit is more generous than the tax deductions and exclusions that it would replace, it will result in a net revenue loss to the federal government of $133 billion between 1997 and 1999. To offset this revenue loss, the bill calls for savings in the Medicare and Medicaid programs of $139 billion over five years.

- Federal Medicaid payments to states for acute care would be distributed on a per capita basis beginning in fiscal year (FY) 1995. The capitated amounts would be set at 20 percent above the FY 93 level in FY 95. In subsequent years, the capitated payment would rise by one percent above the consumer price index (CPI). Total federal Medicaid acute care payments to a state for FY 95 could not exceed the payment for FY 93 plus 20 percent. In subsequent years, the total federal acute care payment to any state could not exceed the previous year's payment plus CPI plus 2.5 percent. This will produce a five-year savings of $72 billion. States would be given broad latitude in how they deliver acute medical care services to their Medicaid population.

- Medicare savings will be achieved by eliminating payments to "disproportionate share" hospitals, reducing payments to hospitals for indirect medical education costs, continuing the transition to a prospective payment system (PPS) for outpatient services, and by updating PPS payments on January 1 of each year, rather than on October 1. Further savings would be achieved by placing a 20- percent coinsurance requirement on laboratory and home health services. These changes will save the Medicare program $67 billion over five years.

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

Program	Consumer Choice	President
Medicare	$67 Billion	$152 Billion
Medicaid	$72 Billion	$225 Billion

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Cutting Costs through Malpractice, Paperwork Reforms

- The Consumer Choice plan would place a $250,000 limit on noneconomic damages, provide for periodic payment of malpractice awards that exceed $100,000, and limit the liability of a defendant for noneconomic and punitive damages to their percentage of fault, as determined by the trier of fact. It would also cap attorney fees, provide for offsets from collateral sources, and set forth rules for any health care malpractice claims filed in state or federal court or resolved through arbitration.

- The Secretary of Health and Human Services would have the power to require all health care providers to submit claims to health insurance companies in accordance with standards developed by the Secretary, if providers are not voluntarily complying with the standards. The Secretary is also directed to adopt standards relating to data elements for use in paper- and electronic-claims processing of health insurance claims, uniform claims forms and uniform electronic transmission of data.

Helping the Disadvantaged

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

Consumer Protections

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

Anti-Trust Provisions

- The bill will create "safe harbors" from federal anti-trust laws for: certain groups of providers; medical self-regulatory entities that do not operate for financial gain; certain joint ventures for high technology and costly equipment and services; and certain hospital mergers. It directs the Attorney General to create additional "safe harbors" for health care

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joint ventures that would increase access to health care, enhance health care quality, establish cost efficiencies from which consumers would benefit, and otherwise make health care services more effective, affordable and efficient.

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

Long-Term Care

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

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SUMMARY: BREAUX

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The Managed Competition Act of 1993

S. 1579

John Breaux (D-LA)—Dave Durenberger (R-MN)

The Managed Competition Act is a market-based approach to health care reform. It guarantees access to high quality, affordable health care for all Americans. It does not rely on heavy-handed government controls, but favors the establishment of new ground rules for fair and effective competition among private health plans. It does not include global budgets or price controls, nor does it compel employers to pay the health plan premiums of their employees.

The bill changes the health care market's ground rules to encourage providers and insurance companies to form health partnerships which will be publicly accountable for costs and quality. Regional purchasing cooperatives will give individuals and small businesses the benefits of greater buying power. A national board will establish a standardized, comprehensive set of benefits. Tax deductible status will only be available for health plans (known as Accountable Health Plans or AHPs) that offer these standard benefits, comply with insurance reforms and disclose information on medical outcomes, cost effectiveness and consumer satisfaction. These changes will give every American the same leverage and choices that are now available only to America's largest companies.

Health Plan Reform——Insurance companies and health care providers will combine to form Accountable Health Plans. These AHPs must have open enrollment and will not be allowed to exclude coverage of pre-existing conditions or to use "experience rating" to charge higher rates for individuals who have a history of higher medical expenses.

Access to Coverage——Individuals and small businesses will be able to afford health coverage by joining Health Plan Purchasing Cooperatives (HPPCs), which will offer group rates with low administrative costs. Consumers who purchase through HPPCs will be able to choose from a menu of all qualified health plans in the area. Large businesses, which already have economies of scale and the ability to adequately spread risk, will be able to contract directly with AHPs.

Improving Incentives——Health plans will have incentives to promote preventive care, eliminate unnecessary tests and ineffective treatments and reduce administrative costs. Since they will be required to report on the health outcomes of their enrollees, health plans will be driven to improve the quality of the care they provide.

Access for Low-Income Individuals——A new federal program will pay health plan premiums for all people below 100% of the poverty level. Individuals and families between 100% and 200% of the poverty level will receive a sliding scale subsidy toward the purchase of a health plan. States will no longer have to finance Medicaid but will gradually assume responsibility for long-term care for the poor.

Tax Fairness——Employers will be allowed to deduct the cost of the most efficient health plans, but not the costs of excess benefits of higher priced plans. Limiting employer deductibility in this way will promote cost-conscious purchasing and will provide revenue to finance 100% deductibility for all individuals and the self-employed.

Access in Underserved Areas——A wide array of resources will be made available through new and existing programs to assist underserved areas in recruitment and retention of providers, development of provider networks, integration of public health clinics and coordination with urban "safety net" hospitals.

Cost Savings——Malpractice reforms, electronic claims processing and administrative simplification will greatly improve the efficiency of the health care system.

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Clinton Draft	**Breaux-Durenberger Bipartisan Bill**	Senate Republican Task Force
Layers of Government Regulation	**Market-Based**	Market-Based
Federal Price Controls	**No Budgets**	No Budgets
51 Different State Regulators	**National Rules/ Local Markets**	States Can Opt Out
Government-Run Alliances	**Private-Sector Regional Co-ops for Small Business**	Multiple Competing Pools
Mandates on Employers	**No Mandates**	Individual Mandates
No Tax Reform	**Tax Reform**	Tax Reform

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Dave Durenberger
United States Senator for Minnesota

Senator Dave Durenberger and Managed Competition

Two Decades Of Work Toward Health Care Reform

Although "managed competition" is a fairly new term in the language of the health care debate, its underlying principles have been at the core of Senator Dave Durenberger's contributions to health care reform for his entire 15 years in the U.S. Senate.

In fact, Senator Durenberger's support for using market forces to rein in health care costs and improve quality actually dates to his pre-Senate days — as public affairs officer for a Fortune 500 company, a community activist, and a trustee of what is now Minneapolis Childrens' Medical Center.

It was in the early-to-mid-1970's that Twin Cities employers began to see the potential to influence the pricing and delivery of health care through the marketplace. Senator Durenberger was part of that discussion, representing his employer, the H.B. Fuller Company. He also served as chairman of Public Service Options (PSO) — a joint venture involving the Citizens League and Upper Midwest Council. PSO was established to explore alternative ways of purchasing and delivering public services — particularly using competition and consumer choice.

An important influence on Senator Durenberger and others in defining and mobilizing market forces in the Twin Cities was Dr. Paul Ellwood, a physician who founded his own health policy group, InterStudy. Dr. Ellwood later founded the "Jackson Hole Group," a collection of health policy leaders from around the country who met at Ellwood's home in Wyoming. As a leading supporter for health market reforms in the Congress, Senator Durenberger was a participant in those discussions.

Senator Durenberger's firm grounding in the principles that now define "managed competition" can also be seen in his speeches to health policy audiences dating back to his early days in the Senate. He was a vocal critic of Carter Administration proposals to contain health care costs through price regulation. And he introduced his own proposal — the Health Incentives Reform Act of 1979 — to encourage the same kind of competition and consumer choice he had seen begin to take hold in the Twin Cities.

In October of 1980, Senator Durenberger challenged his fellow hospital trustees in Minnesota to become part of the solution. In his speech to the East/West Metro Hospital Trustee Council, he also began defining a governmental role in promoting the use of market forces in health care by warning that "*meaningful competition may just be our last defense against regulation. The kinds of activity we see here (in the Twin Cities) need to be explored and expanded upon in other areas of the country. The legislation I introduced last year... will facilitate the emergence of competition on a broader scale by encouraging multiple choice by employers, requiring equal employer contributions to health benefits.*"

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Less than a year later, Senator Durenberger outlined "A Framework for Health System Reform" in a speech to the National Health Council in Washington. He identified what he called "eight guiding principles for change" — principles that are evident in several of the major managed competition proposals being debated.

He began what would become a decade-long crusade for market forces against the regulatory impulse — by pointing out that "*choice gives individual consumers the opportunity to select a product or service that best meets their needs. The most successful provider of that good or service will be the one that best responds to consumer desires....(But) these very basic elements of a competitive market do not exist in health care. The ultimate consumer of health services — the patient — is usually insulated from the cost of care by a private or government insurance plan. When patients do share in the cost of their health care, they find there's nothing to shop around for — no choices. How many employees have a choice of health plans?....Not many.*

"And, without consumer choice to stimulate providers to be responsive and efficient, we really can't expect doctors and hospitals to change their behavior. More regulation won't cure the ills of our health system. But neither will the status quo. We simply must introduce the basic elements of choice and competition into health care."

By March of 1985, this vision of a new health care marketplace had evolved to the point that Senator Durenberger was able to tell a public affairs conference at Brown University in Providence: "*Under my ideal world, the worker becomes a smarter shopper, and pays for what he gets. The elderly and disabled have a Medicare system better tailored to their needs. The poor have financing to give them access to health plans. The individual tries harder to stay well. Health care providers have moved to a price-oriented marketplace. Consumers have choice, and you can bet they choose what's best for them. That includes buying the best quality health care for their dollar.*"

As ranking member of the Senate Finance Medicare Subcommittee, Durenberger authored significant physician payment reform legislation (resource-based relative value scales or RBRVS). And as chairman of the Finance Health Subcommittee, he authored important hospital payment reforms (diagnostic related groups or DRGs), as well as the establishment of the Agency for Health Care Policy and Research and the Medicare catastrophic legislation.

The last few years have seen a great deal of progress toward Durenberger's goal. The Bentsen-Durenberger insurance reforms passed the Senate by a vote of 97-0 last year before being stopped in the House. And the Health Insurance Purchasing Cooperative Bill introduced last year by Durenberger and Senator Jeff Bingaman (D-NM) would have allowed states to design purchasing cooperatives for small business with Federal assistance — a precursor of today's managed competition consensus.

Dave Durenberger, a Republican, is the senior U.S. Senator from Minnesota

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THE MANAGED COMPETITION ACT OF 1993

Summary

Breaux/Durenberger

The Managed Competition Act is a market based approach to health care reform. It guarantees access to high-quality, affordable health care for all Americans. It does not rely on heavy-handed government controls, but favors the establishment of new ground rules for fair and effective competition among private health plans. It does not include global budgets or price controls, nor does it compel employers to pay the health plan premiums of their employees.

The bill changes the health care market's groundrules to encourage providers and insurance companies to form health partnerships which will be publicly accountable for costs and quality. Regional purchasing cooperatives will give individuals and small businesses the benefits of greater buying power. A national board will establish standardized, comprehensive set of benefits. Tax deductible status will only be available for health plans (known as Accountable Health Plans or AHPs) that offer these standard benefits, comply with insurance reforms and disclose information on medical outcomes, cost effectiveness and consumer satisfaction. These changes will give every American the same leverage and choices that are now available only to America's largest companies.

- *Health Plan Reform: Insurance companies and health care providers will combine to form Accountable Health Plans. These AHPs must have open enrollment and will not be allowed to exclude coverage of pre-existing conditions or to use "experience rating" to charge higher rates for individuals who have a history of higher medical expenses.*

- *Access to coverage: Individuals and small businesses will be able to afford health coverage by joining Health Plan Purchasing Cooperatives (HPPCs), which will offer group rates with low administrative costs. Consumers who purchase through HPPCs will be able to choose from a menu of all qualified health plans in the area. Large businesses, which already have economies of scale and the ability to adequately spread risk, will be able to contract directly with AHPs.*

- *Improving Incentives: Health plans will have incentives to promote preventive care, eliminate unnecessary tests and ineffective treatments and reduce administrative costs. Since they will be required to report on the health outcomes of their enrollees, health plans will be driven to improve the quality of the care they provide.*

- *Access for low-income individuals: A new federal program will pay health plan premiums for all people below 100% of the poverty level. Individuals and families between 100% and 200% of the poverty level will receive a sliding scale subsidy toward the purchase of a health plan. States will no longer have to finance Medicaid but will gradually assume responsibility for long-term care for the poor.*

- *Tax Fairness: Employers will be allowed to deduct the cost of the most efficient health plans, but not the costs of excess benefits or higher priced plans. Limiting employer deductibility in this way will promote cost-conscious purchasing and will provide revenue to finance 100% deductibility for all individuals and the self-employed.*

- *Access in underserved areas: A wide array of resources will be made available through new and existing programs to assist underserved areas in recruitment and retention of providers, development of provider networks, integration of public health clinics and coordination with urban "safety net" hospitals.*

- *Cost savings: also will be achieved through malpractice reforms, electronic claims processing and administrative simplification.*

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ICKIE: file with Cooper

United States Senate

DAVE DURENBERGER

December 1, 1993

d: EB, Jw, VH
ATT ⇒ VH, SB

Dear Colleague:

Over the next twelve months, you and I will be working to reform America's health care system. The American people are ready for it — they are demanding it — so it's essential that *we get it right.*

In Minnesota, we have experimented with reforms that have *contained costs* while at the same time *improving quality*. John Breaux and I have introduced a bill that reflects the lessons learned in Minnesota. *It sets national rules for local markets — making markets work for consumers*, instead of *replacing* the market with government bureaucracy.

Our bill is the companion measure to the Cooper-Grandy legislation introduced in the House earlier this year. America's leading journal of opinion, The New Republic, has just published an editorial endorsing our bill. I recommend it to your attention and have enclosed a copy for your review.

Please don't hesitate to call if you have questions.

Sincerely,

Dave Durenberger

enclosure

COMMITTEE ASSIGNMENTS:
FINANCE
ENVIRONMENT AND PUBLIC WORKS
LABOR AND HUMAN RESOURCES
SPECIAL COMMITTEE ON AGING

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THE NEW REPUBLIC

DECEMBER 6, 1993

FOR THE COOPER PLAN

Nearly everyone in favor of health care reform agrees on the two basic problems that must be tackled: the large number of uninsured people and the escalation of health care costs. This is not an ideological matter. The desire to solve the first problem comes from a simple humanitarian impulse—it's wrong that any American should live in fear of not receiving decent medical care, or of being financially ruined by sickness. The desire to solve the second problem comes from an economic worry: the market, because of the nature of health care as a product, and the unique third-party method of payment, has become distorted and wastes an increasing amount of economic resources.

So what to do? There are several options available: put government in control of the entire industry to ensure equal universal coverage and complete market control, including price controls and rationing (the Old Democrat option); reform the market to ensure greater efficiency and provide incentives to give everyone the opportunity to buy a decent health care plan (the New Democrat approach, embodied best in Representative Jim Cooper's proposal); reform the market, mandate universal coverage, have government price controls if you need them and have government oversee the entire process (the Clinton plan); or split the difference still further between Clinton and Cooper (the liberal Republican plan touted by Senator John Chafee). There are also various conservative proposals, including Phil Gramm's, which rely entirely on the free market, but this does so little to address either problem that it's hardly worth taking seriously. Our conviction is that health care should be made available to every American citizen; but we also believe that the last thirty years' experience of government overreaching, the complexity of the problem and the law of unintended consequences all point to the superiority of the New Democrat approach.

Cooper's plan bears a family resemblance to Clinton's when it comes to controlling spending. Both aim to rein in rising expenses by restructuring the health care market in a way that sensitizes individuals and employers to costs that are now largely invisible to them. They do this through variants on the idea of managed competition; the plans give small purchasers of insurance buying power by banding them together in statewide cooperatives. These alliances, as they are called in the Clinton version, require insurance companies and health plans to provide information on results. But where Cooper relies purely on managed competition devices, such as the so-called tax cap, which reduces expenditures by limiting the deductibility of employer-provided plans, Clinton loses faith in his market principles and turns to external controls: global budgets, enforced by limits on price increases for insurance.

When it comes to the question of extending coverage, the plans diverge entirely. Clinton relies on mandates: employers have to pay 80 percent of the cost of a basic benefits package, while employees contribute 20 percent. The government guarantees small employers that they won't have to pay more than a fixed percentage of their payroll costs for health insurance. It also offers subsidies to the unemployed and requires them to obtain coverage through the alliances. Cooper, in contrast, has no mandate on employers or individuals: instead, he offers subsidies to individuals who can't afford coverage. His plan proposes a total subsidy for workers at or below the poverty line. The subsidy would decline along the income scale, up to 200 percent of the poverty line, at which point it would disappear altogether. The result is that Cooper's plan promises universal "access" to care rather than the cradle-to-grave guarantee of Clinton's.

Most of its critics identify the lack of universal coverage as a devastating fault in the Cooper plan. But in our view, it's a central strength. Cooper shares with Clinton a desire to extend insurance to the 37 million Americans who currently lack it. He too wants government to regulate the insurance industry in order to remove the barriers that make it impossible for many people to obtain coverage, and leave millions more in fear of losing it. He too thinks government has an obligation to help the poor and near-poor pay for health care. Beyond that, however, Cooper regards medical coverage as a matter of personal responsibility, not a new entitlement. This distinction is what makes Cooper's proposal the true New Democrat alternative, and marks Clinton's as a more traditionally liberal one. The New Democrat says that once government removes the barriers that prevent its citizens from taking care of themselves, it's up to individuals to act on their own behalf.

A more circumscribed view of government's proper role echoes throughout Cooper's plan. Cooper tries to encourage good behavior with incentives such as the tax cap, rather than compelling it by force of law. The result is a system far less bureaucratic and complex than Clin-

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ton's, under which, to take a random example, the cost of a child's health insurance might be met through contributions from four different sources: father's employer, mother's employer, family income and the federal government. It is also one that does less to compromise personal freedom. Cooper places no mandate on employers or individuals. And unlike Clinton, he does not deploy a backup apparatus of price controls, should managed competition fail to work its magic. If people still wish, in full knowledge of what they are doing, and with greater market efficiency, to devote more of their paychecks to health care, Cooper lets them.

It is not certain that Cooper would do a better job than Clinton in controlling costs. But he is willing to face more directly the fact of limits to our resources and choices. Clinton spells out a generous basic benefits package that insurers must offer for a legally controlled price, and plans to make it even more generous in the future. He has included sops for unions and for both large and small employers. There will be no sacrifices in "quality." Gains in efficiency—along with a small tax increase—will pay for it all. Cooper recognizes that we can't have more and more for less and less. His plan would defer the issue of the basic benefits package to the national health care board that his bill would create. It would be up to the board to determine what procedures are "medically appropriate." This is probably necessary as political cover; Cooper is no more inclined to crow about rationing than Clinton. But Cooper seems to understand that the only way to get a handle on the explosion in costs is to declare that basic insurance cannot pay for treatments that are not cost-effective.

What you lose, of course, is the historic watershed of completely guaranteed coverage, which is the major social (and political) attraction of a mandate-based scheme. But whether they are applied to businesses or individuals, mandates are fraught with problems. A requirement that employers provide insurance is sure to cost some jobs. It also ignores the social reality that fewer and fewer American workers are tied to a single company; because mandates of all kinds are a hassle and an expense, employers are increasingly using part-time workers and subcontracting for their labor needs. A health care mandate accelerates this trend even as it clings to the old system. An individual mandate such as the one that forms the basis of the liberal Republican alternative sponsored by Chafee is easier to justify on the same grounds that states require drivers to obtain auto insurance: Those who don't get coverage are free riders, passing costs to everyone else on the road. But an individual health care mandate must be accompanied by the means for everyone to fulfill it. Otherwise, the government is in effect outlawing poverty. And even with a generous subsidy, an individual mandate is nearly impossible to enforce. People who show up in emergency rooms without insurance still have to be treated.

Clinton's plan actually relies on a mixed mandate; as such, it combines some problems of each; it chills job creation, entails massive regulatory power for state-based alliances and applies an unenforceable requirement to individuals. Of course, a system without mandates has a disadvantage, too—it leaves some people uncovered. Which is the graver ill depends largely on how many go without insurance under a Cooper-type scheme. That number is largely a function of how generously the government decides to subsidize low-wage workers. At the level Cooper's subsidies are now set; a family of four with an income of $21,000 would get a subsidy of about $2,000 (toward the purchase of insurance that now costs an average of about $4,000). We'd prefer a more generous package, but under current fiscal conditions, the initial goal should be to remove the structurally uninsured—the working poor and those between jobs—from the ranks of the uncovered. After that, the government could attack a smaller and better-defined uninsured population with targeted incentives. If, for example, large numbers of young people still failed to obtain policies, they might be reached through deferred loan repayments.

The single biggest problem with Cooper's bill is that, like Chafee's, it may encourage the dumping of low-wage workers onto the public system. If the government provides a substantial subsidy, employers will feel less pressure to maintain coverage—especially if government actually *requires* individuals to obtain insurance. This is not necessarily a bad thing; evolution toward a system where individuals rather than businesses shop for health care probably makes sense in the long run. But it is a political problem. As the changeover occurs, more and more Americans will be insured with the aid of a government subsidy. If it happens quickly, this means tax increases to cover the expense. This is an implication the Republican supporters of Chafee's proposal don't seem to have noticed yet. But then, being Republicans, they haven't even stipulated how they intend to pay for the generous subsidies (up to 250 percent of poverty) in their plan. A good place to start is Clinton's proposed seventy-five-cent-a-pack cigarette tax, which Cooper and Chafee should endorse as sound policy in any case. If the revenue isn't needed to pay for the uninsured, the money can go toward reducing the deficit.

No plan is likely to pass next year without the support of the blocks of votes represented by Clinton, Chafee and Cooper. We'd like to see a compromise based on the Cooper version because we think its market-based mechanisms will work best to cover the uninsured and control costs without creating a bureaucratic nightmare. But Cooper's plan wins our support because of an additional virtue, which is connected to the others: restraint. This is a quality appropriate to the enactment of the first major social program since the mixed successes of the War on Poverty and the Great Society. Those examples should encourage liberals not to remake the errors that led to the general distrust of government action, but rather to learn from them in order to win back the public confidence that old-style liberalism lost. Unlike the Clinton plan, Cooper's doesn't envision wholesale remaking of present arrangements. It builds on the system we already have; it's a real step forward, but one that is based on New Democrat pragmatism, rather than Old Democrat ambition. We think it's the place to start. •

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THE WALL STREET JOURNAL MONDAY, FEBRUARY 14, 1994

Cooper Plan, Clinton Lite

By Michael Tanner

Rep. Jim Cooper is the latest darling of health care reform, according to much of Washington. The Business Roundtable endorsed much of his plan. The nation's governors are reported leaning his way. Even Ross Perot invited him to lunch.

But while the desperate search for an alternative to President Clinton's health reform plan is understandable, everyone should think twice before embracing Mr. Cooper's proposal. "Clinton Heavy" may be terrible, but "Clinton Lite" is not a whole lot better.

Rep. Cooper's bill owes its popularity to the absence of many of the Clinton plan's worst features—employer mandates, price controls, mandatory purchasing alliances, etc. It even avoids the individual mandate popular in some "conservative" reforms. However, a closer look at Rep. Cooper's proposal reveals its own litany of horrors.

Like its Clinton progenitor, the Cooper plan is based on the untested concept of "managed competition." As Alain Enthoven, one of the leading proponents of managed competition admits, managed competition is not "a free market system." He is certainly correct about that. It is possible to have either managed health care or to have open competition in health care services. It is not possible to have both.

Misplaced Faith

Advocates of managed competition—including both Mr. Clinton and Mr. Cooper—want government regulation to substitute for market processes. They lack confidence in the ability of health care consumers to make their own decisions. Even more than the Clinton plan, Rep. Cooper's bill is designed to funnel Americans into health maintenance organizations. He accomplishes this by limiting the tax deductibility of employer-provided insurance to the lowest-cost plan available.

PRICING HEALTH CARE

Rep. Cooper and other advocates of managed competition have a tremendous faith in the ability of managed care to control health care costs. However, a 1992 report by A. Foster Higgins Co. indicated that half of employers who switched from non-managed care plans to HMOs said their HMO rates were as high or higher than their previous rates. Likewise, a Congressional Budget Office report found that shifting Medicare patients to HMOs "had little or no effect on hospital use and costs." In addition, a recent RAND Corp. study indicates that managed care providers were as likely as fee-for-service providers to perform unnecessary procedures.

By pushing Americans into managed care, the Cooper bill holds the potential to severely disrupt the traditional doctor-patient relationship. Managed competition changes insurers, in Mr. Enthoven's words, from "financial intermediaries with expertise in underwriting risks" into "health care delivery systems . . . organizing, managing and purchasing medical care."

In short, advocates of managed competition believe physicians should be responsible to insurers, rather than to the patient. Thus, the patient's choice of physician should be limited to give the insurer increased bargaining power with the doctor. And insurers must have increasing control over physicians' choice of treatment, so that insurers can "apply quality assurance or review of appropriateness." Managed care plans are notorious for second-guessing physicians and limiting access to some types of treatment.

The Cooper health care bill—like the Clinton plan—is based on the mistaken belief that government can manage a marketplace better than consumers themselves.

As Swiss medical philosopher Ernest Truffer has noted, the increasing interjection of third parties between doctor and patient "amounts to a rejection of the *medical* ethic—which is to care for a patient according to the latter's specific [medical] requirements—in favor of a *veterinary* ethic, which consists in caring for the sick animal not in accordance with its specific medical needs, but according to the requirements of its master and owner, the person responsible for meeting any costs incurred."

A second major problem with the Cooper plan is its requirement that insurers must accept all applicants, regardless of whether they are in perfect health or on their death beds. That includes those with active illnesses, such as cancer or AIDS. The goal for such a requirement, known as "guaranteed issue," is to increase access to insurance for individuals with pre-existing medical conditions. But at what cost?

Studies indicate that while employers with high-risk employees would certainly notice improved access to coverage under proposed insurance reforms, overall premiums could increase substantially. A study by the American Society of Actuaries found that claims costs of guaranteed-issue policies averaged 38% higher. This confirms earlier studies by Community Mutual Insurance of Ohio and Tillinghast Corp. that showed premiums increasing by 25% to 35% under guaranteed issue. Even the liberal advocacy group Families USA Foundation estimates that 50% of small groups would experience a rate increase if guaranteed issue is adopted.

The net result would be to force many small businesses to drop their current insurance coverage. While some currently uninsured workers would move into the insurance market, others, who now have insurance, would be forced out. Thus the Cooper bill could actually increase the number of uninsured.

These problems are compounded by the ability of people to "game" the system. The reason that healthy people purchase health insurance is the fear that they may lack such insurance if they become sick. However, if health insurance becomes available regardless of health status, much of the incentive to pay for insurance while healthy is removed. Since the Cooper bill does not require people to purchase insurance, it would become a rational choice to do without health insurance until the need arises.

Automobile insurance provides a good analogy. If it were possible to purchase auto insurance after an accident occurred, would people be likely to purchase insurance before the accident?

Rep. Cooper would also require modified "community rating" of insurance premiums. Insurers would be prohibited from basing premiums on an individual's health. Healthy people and sick people would pay the same for insurance.

But insurance is a business of risk allocation, in which the insurer receives payment in exchange for agreeing to cover the expense of certain risks. The cost and scope of coverage is determined by morbidity/mortality statistical analysis. To the degree that insurers are prevented from basing their contracts on such actuarial values, other policyholders will be forced to absorb the additional costs. Thus, in order to provide coverage for a person with AIDS, a person without AIDS must pay a higher premium.

Moreover, the additional costs are highly regressive, forcing the highest marginal costs on those least able to afford the increase. For example, if community rating causes the premiums for a family policy to increase by $1,000, that's a 5% surcharge for a family earning only $20,000 a year, but only a 1% surcharge for a family earning $100,000.

We should also recognize that community rating relieves individuals of the responsibility for unhealthy lifestyles. There is no question that individuals who smoke, drink, use drugs, practice unsafe sex, have poor diets, and fail to exercise have far higher health costs than individuals with healthy lifestyles. In fact, the top 10 causes of death in the U.S. are all lifestyle related. By spreading the cost over the entire population, community rating and guaranteed issue "socialize" the costs in the truest sense of the word.

Lobbyists vs. Consumers

Unlike President Clinton's bill, Rep. Cooper's does not spell out the services to be covered under the minimum standard benefits package, leaving that task up to an independent commission. This is apparently an attempt to insulate decisions on what benefits to include from political pressure. But based on history and human nature, inclusion in the mandated benefits package is much more likely to be based on the relative lobbying strength of various providers than on a rational view of medical necessity. Whatever benefits are mandated will increase the cost of insurance. And consumers will be deprived of the ability to make individual choices regarding the benefits they wish to purchase.

Ultimately, the Cooper bill—like the Clinton plan—is based on the mistaken belief that government can manage a marketplace better than consumers themselves.

The talk on Capitol Hill is that health care reform will ultimately be a compromise between the Clinton and Cooper bills. A compromise between a bad plan and a not-quite-as-bad plan cannot possibly be good for the American people.

Mr. Tanner is director of health and welfare studies at the Cato Institute in Washington.

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Clinton and Cooper Health Proposals: How They Compare on Major Issues

By Hilary Stout
Staff Reporter of The Wall Street Journal

WASHINGTON—Legislation written by Rep. Jim Cooper (D., Tenn.) gained new attention this week when the Business Roundtable supported it as a "starting point" for congressional deliberations on health care.

To many people, the Cooper bill has become the leading alternative to President Clinton's health plan, the rallying symbol for those who consider the White House proposal to be too rich, too regulatory and too bureaucratic. But to others, including the administration, the Cooper plan is too timid and too vague.

Here is how the two bills compare on the major issues:

Coverage. The Clinton bill would guarantee health coverage for all Americans. The Cooper bill wouldn't, although its authors argue it would remove so many obstacles that nearly everyone could obtain health insurance.

Under the White House plan, all employers would be required to pay, on behalf of each full-time worker, at least 80% of the cost of the average price of a federally defined health-benefits package. Lesser contributions would be required for part-time workers. Poor and unemployed people would get government subsidies to help pay for coverage.

The Cooper bill would require all employers to offer their employees a health plan, but it wouldn't require them to pay for it. It would provide subsidies to help low-income people buy health insurance.

Both the Clinton and Cooper proposals would outlaw a number of insurance practices that make it difficult for people to obtain coverage. They would forbid insurance firms from denying coverage to people with so-called "pre-existing" medical conditions, from raising premiums on the sick and from dropping high-risk people from health policies.

Benefits. The Clinton bill would establish a national benefits package for every American — including coverage for hospitalization, physician visits, prescription drugs and a range of preventive services like childhood immunizations. The Cooper bill also provides for a standard benefits package, but the details would be determined later by a federal commission, and would be subject to congressional approval. Guidelines in the Cooper legislation say the package would have to cover preventive care, prescription drugs and medically appropriate services and procedures. Mr. Cooper said this week he is willing to specify an interim benefits package in the bill.

Purchasing Pools. Both plans would unite businesses and consumers in insurance-buying pools. The pools would collect premiums from individuals and businesses to pay for various plans providing the standard benefits package. Individuals then would select from among the plans. The idea behind the pools is to spread insurance risk and increase the negotiating power of consumers in the health-care market.

But there are big differences between the Clinton and the Cooper plans.

The Clinton bill would require all employers with fewer than 5,000 workers to join the "health alliances" in their regions. The alliances would be set up and supervised by the states. They would monitor the quality of health plans, and would impose ceilings on health-insurance premiums.

The Cooper bill would set up regional, nonprofit, state-chartered "health-plan purchasing cooperatives." Only businesses with fewer than 100 employees would be required to join the cooperatives, which wouldn't have as many powers as the Clinton health alliances.

Cost Containment. Both bills seek to stimulate competition in the health industry in order to hold down prices. But the Clinton plan also would place legal ceilings on premiums for the standard benefits package. Both would offer incentives to encourage enrollment in health-maintenance organizations and other prepaid networks of doctors and hospitals.

Taxation of Health Benefits. Ten years after enactment of the Clinton bill, employees would have to pay taxes on any health benefits they receive that aren't in the standard benefits package — unless they were receiving these extra benefits as of Jan. 1, 1993. Employers could continue to deduct all their health-benefits costs.

The Cooper bill would limit employer deductions to the cost of the lowest-price "accountable health plan" in each region. For workers, health benefits would continue to be tax free. The Cooper plan also would allow individuals to deduct any portion of their health benefits that they pay themselves.

Both plans would allow self-employed people to deduct 100% of the cost of their health coverage.

Financing. The Clinton plan would raise taxes on cigarettes and other tobacco products. It would cap spending on Medicare and Medicaid, the two big government health programs, and use the savings to help finance universal coverage. It also would assess a 1% payroll charge on large corporations that opt not to join the regional alliances.

The Cooper plan would use revenues raised from limiting employer deductions for health benefits to finance subsidies for low-income people.

Subsidies. The Clinton plan would subsidize health premiums for people whose income is less than 150% of the poverty level, and for businesses with fewer than 75 workers and wages that average under $24,000. It also would have the federal government absorb 80% of the health-insurance costs of people who retire before age 65.

The Cooper plan would subsidize health premiums for people who earn less than 200% of the poverty level.

Medicare. Both plans would leave it virtually alone.

Sponsorship. The Clinton plan is sponsored almost entirely by Democrats, with the exception of Sen. James Jeffords (R., Vt.). The Cooper plan has bipartisan sponsorship, consisting mostly of conservative Democrats and moderate Republicans. While Mr. Cooper has gotten most of the publicity, the legislation's other chief sponsor in the house is Rep. Fred Grandy (R., Iowa).

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SUMMARY: CLINTON

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State

Jeffords Favors Tax-Based Health Care Plan

By BRYAN PFEIFFER
Vermont Press Bureau

WASHINGTON — Sen. James Jeffords, R-Vt., once again buck-g the party line, says Vermonters uld be better off paying taxes to e state for health care instead of ying premiums to insurance com-nies.

Jeffords expressed support ursday for a proposal emerging the Vermont House that would place insurance premiums with ndatory taxes on businesses and useholds.

To most Republicans, especially ders in the Vermont Senate, the tion of taxes for health care is too dical. To Jeffords it is nothing w. For more than a year he has shed a national reform plan that, some respects, resembles Cana-s system because it relies on es and a greater government e in health care.

effords says taxes are a better asure of a household's or an em-yer's ability to pay for health in-ance, and would therefore be a ter deal for small businesses and sumers in Vermont compared to at they would pay in insurance miums.

For businesses, especially those inesses that have relatively low-ried people, it would be a lot aper for them," Jeffords said in interview in his Washington ate office. "And unfortunately ave a lot of those in Vermont."

oy. Howard B. Dean, like Sen-Republicans, opposes raising s for health care, even if they laced insurance premiums. n argues that the House plan pushed by Speaker Ralph G. Wright and Democratic Leader Sean P. Campbell of Rockingham, would put Vermont's taxes out of whack with its neighbors and deter people with higher incomes who start busi-nesses and create jobs.

Dean also says a tax-based plan would never pass the Republican-controlled Vermont Senate and would be less acceptable to the U.S. Congress, which must change a federal law if Vermont wants to get an early start on health care reform.

A tax-based health care system may be fairer, Dean says, but it is useless unless it can pass and get all Vermonters insured by next January.

"Being the right thing to do is different than doing something that isn't going to pass," said Dean's spokesman, Glenn Gershaneck. "If you do the 'right thing' and haven't gotten anywhere with it then you haven't done the right thing."

Dean's own health reform proposal would require all employers to pay at least half of the insurance premium for their workers. An expanded Medicaid program would ease the cost for families and employers, and subsidies would help the uninsured. For a married employee earning $20,000, the employer share would be at least $2,034 and the worker's share would be no more than $2,034.

Both the employer and the worker would fare better under even the highest tax rates mentioned so far for Vermont — about 8 percent on employer payroll and 3.5 percent on household income. For the same married employee, the business would pay $1,600 and the worker would pay $700 under the tax-based plan, which shifts costs to wealthier individuals and employers paying higher wages.

Rep. Bernard Sanders, I-Vt., lit into Dean and his proposal Thursday. Sanders compared the governor to former president Ronald Reagan and his zeal to protect wealthy people from higher taxes.

Sanders said health care, like education, should be is a right guaranteed by the state and financed in a progressive way.

"What the governor has done is adopted the Republican position of making sure that the money is raised from working people, low-income people and not from the very wealthy," Sanders said in an interview. "Nothing new about that. I see this every single day right here in the Congress from conservative Republicans."

"That is exactly what the governor's so-called health care reform is all about," Sanders continued. "It raises taxes on working people and the poor and protects the interests of the wealthy. And somehow when we do that, when we're very nice to the rich they will trickle down on us and provide us with jobs and all kinds of benefits? It's a fraud. Reaganomics has not worked."

Interestingly enough, Sanders and Jeffords have a few things in common on health care. Jeffords' own reform proposal would replace insurance premiums with a 4 percent federal tax on employer payroll and a 2 percent tax on employee income, with an additional income tax that would apply to the wealthiest Americans.

The federal government would distribute money to states, which would run their own health care systems in ways that encourage competition among networks of doctors and hospitals that resemble health maintenance organizations.

Jeffords said he was comfortable with his position favoring taxes, even though it runs counter to Republican philosophy. When more Vermonters look at the bottom line, he said, they will find the tax-based system more acceptable, in spite of Dean's concerns about the state's income tax rates.

"If you've got more cash in your pocket, it's going to cost you less ... then you're not going to be unhappy," Jeffords said.

Jeffords noted that the Vermont Retail Association, representing more than 700 small businesses, has endorsed a health care plan similar to his own — a state-run health care system financed with taxes on employer payroll and household income.

Although he at one time considered payroll taxes, Clinton and many others in Washington now say it would be unrealistic to expect Congress to raise taxes, even if they were to replace insurance premiums.

Jeffords is nevertheless the only Republican in Congress to support Clinton's health bill, saying it would allow Vermont the flexibility to continue with its own health care reform initiative.

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Cops and Doctors

It May Take a National Police Force to Monitor the Clinton Health Plan

By Grace-Marie Arnett

ONE OF the more arcane gripes about President Clinton's health care plan is that prisoners might not be adequately covered. They needn't worry: The Clinton plan creates plenty of opportunities for doctors to go to jail.

In fact, not just doctors. The 1,342-page Health Security Act text provides a cornucopia of fines and prison sentences for everyone involved in health care—physicians, health alliance and health plan employees, lawyers, drug manufacturers, medical suppliers and even patients.

These draconian punishments have been largely overlooked in the debate over other hot-button questions about the Clinton plan such as its financing, de facto rationing, price controls and creation of powerful new government bureaucracies.

But the enforcement provisions deserve scrutiny as well. Not only would they subject virtually every citizen to civil and criminal penalties, but they could make it financially and legally risky for physicians to open or maintain independent practices, significantly limiting physician choice.

The White House certainly did not set out to create a punitive system. The president directed his health care task force to design a system built around the concept of "managed competition," under which health plans compete to provide a basic package of health services to subscribers. But the president also said his plan must guarantee universal coverage—a government mandate at odds with the managed competition concept. While any bill must have enforcement provisions, the result of this marriage is a bureaucratic compliance maze and a system that could be hostile to both physicians and patients.

Grace-Marie Arnett is president of Arnett & Co., a Washington firm that specializes in health policy consulting to innovative medical companies. Cliff R. Balkam assisted in the preparation of this article.

Here are a few of the powers, penalties and enforcement authorities proposed in the Health Security Act that the president sent to Congress:

- All American citizens not specifically exempted will be required to register with a health alliance. Individuals, families or employers must pay their required premiums. Failure to pay can result in a fine of $5,000 or three times the amount owed, whichever is greater. Health alliances will have government help in collecting from deadbeat subscribers: "Each State shall assure that the amounts owed to regional alliances in the State are collected and paid to such alliances."
- The bill creates a new "All-Payer Health Care Fraud and Abuse Control Program." It will be run by federal authorities but will receive no federal appropriation. Instead, all of its revenues will come from penalties and property forfeitures collected from doctors, individuals and health plans that commit "health care offenses," creating a clear incentive for the feds to aggressively seek out offenders.
- "Whoever, in any matter involving a health alliance or health plan . . ." knowingly creates or uses any documents that contain false statements can be fined, imprisoned for five years, or both.
- Anyone who acquires services or property from a health alliance, plan or provider under false pretenses shall be fined or imprisoned for up to 10 years, or both. If the incident were to result in "serious bodily injury," the offender can be jailed for life.
- What might today be considered normal patient advocacy can become a federal criminal offense under the Clinton plan. For example, if a doctor working for a health plan wants to get her patient an earlier date for surgery and takes "anything of value" from the patient, both the physician who takes the payment and the patient who offers it are subject to fines and prison terms of up to 15 years.
- Doctors and health plans that fail to pro-

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vide proper data on "clinical encounters" or who fail to submit data in the form required by the Quality Management Council can be fined up to $10,000 for each violation.

■ Drug companies that do not provide cost information to the government quickly enough risk $10,000-a-day fines, and if the government finds an error, the fines increase to $100,000 per violation.

While the president insists that patients will be able to choose their doctors, a special set of rules will make it perilous for doctors in independent practice to continue going it alone and even more difficult for new physicians to establish their own practices. Most doctors likely will feel compelled to join a health plan that provides bureaucratic cover. Among those rules:

■ Although physicians and other fee-for-service providers "may collectively negotiate the fee schedule with the regional alliance," the state may at its option "establish its own statewide fee schedule" that overrides the negotiated rates.

■ Physicians and other providers who are part of a fee-for-service plan may not withhold their services, even if they object to the state-imposed rates, because the bill prohibits them from "engaging in or threatening to engage in a boycott."

■ Regardless of the negotiated fees, an alliance that exceeds its budget can withhold or delay payments to providers "in such a manner and by such amounts as necessary to assure that expenditures will not exceed the budget."

■ Physicians practicing in a state that opts to create its own single-payer system face "automatic, mandatory, non-discretionary reductions in payments" to allow the state to stay within its budget.

Once an individual is enrolled in a health plan, the plan may not drop the subscriber no matter what—that is, it may not "terminate, restrict or limit coverage . . . for any reason including nonpayment of premiums." Without the ability to withhold service, it will be very hard for plans to collect premiums in a timely fashion—notwithstanding the various fines and enforcement mechanisms described earlier.

As a result, some health plans may find themselves insolvent. To protect against another savings and loan-type taxpayer bailout, the administration plan forces successful health plans to bailout the losers. If one plan in an alliance fails, the other plans may be required to pay an assessment of up to 2 percent of their premiums "for so long as necessary to generate sufficient revenue to cover any outstanding claims against the failed plan."

But physicians and health plans aren't the only ones at financial risk; employers and individuals are, too. If the National Health Board determines that any state's system fails to provide the prescribed benefits package, the federal government will move in, take over the state system and collect premiums from alliance members, plus a 15 percent surcharge "for any administrative or other expenses incurred as a result of establishing and operating the system."

The primary authority the bill grants to patients is the right to select, once a year, a health plan from among those pre-selected by their alliance. But those choices are circumscribed: If a plan is oversubscribed, those already enrolled get preference to stay, and remaining slots will be filled by the alliance through a "random selection method." Those who fail to choose a plan will have one selected for them by the alliance, also "on a random basis." Anticipating dissatisfied consumers, the bill clearly defines individuals' rights to sue and to file complaints.

Other powers are directed toward ensuring that 55 percent of all medical school graduates are trained in primary care. Training slots for specialists will be rationed, using $6 billion in federal funding for graduate medical education as the stick. The new National Council on Graduate Medical Education will decide how many specialists will be trained in which fields based upon "the incidence and prevalence . . . of the diseases, disorders, or other health conditions with which the specialty is concerned." Because it can take up to a decade to train a specialist, the council's first investment should be in a good crystal ball.

Perhaps all these proposed sanctions and penalties would serve to direct patients, physicians and health plans into a more equitable health care system. But some skepticism is warranted. "No matter how clever these legislative drafters may be," said John S. Hoff, a leading health care lawyer and reform analyst, "the bill reflects real hubris in trying to close all of the escape routes for 257 million people."

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KEY ISSUES

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MANDATES : INDIVIDUAL

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Players and Payers

By Michael Graetz and James Tobin

The President and First Lady have achieved remarkable consensus on a truly revolutionary principle: all Americans must be entitled to adequate medical services without regard to ability to pay or risk of ill health. Now it's up to Congress to embody that principle in law, a historic opportunity comparable to the enactments of Social Security in 1935 and Medicare in 1965.

Unfortunately, excessive solicitude for existing institutions and interests, and the difficulties of reconciling them with the Clintons' fundamental principles, have made their proposal a bureaucratic and legalistic morass.

The issue is much more basic than what is now preoccupying Washington: whether the reforms would modestly raise the Federal deficit in the short term, as the Congressional Budget Office said this week, and whether federally mandated insurance premiums should be "on budget." The biggest flaw in the Administration proposal is the requirement that employers pay the premiums — a mandate whose awkwardness and unfairness stand out starkly in a system dedicated to universal coverage.

Employer-based medical insurance is a historical accident — one that no one would choose now if given a clean slate. During World War II, trade unions and employers circumvented Federal wage ceilings by offering medical fringe benefits. Their popularity and generosity boomed after the war, as Congress sheltered them without limit from income and Social Security taxes.

The fact that employers write the checks for medical care does not mean that they bear the full costs. They can generally shift some costs to workers in reduced take-home pay and some to customers in higher prices. The sure losers are taxpayers who have to make up the revenue lost to the tax shelter.

Much of the Administration's 1,342-page proposal is devoted to expedients intended to mitigate the difficulties and anomalies of employer mandates. It's a hopeless task. Some families have no employed members. Some have two or more. Many employees work part time. Some have more than one job. Americans frequently change jobs, employers, work locations, places — even states — of residence.

Responsibilities for paying a family's premiums would frequently be divided among several sources — various employers, governments and the family itself — in proportions varying month to month. Keeping track of these liabilities would surely involve extensive paperwork and administrative hassle, contrary to Mrs. Clinton's claim that an employer mandate eliminates the need to track individuals.

Nor would the new system be equitable. Equity demands that public subsidies, direct or via employers, be a larger share of premiums and of income the poorer the family. Equity also requires that families' subsidies be the same if their incomes are the same. But in the Clinton plan, subsidies depend more on the size of employers' payrolls than on families' ability to pay. The system is also full of bad incentives — for example, not to hire workers with dependents.

It's individuals who get sick and need medical services. It's individuals and families whose ability to pay is the natural criterion of equity. It's individuals who must be guaranteed coverage. So it is it's individuals who must be required to have insurance. Let employers help pay the premiums if they wish, but count those payments as taxable income. Treat the self-employed exactly the same as employees.

HEALTH CARE SECOND OPINIONS
An occasional series.

Let people choose where they will buy insurance. One option should be a kind of Medicare for those under 65; call it perhaps Fedmed.

Fedmed would offer the basic universal medical insurance package at premiums that in total would cover the costs. Let private health plans offer the same package, provided they do not pick and choose members or charge higher premiums for risky cases. As in the Clinton plan, it would probably be necessary to collect money from plans that happen to have low-risk clienteles and distribute them to plans with high-risk members.

With these provisions, Fedmed would be protected against becoming the last-resort insurer of bad risks. As in Medicare itself (which would continue as at present), people could choose their own physicians and other providers. Like Medicare, Fedmed would have low administrative costs and would wield enough clout to limit payments to providers. Like Medicare, Fedmed would let people change employment status, residence or family situation without losing coverage. But it need not be a monopoly.

Abandon the employer mandate.

Federal subsidies to individuals would take the form of refundable tax credits, "vouchers" payable to Fedmed or other insurers. For low-income families the subsidies would cover the whole premium of the basic package; most other families would receive vouchers at least as valuable to them as the current tax exemption for employer-provided insurance.

A family of four in the 28 percent tax bracket with a $4,300 insurance package would receive vouchers of $1,204 — 28 percent of the premium. No family would face an out-of-pocket cost of more than 8 or 10 percent of their income for the basic package.

This plan would not require new broad-based taxes or new burdens on employers. One source of financing would be redirecting the Clintons' proposed subsidies to employers and low-income people, estimated at $100 billion in 1999 (somewhat more by the Congressional Budget Office). Eliminating the tax shelter for employer-paid premiums would contribute $125 billion, and our plan would replace Medicaid acute care for those under 65 ($75 billion more).

Robert Reischauer of the C.B.O. destroyed a semantic attraction of employer mandates when he testified that federally required purchases of insurance should be included in the budget. Their popularity is waning among businesses and in Congress, where support appears to be growing for the plans of Representative Jim Cooper and Senator John Chafee; unfortunately, these plans do not assure universal coverage in this century.

Our proposal is not a radical reconstruction. It builds on the best of existing institutions. A victory for it would be a victory for the basic principles that the Clintons have so eloquently set forth. □

Michael Graetz, professor of law at Yale, was Assistant to the Secretary of the Treasury from 1990 to 1992. James Tobin, emeritus professor of economics at Yale, won the Nobel Prize in Economic Science in 1981.

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MISPLACED MANDATE: WHY INDIVIDUALS, NOT EMPLOYERS, SHOULD PICK UP THE TAB

BY MICHAEL J. GRAETZ

My message here is simple. First, universal health insurance, like universal auto accident insurance, requires that coverage be mandated. Second, many current proposals either fail to face the mandate issue or, as in President Bill Clinton's proposals, put the mandate in the wrong place: on employers. Both alternatives increase the danger of stumbling into health-care reforms that will fail to provide the secure, portable, adequate, universal, and reasonably priced medical care we all want.

The impetus for employer-mandated health coverage is not grounded in a vision of appropriate delivery of health insurance coverage, but rather concerns for maintaining existing sources of health insurance financing and the political need to minimize taxes to finance health reform. If universal health insurance coverage is the government's responsibility, like providing roads and libraries, it is simply bizarre public policy to link health coverage to employment and then fill in the gaps for those unemployed or retired.

The only reason for this link is that employment now provides much such coverage, and no one is willing to challenge that status quo. Employer mandates have far less to do with where we wish to take health reform than where we are now.

COMMENTARY

The current failing health-care financing apparatus in the United States has resulted from a series of incremental policy decisions that have had little or nothing to do with the development of a coherent national health system. Employer-provided health coverage received an important stimulus from the exemption of such fringe benefits from the wage and price controls of the 1940s.

An enduring further boost was provided by the exemptions from income and Social Security taxes for employer-provided health insurance. Because of the tax advantages, employers find that about 65 cents of additional heath coverage is worth a dollar of cash wages for most of their employees, and, therefore prefer paying health benefits over cash wages.

Finally, the Employee Retirement Income Security Act of 1974 (ERISA), concerned principally with protecting employee pension benefits, made employers' self-insurance of employee health benefits desirable by insulating employer self-insurance plans from state premium taxes and regulations.

Despite uneven effects, these incentives for employer health coverage have enjoyed some success: Employers provide health insurance to about 60 percent of the U.S. population, and employment-based insurance accounts for about one-third of total health-care spending. The government loses about $65 billion of tax revenue annually. But this nation can no longer rely on voluntary employer health insurance as the backbone of health-care finance.

If we really mean *everyone* when we say "universal," then a government requirement—a mandate—to purchase health insurance seems inevitable. Many young healthy people regard the purchase of health insurance as a bad deal now, and the forthcoming community rating of health insurance, which will bar insurers from taking good health (as well as bad) into account in setting premiums, will raise costs for healthy people (although some of this increase may be offset by the purchasing power of the entity purchasing large quantities of insurance). To spread the financial risks of poor health across the whole populace, coverage must be mandatory.

Moreover, the existence of the medical safety net—porous as Medicaid and free hospital emergency room care are—demands mandatory heath insurance coverage. Otherwise people who experience remote risks, but expensive costs, of bad health will be paid for not through their own insurance, but instead through shifting these costs onto others.

To be sure, a mandate would have to be accompanied by subsidies for the poor, many of the disabled and elderly, the unemployed and at least a very large number of middle-income families. But this pattern of subvention would not be new in health-care financing; federal, state, and local governments now pay large subsidies for each of these groups, albeit in a haphazard and often uncoordinated way.

Many key political actors, including President Clinton, have accepted the view that a mandate is necessary to make health reform work, but have chosen to mandate employers to provide health insurance coverage for their employees. For those mostly large employers who already provide good health coverage there is, of course, little burden associated with a requirement to provide a standard package of health insurance benefits; these firms just would not be permitted to drop coverage below the level of the government's mandate. On the other hand, for small businesses, who do not now provide employees with health insurance, mandated coverage would substantially increase the costs both of keeping their employees and of hiring new ones.

Those who support employer mandates must have concluded that current circumstances demand that we preserve the existing health insurance base by prohibiting employers from abandoning existing employee coverage, and the quest for universal coverage moves them to require that other employers also provide equivalent health coverage for their employees.

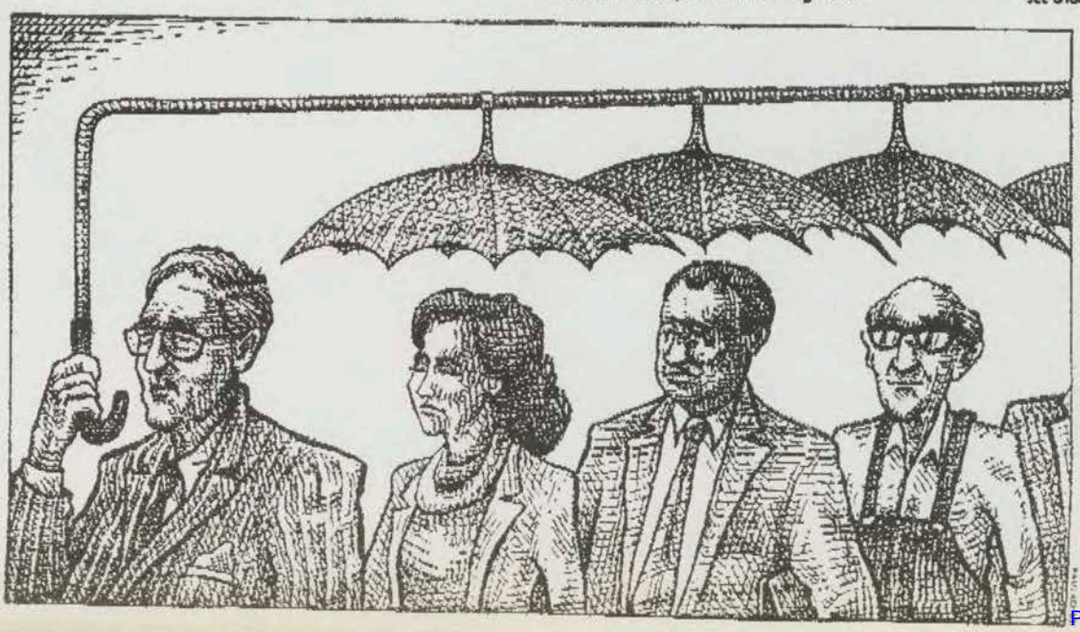
The consequences of an employer mandate, however, would be quite different from a requirement that all individuals or families obtain health insurance coverage. For those employers who wished to circumvent such a mandate, there could be incentives to use temporary help, overtime, cash transactions, and independent contractors rather than employees.

Adverse Consequences

The adverse consequences of employer mandates would be harshest for marginal employees and marginal businesses. Often, Congress attempts to avoid some adverse consequences of mandates by exempting small businesses. Such exceptions are not possible in health-care reform, however, if coverage is to be universal. The percentage of employees

SEE GRAETZ, PAGE 45

Michael J. Graetz is the Justus S. Hotchkiss Professor of Law at Yale University. He served as deputy assistant treasury secretary for tax policy from 1990 to 1991 and as assistant to the secretary and special counsel in 1992. This commentary is adapted from an article that appeared in the fall 1993 health-care issue of Domestic Affairs.



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HEALTH-CARE INTERESTS AND AGENDAS

Employer Mandate Ties Health Coverage to Employment

GRATZ FROM PAGE 41

lacking health coverage is much higher in smaller firms—and there are roughly four million small businesses with 50 or fewer employees.

Any employer mandate certainly will be accompanied by some new subsidy for small or marginal businesses—additional charges on the Treasury that seem unlikely either to be well-targeted or equitable. Only adjusting the amount of the subsidy based on workers' incomes would address these problems, but this would make them individual subsidies, which seem incompatible and administratively difficult to coordinate with an employer mandate.

Enacting employer mandates now makes far more likely a health insurance delivery system forever tied to employment, rather than a system in which one's health insurance coverage is independent of where or for whom one works. And if we are serious about disengaging health coverage from job lock or job changes—given the secretary of labor's estimate that workers change jobs an average of eight times—an employer mandate seems a very bad prescription, indeed. What we are confronting is the familiar, but difficult, issue of transition from one public policy to another. Recognizing this to be a transitional issue, however, demands that we ask where are we heading and where do we want to end up.

We will never wean ourselves from employer-provided health insurance unless the employer-based tax incentives for health insurance are dramatically revised, and that will be no easy task. But if such change ever is to be accomplished, it should be done now while the nation is setting a new course for the delivery and financing of health care.

We need to redesign our public subsidies to create a fair and effective system that facilitates mandated purchases of health insurance for all U.S. families. To the extent that employers want to purchase or finance health insurance for their employees, the system should facilitate that. But individuals, not employers, should have the legal responsibility for obtaining health insurance.

An essential step in moving to such a system is to phase out the current tax exclusions for employer-provided health insurance and to replace them with a tax credit or voucher for the purchase of health insurance. Within the existing system there is enough money to fund a standard package of insurance coverage for all Americans, including equitable and generous tax credits.

Leaping the Transition Hurdles

With enough reshuffling of existing expenditures, additional government financing should not be necessary. The political trick—and no one should underestimate how great a trick it is—is to manage the transition from the system we now have to a system of individually based universal coverage.

In order to reduce windfalls where employers are now providing health coverage for their employees, employers could be required to maintain their current efforts for some period of transition. Such a maintenance of effort requirement should allow, or even encourage, employers to substitute cash wages for health insurance as individual tax credits are phased in.

To ensure universal health insurance coverage, the tax credits or vouchers should fully finance the standard health insurance benefits for people at the poverty level and decline gradually as family income rises. To avoid limiting their availability to those who meet a means test, and also not unduly increase the taxes of people who currently enjoy employer-provided health insurance, some minimum amount of credit should be made available to everyone. Such a progressive distribution of benefits might resemble Social Security's schedule of retirement benefits.

Such a universal tax credit financing system for health insurance coverage would have employment effects directly opposite an employer mandate. Since low-income workers would come to jobs with their health insurance largely financed, they would become less expensive to hire—not, as under an employer mandate, substantially more expensive.

Such revision of our health coverage financing system would be compatible with virtually any approach to health-care reform not employer-based. To be sure, transitional difficulties in the short run might be avoided by pitching an employer mandate onto the current system. But if we are bold now, we can move to a rational and stable, yet flexible, system of health-care finance well-suited to a modern mobile labor force—a system in which no one would lose, or even have to change, their health insurance because of job change or job loss.

If, instead, we opt for an employer mandate, we simply will have deferred the need to rationalize the system—and in the meantime, added to the costs of, and thereby jeopardized, employment. Moreover, we will fail to address the underlying concerns that working people now have about the affordability and fragility of health coverage. Moving to an employer mandate, instead of an individual mandate, would be a big mistake—a mistake that we can, and should, avoid.

An employer mandate would be a big mistake that we can and should avoid.

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sured a standard perquisite of citizenship in modern developed nations: access to health care they can afford.

Universal Health Coverage Without an Employer Mandate

Michael J. Graetz

Michael J. Graetz is the Justus S. Hotchkiss Professor of Law at Yale. He served in the U.S. Department of the Treasury as Deputy Assistant Secretary for Tax Policy from 1990 to 1991 and as Assistant to the Secretary and Special Counsel in 1992.

The message of this article is simple. First, universal health insurance, like universal auto accident insurance, requires that coverage be mandated. Second, many current proposals either fail to face the mandate issue or, as in President Clinton's plan, put the mandate in the wrong place: on employers. Both of these alternatives increase the danger of our stumbling into major health care reforms that in the long run will fail to provide the secure, portable, adequate, universal, and reasonably priced medical care that we all want.

In my view, the impetus for mandated employer health coverage is not grounded in a vision of appropriate delivery of health insurance, but rather in concerns for the maintenance of existing sources of

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health insurance financing and the attendant political need to minimize tax increases or new taxes to finance health care reform. If the assurance of universal health care insurance coverage is the government's responsibility—like the provision of roads and sidewalks, parks and libraries, and elementary and secondary education—it is simply bizarre public policy to link the right to health care coverage to employment and then fill in gaps for those who work for businesses or are unemployed or retired. The only reason for linking health coverage to employment is that employment now provides much such coverage, and no one is willing to challenge that status quo. In other words, employer mandates have far less to do with where we wish to take health care reform than with where we are now and where we have been.

Where Are We? How Did We Get Here?

Following Sergeant Joe Friday's worthy example, let us start with some facts. Americans spend more per capita on health care than do residents of Europe or Japan, but are less satisfied with what they get. Those people for whom the American health care system is working reasonably well generally get their health insurance coverage either through their employer or the government. Obviously, employer- or government-provided health insurance works better for some people than for others. Employees of large firms or government entities enjoy more and better coverage than those who work for small businesses. Union health plans usually are considerably more generous than non-union plans. Although the issue is complex because the elderly pay about half of their own medical bills and Medicare does not cover prescription drugs, Medicare generally provides for the elderly better coverage of acute care than Medicaid provides for the poor.

But even those who are well-insured today fear losing their coverage or suffering devastating cutbacks. Nearly everyone has heard about James McGann—the plaintiff in a notorious unsuccessful lawsuit—who saw his employer reduce his lifetime health coverage limit from $1 million to $5,000 the year after he learned he had AIDS, or knows someone who has lost health coverage.

The current failing health care financing apparatus in the United States has resulted from a series of incremental policy decisions that have had little or nothing to do with the development of a coherent national health care system. Employer-provided health coverage received an important stimulus from the exemption of such fringe benefits from the wage and price controls of the 1940s. This exemption allowed employers to pay their employees additional fringe benefits when they were barred from increasing cash wages.

An enduring further boost was provided by the income and Social Security tax exemptions for recipients of employer-provided health insurance. These exemptions became more valuable due to the income tax bracket creep and Social Security tax rate increases of recent decades. Today, the combined federal tax rate (including the individual income tax and the employer and employee shares of Social Security and Medicare taxes) on the median worker is about 30 percent—down from a 1982 high of nearly 40 percent, but much higher than the 17 percent rate of 1965.[1] State income taxes, with top rates as high as 12 percent, also typically exempt employer-provided

[1] Economic Report of the President, January 1993, p. 125.

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health insurance. Because of the tax advantages, employers find that about 65 cents of additional health coverage is worth as much as a dollar of cash wages for most of their employees, and, as a result, have preferred paying additional wages in the form of expanded health benefits. By the same token, union negotiators have found it easier to negotiate increases in health benefits than greater cash wages for their members.

The Employee Retirement Income Security Act of 1974 (ERISA), which was concerned principally with protecting employees' pension benefits, made employers' self-insurance of their employees' health benefits particularly desirable through a little-noticed and undebated provision that insulated employer self-insurance plans from state premium taxes and regulations. Recent court interpretations of this "preemption" provision have broadly extended self-insuring employers' protections to permit many self-insurers to avoid contributing to state health insurance reform programs. One additional unforeseen consequence of the ERISA incentives for employer self-insurance is that employers and their employees—rather than insurance companies—have borne a greater share of the burden of escalating health care costs. More than one half of the increase in employees' average real wages during the period from 1974 to 1989 took the form of increases in the costs of health benefits.

While uneven and often unfair in their effects, these various tax and other incentives for employer health coverage have enjoyed a degree of success. Today, employers provide health insurance to about 60 percent of the U.S. population and contribute more than $200 billion toward health insurance coverage of their employees. The employees themselves pay directly more than an additional $50 billion for their coverage and that of their families. The income and Social Security tax revenue that the government loses due to compensation taking this form rather than cash wages has been estimated to amount to about $65 billion this year.

But the days when this nation could rely on voluntary employer provision of health insurance as the backbone of health care finance are now past. The escalation of health care costs—coupled with increasing job mobility and insecurity and the efforts of insurers and employers alike to reduce costs by selecting people with low risks or eliminating coverage for people when they become unhealthy—has made health insurance coverage a major financial concern for virtually all Americans. Fears that employers will drop or reduce health insurance coverage are rampant, and having a good job no longer means being assured of good, or even any, health insurance coverage, if it ever did. Hardly a night passes that the evening news or a news magazine program fails to report a case of bankruptcy or Medicaid fraud, by an otherwise upstanding middle-class family, due to some unexpected health care cost emergency. Protecting all Americans against the loss of health insurance—whether due to changes or losses of jobs, moves from state to state, or bad or deteriorating health—has become one of the essential goals of health care reform.

There is now agreement across the political spectrum that something must be done—and that reform of the health insurance market is a minimum first step. Community rating, which would bar insurers and employers from precluding coverage based on preexisting conditions or deteriorating health, will be a feature of any health care reform plan, and the em-

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powerment of health insurance purchasers through greater information and larger purchasing units—so-called health insurance purchasing cooperatives (HIPCs) or health alliances—is also inevitable. This should lower substantially the average costs of health insurance coverage purchased by individuals or families for themselves and the costs of insuring a small number of employees or other small groups. Consensus ends, however, when the question of whether health insurance coverage should be voluntary or mandatory must be faced.

Why a Mandate Is Necessary

I have argued elsewhere that reliance on a voluntary tax-incentive-based private pension system to ensure *retirement security* is problematic,* and even now, two decades after ERISA increased employees' security through vesting, funding, and other requirements, many employees do not get the retirement benefits they had reasonably expected. But reliance on voluntary provision of *health insurance* is far more risky. The mandatory Social Security system guarantees a minimum level of retirement income security for both retirees and disabled employees, while, by comparison, only Medicaid and mandatory free hospital emergency room care cushion the lack of health insurance coverage.

In principle at least, virtually everyone prefers solutions to problems that emerge through voluntary, rather than government-coerced, behavior. But in this case, it would be ineffective and expensive to depend on voluntary behavior. Because access to a basic package of health coverage is not universal, cost-shifting is routine in the American health care system. When a healthy uninsured young person is injured riding her motorcycle without a helmet and receives expensive emergency room care, we all pay. Often uninsured or underinsured patients have to turn to costly emergency rooms for routine medical care and forego preventive care altogether. Hospitals currently provide $10 billion to $15 billion of uncompensated care annually, and insured patients (and their insurers) pay hospitals more to cover the costs of both the uninsured and underinsured.

In the current voluntary, employer-based financing system, health insurance tax incentives must be large enough to encourage employers to provide health insurance they would not otherwise buy, or else they are simply a waste of government largesse totally without merit. But whenever they actually encourage such purchases at the margin, they also reward people for conduct they would have undertaken in any event. Tax policy wonks, to use the Clintonese appellation, call this "buying the base." Other people call it throwing money away.

If we are really serious about universal health insurance as a fundamental goal of health care reform and if we really mean *everyone* when we say "universal," then a government requirement—a mandate—to purchase health insurance seems inevitable. Many young healthy people regard the purchase of health insurance as a bad deal now. The forthcoming community rating of the health insurance market—which will bar insurers from taking the good health as well as the bad of their applicants into account in setting premiums—will mean that healthy people will have to pay more for health insurance than their own health risks would warrant in an unregulated market (although some of this additional

* Michael J. Graetz, "The Troubled Marriage of Retirement Security and Tax Policies," 135 University of Pennsylvania Law Review 851 (1987).

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cost may be offset by the purchasing power of the HIPC or other entity buying large quantities of insurance). If we are going to spread the financial risks of poor health across the whole populace, then coverage will have to be mandatory.

Moreover, the existence of the medical safety net—porous as it is—demands mandatory health insurance coverage. Otherwise people who experience remote risks, but expensive costs, of bad health will be paid for not through their own insurance, but instead through the insurance of others, government-subsidized or financed emergency room care, or—at least after declarations of bankruptcy—the public fisc (via Medicaid or otherwise). Mandated universal basic health insurance coverage has the potential not only to reduce opportunities for adverse selection and cost- and risk-shifting, but also to reduce administrative costs through a universally accepted health insurance card and simplified billing. (Perhaps as in Germany, we could exempt those with high incomes from mandated coverage, if we could effectively monitor bankruptcy and Medicaid fraud, but concerns about the burden of a health insurance mandate on the rich surely do not explain the resistance to mandated coverage. The weight of opinion is that the wealthy should not only pay for their own health insurance coverage, but should also contribute to the costs of the less fortunate.)

In sum, I believe that the case for mandated universal health insurance coverage is compelling, regardless of what other major decisions we make about the direction of reform of our health insurance or health care delivery systems. Mandatory health insurance should be a part of any reform, whether it is so-called managed competition, which would rely on large purchasing cooperatives to bring health care costs

under control; a Canadian-style single-payer system; or some hybrid. To be sure, a mandate would have to be accompanied by subsidies for the poor, many of the disabled and elderly, the unemployed, and at least a very large number of middle-income families. But this pattern of subvention would not be new in our financing of health care; federal, state and local governments now pay large subsidies for each of these groups, albeit in a haphazard and often uncoordinated way.

However, neither the wisdom nor the inevitability of a mandate has been accepted by many of the key players in the health care reform debate. The health care reform strategy preferred by members of the Conservative Democratic Forum, led by Congressman Jim Cooper of Tennessee, and the plan advanced by President Bush in 1992, which reflected a consensus among a significant number of House and Senate Republicans, would rely on community rating and the creation of large purchasing cooperatives required to take all comers to make health insurance sufficiently affordable; both reform packages would provide that coverage is voluntary, not mandatory. In contrast, the Senate Republican Health Care Task Force, chaired by Senator Chaffee of Rhode Island, has proposed phasing in a requirement that all individuals obtain health insurance, and President Clinton has called for mandating that employers provide coverage to their employees and that others obtain health insurance coverage.

The proposals that rely on voluntary coverage may simply reflect the fact that the current system is in such bad shape that substantial progress can be made without having to impose controversial and, for some at least, distasteful mandates. Alternatively, they may be seen as merely postponing the inevitable. When

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mandates prove essential to make the new system work, they could be added later—after coverage has been sufficiently broadened to make mandated insurance both less radical and less likely to be resisted. A mandate, after all, is no burden to those who are already complying with it.

Of course, the decision by some political actors to rely on a purely voluntary health insurance system may be based on an abiding philosophical rejection of mandated health coverage. This, however, seems unlikely (or at least somewhat hypocritical), since none of these players is clamoring for the repeal of mandatory hospital insurance under Part A of Medicare.

Why an Employer Mandate Would Be a Big Mistake

Many key political actors seem to have accepted the view that a mandate is necessary to make health care reform work, but have chosen to mandate employers to provide health insurance coverage for their employees. This group includes President Clinton, the Pepper Commission, the chairman of the House Committee on Ways and Means, and many other House and Senate Democrats who have either explicitly endorsed an employer mandate or embraced its cousin, a play-or-pay system, which mandates employer coverage either directly or through a payroll tax. Under play or pay, employers will choose to play—that is, to provide health coverage directly to their employees—if the level of the pay requirement is set high enough. On the other hand, if the pay requirement is set at a very low level, play-or-pay will induce many employers to abandon direct coverage in favor of government-provided health insurance.

For those mostly large employers who are already providing health coverage to their employees, there is, of course, little burden associated with a requirement to provide a standard package of health insurance benefits; all such a requirement would mean is that these firms would not be permitted to drop coverage below the level of the government's mandate. For most large employers, this restriction would be unlikely to chafe (unless their deductions for health coverage were limited), because the coverage they now provide is at least equal to, and often better than, the probable level of mandated coverage. On the other hand, for small businesses, many of which do not now provide their employees with health insurance, mandated coverage would substantially increase the costs both of keeping the employees they now have and of hiring new ones.

Again, there is more than one way to understand the thinking of those who support employer mandates. They may have concluded that health insurance coverage ought to be provided through employment and should be regarded as a fundamental obligation of employers to their employees—even when compared to a higher cash wage. (As I suggested above, one should wonder, of course, how this view distinguishes health care from, say, housing, education, retirement packages, or other "benefits" that could be employer-based.) Alternatively, they could have determined that current circumstances—in which employers provide and finance the bulk of adequate health insurance for the nonelderly population—demand that we preserve the health insurance base that we already have by prohibiting employers from abandoning existing employee coverage. Presumably, a notion of equity among employers—the idealized "level playing field,"

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whatever that might mean here given the inevitability in an employer-mandate system of providing some employers with government subsidies to enable them to fulfill their mandate—and the quest for universal coverage move them to require that other employers also provide equivalent health coverage for their employees.

The consequences of an employer mandate, however, would be quite different from those of a requirement that all individuals or families obtain health insurance coverage. For those employers who wished to circumvent such a mandate, there could be incentives to use part-time workers (depending on how the mandate is structured)—and there certainly would be incentives to use temporary help, to substitute overtime for additional hiring, to engage in cash transactions off the books, and to classify workers as independent contractors rather than as employees. The determination of whether an individual is an employee or an independent contractor under both state law and the federal income and payroll taxes now turns on the application of twenty common law factors, such as whether the person is paid by the hour or week or by the job, whether the hours of work are set or flexible, whether the relationship between the individual and a firm is a continuing one, whether the person is free to provide services to two or more unrelated persons at the same time or to hire assistants, whether the services must be rendered personally, who supplies the tools used, whether the payer can control how results are achieved, and whether the service provider is responsible only for results. This multifaceted test applies both to businesses and to households that engage people to perform child care, housekeeping, or other domestic services.

Application of this test is so inconsistent, its results so uncertain, that in 1978 Congress generally prohibited the Internal Revenue Service from challenging an employer's erroneous treatment of an employee as an independent contractor if the employer has a "reasonable basis" for such treatment. Congress also prohibited the IRS from issuing regulations or rulings addressing the status of workers as employees or independent contractors until it "has adequate time to resolve the many complex issues involved in this area." In 1982 Congress extended this "interim" measure indefinitely. The Treasury Department in 1982 and again in 1991 said that "applying the common law test in employment tax issues does not yield clear, consistent or satisfactory answers, and reasonable persons may differ as to the correct classification."

The IRS estimates that many billions of dollars of tax revenues are lost each year due to the misclassification of employees as independent contractors. If employers were required to provide health insurance to employees—a mandate with very substantial financial implications for employers—the incentives for misclassification would be greatly increased.

The adverse consequences of employer mandates would be harshest for marginal employees and marginal businesses. Often Congress attempts to avoid some of the adverse consequences of mandates by creating exemptions. For example, the Family Leave Act, enacted earlier this year, covers only employees who have been employed by the same employer for at least twelve months and have worked at least 1250 hours in the twelve-month period, and it completely exempts small businesses, defined as those that employ fifty or fewer people within a seventy-five mile radius. However, exceptions of this sort are simply not possible in the context of health care reform, if

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the goal of universal coverage is to be ~~more~~ Indeed, the percentage of employees lacking health coverage is much higher in smaller firms than in larger ones—and there are roughly 4 million small businesses with fifty or fewer employees.

This means that an employer mandate would raise the costs of hiring and retaining workers most for small businesses and thus would almost certainly be accompanied by some new subsidies for small or marginal businesses—additional charges on the Treasury that seem unlikely either to be well-targeted or equitable. For example, subsidies based solely on the size of a business—whether in terms of numbers of employees, assets, or receipts—would not distinguish those able to afford the additional costs of employer-mandated health coverage from those less able. Adding a requirement that a business demonstrate need would increase administrative costs and probably require a bureaucracy for adjudication. Subsidies based on the average wage levels of employees, which would be more generous for businesses with lower average wages, might be somewhat better targeted on the whole—inasmuch as a mandate to buy a standard health insurance package for each employee can be viewed as in effect an increase in the required minimum wage—but precisely because it would use averages, would still be inefficient and inequitable. Only adjustments in subsidies on the basis of each worker's income would address these problems. But such individuated adjustments seem incompatible with an employer mandate and administratively difficult to coordinate with one.

To blunt the effect of a new requirement that employers purchase health insurance for their employees, some contribution toward its costs might be required from the employees, and the financing of the

employers' share could take the form of a payroll tax—euphemistically, a "payroll-based premium" or, to borrow the Social Security lingo, a "contribution." Such a payroll tax would be intended to serve as a less regressive source of financing than a mandated payment of each employee's premium, and, depending on the wage base used for imposing the payroll tax, would result in higher-paid employees subsidizing the health insurance of lower-paid employees and thus would cushion the impact of an employer mandate on the latter.

Viewed simply as a financing device, however, there seems to be little to commend a payroll tax other than its ease of administration. The unemployment and Social Security taxes are used to finance the replacement of wages in the event of unemployment, retirement, or disability. Health insurance, however, is not a wage replacement, but a universal need. Despite the fact that we now finance Part A Medicare hospital insurance with a 2.9 percent payroll tax, the question of how any government contribution to a broader health insurance program should be financed deserves separate analysis.

The growth in existing payroll taxes is by far the most significant shift in federal finances in recent decades. The proportion of federal revenues generated by employment taxes has risen from less than 10 percent in 1952 to about 40 percent today. Indeed, increased payroll taxes to finance Social Security account fully for the much-lamented increase in the tax burden of middle-income families during the 1980s. Although the wage bases for the current Social Security, Medicare, and unemployment taxes vary greatly, their combined rates can now total nearly 25 percent of wages (15.3 percent for Social Security, 2.9 percent for Medicare, and 6.4 percent for unem-

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ployment insurance). Adding an additional payroll tax in the 10 percent range to finance health insurance would increase the maximum payroll tax rate to about 35 percent—an event that might be of little or no consequence to those companies that already provide health insurance to their employees, but that would represent a substantial increase in the costs of hiring and retaining workers for those firms that do not.

The fundamental problem is that we are not designing a health care delivery or financing system from scratch, but rather are trying to make substantial improvements in what we have now and to do so in a manner that does not either transfer unwarranted windfalls to people or firms or impose undue or inequitable burdens on them. The goal is to capture existing sources of finance of health insurance—and, as I indicated earlier, employment-based contributions constitute more than $200 billion of this total—and to minimize any new taxes needed to make health coverage universal. Put this way, what we are confronting is the familiar, but nevertheless difficult, issue of transition from one public policy—one set of institutional arrangements—to another. Recognizing this to be a transitional issue, however, demands that we address explicitly the questions of where we are heading and where we want to end up.

The enactment of employer mandates in this round of health care reform would make it far more likely that we will forever have a health insurance delivery system tied to employment, rather than a system in which one's health insurance coverage is independent of where or for whom one works. If workers change jobs an average of eight times in their working lives, as has recently been suggested by the Secretary of Labor, and if we are serious about disengaging health coverage from job lock or job changes, moving in the direction of an employer mandate seems a very bad prescription, indeed.

As I indicated earlier, the provision of health insurance by employers largely resulted from wage and price control rules and tax incentives; today, only the latter remain important. The current tax system subsidizes employer-provided health insurance and greatly favors it over coverage that people purchase for themselves. If health insurance is provided by an employer, the costs—including those borne by the employee, if the employer has a so-called cafeteria plan—can be excluded from both income and Social Security taxes. By contrast, health insurance that individuals or families purchase for themselves almost always must be paid for with after-tax dollars—except for coverage purchased by the self-employed, who have been allowed to deduct 25 percent of the costs of health insurance (and, under the Clinton proposal, would be permitted to deduct 100 percent). The tax system serves therefore as a powerful inducement for employers to provide health insurance directly to their employees, rather than paying cash wages and letting the employees purchase their own health insurance. The current tax benefit is, of course, worth more to people in higher tax brackets—those with greater income—and, among employees with equal wages, to those who receive greater health benefits from their employers. Thus, the subsidy cannot be defended on the grounds of equity.

In addition, many critics of the current tax exclusion contend that by both lowering and hiding the actual costs of health insurance, it contributes substantially to rising health costs. This claim is quite

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speculative; however. In my view, the effects of the tax exclusion on health care costs are often overstated. Some prominent advocates of a limitation on the tax exclusion, such as Alain Enthoven, contend that excessive and nonproductive health care (for example, unwarranted heart bypass operations and prostatectomies) are directly attributable to the exclusion. In considering the effect of the tax exclusion on health care costs, it is critical to distinguish the purchase of insurance from the purchase of health care. It may be that by lowering the costs of more expensive health insurance plans, the tax favoritism somewhat reduces the likelihood that employees will choose less expensive managed care insurance plans offered by their employers. It is clear, however, that the freedom that fee-for-service plans offer their enrollees to choose their own doctors also plays a major role in the American public's resistance to health maintenance organizations. Once an employee has enrolled in a health insurance plan, excessive consumption of health care is driven by the availability of payments from a third-party insurer, not the tax treatment accorded an employer's expenditures for the insurance.

There are good reasons to limit or eliminate the current tax exclusion—and no good reason for the government to subsidize gold-plated health insurance purchases by the well-to-do—but I regard it as highly unlikely that a revision in the tax treatment of employer-provided health insurance would result in even one less coronary bypass operation being performed. Only basic changes in the way Americans approach and receive their health care—including, for example, better conversations between physicians and patients about the likely benefits of long-shot medical procedures as well as the development and dissemination of much better information about the outcomes of alternative treatments—would reduce the frequency of these kinds of expensive treatments, even if they are often ineffective.

The more important political constraint on changing the current system is suggested by a remark that Daniel Rostenkowski, chairman of the House Committee on Ways and Means, recently made in another context:

> [A]s I've been sitting on this committee, it almost always comes into focus that once you give business or the taxpayer a break in an area—like an incentive—there's no way you can rescind that incentive. I mean, it's like a sick patient.[3]

A Direction for Change

The truth is that we will never wean ourselves from a system of employer-provided health insurance unless the tax incentives for health insurance are dramatically revised, and that will be no easy task. But if such change is ever to be accomplished, it should be accomplished now, while the nation is setting a new course for the delivery and financing of health care. The failure to change direction in this round of reform will only lock us further into the existing system.

What we need to do is redesign our system of public subsidies in order to create a fair and effective system that facilitates mandated purchases of health insurance for all American families. To the extent that employers want to purchase or finance health insurance for their employees, the system should be flexible enough to accommodate and even facilitate their tak-

[3] Hearings of the House Ways and Means Committee on the President's Budget Proposals, March 9, 1993 (in connection with testimony of Laura Tyson, Chair of the President's Council of Economic Advisers).

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ing on those roles. But individuals, not employers, should have the legal responsibility for obtaining health insurance.

An essential step in moving to such a system is to phase out the current tax exclusion for employer-provided health insurance and to replace it with a taxable tax credit or voucher for the purchase of health insurance. Treating the revenues lost due to payroll and income tax exclusions for employer-provided health coverage as government expenditures, C. Eugene Steuerle has estimated that in 1992, the federal, state, and local governments accounted for about one half of total U.S. expenditures on health care—nearly $400 billion, an average of $4,000 for each of the 100 million U.S. households. An additional $150 billion was contributed by employers (or, more accurately in real economic terms, by employees in the form of lower cash wages), and nearly $200 billion more was spent out of pocket by individuals, for a total of about $750 billion.[4]

A standard health insurance package that covers all medically necessary or appropriate health care (but not long-term care, cosmetic surgery, or unlimited mental health benefits) is estimated to cost about $2,000 per capita or about $5,250 for an average family, a total of about $525 billion for the entire U.S. population. A more generous $3,000 per capita policy would bring the total up to about $800 billion. Community rating requirements and reform of health insurance markets through the creation of HIPCs or health alliances means that individuals with chronic illnesses or preexisting conditions would not have to pay more for their health insurance and that individuals would enjoy the same economies of aggregation into large purchasing units that are now ordinarily possible only for large employers.

These figures, approximate though they may be, certainly suggest that within the existing system there is enough money to fund a standard package of insurance coverage for all Americans, including an equitable and even generous system of tax credits. This means that with enough reshuffling of existing expenditures, additional government financing may not be necessary. In any case, it is essential to make much more effective use of the revenues that current subsidies cost the government. The political trick—and no one should underestimate how great a trick it is—is to manage a transition from the system we now have to the system of individually-based universal coverage I have proposed.

The revenue costs of the current tax exclusion alone would finance tax credits equal to about half the cost of a reasonable package of health insurance benefits for all those families that are now enjoying the benefits of the exclusion—and the deduction currently available for medical expenses might also be repealed in the new system of universal health insurance coverage. As recent analyses of the taxation of Social Security benefits or Part B Medicare (physicians' services) subsidies for high-income people have demonstrated, it is important in designing an equitable universally available government subsidy that the subsidy be includable in the taxable incomes of recipients in order to avoid giving greater net benefits to high-income people.

Similar tax credits or vouchers should serve as the mechanisms for facilitating the purchase of health insurance for those who are currently uninsured. As I suggested earlier, the financing of coverage for the

[4] See C. Eugene Steurle, "The Search for Adaptable Health Policy through Finance-Based Reform," in Robert B. Helms (ed.) *American Health Policy: Critical Issues for Reform* (AEI Press, 1993).

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uninsured might come from shuffling funds from existing financing sources, supplemented by cost savings elsewhere in the health care system due to reforms (for example, with the advent of universal coverage, the phase-out of many billions of dollars in so-called disproportionate-share payments to hospitals that disproportionately serve the poor and uninsured). If, however, revenues from other sources—such as taxes on cigarettes, alcohol, firearms, energy, or consumption generally—prove necessary to finance coverage for the uninsured and subsidies for small businesses, we should bear in mind that such revenues would be at least equally required if the current tax exclusions were left in place.

Ideally, as we moved toward a unified individually-based system of universal health insurance coverage, per-capita tax credits or vouchers would also replace the current Medicaid program for acute care of the poor. To maintain the existing financial division of labor between the federal government and the states, state governments would have to help finance tax credits for those now receiving such coverage through Medicaid. Over time, such credits might even substitute for the subsidies now provided for the voluntary physician coverage (Part B) of Medicare.

These tax credits or vouchers should be transferable to employers, insurers, health insurance purchasing cooperatives, or health provider networks for the purchase of health coverage. In order to reduce windfalls to those employers who are now providing health coverage for their employees, for some period of transition employers could be required to maintain their current efforts. Such a maintenance-of-effort requirement should be structured in a manner that allows, or even encourages, employers to substitute cash wages for health insurance coverage as individual tax credits are phased in. A maintenance-of-effort requirement of this sort could prove quite difficult to enforce; the potential denial of otherwise available tax deductions could be used to help induce compliance. Similarly, the potential denial of tax deductions or tax credits, or the imposition of a special excise tax, could be used as tools for enforcing the individual mandate to obtain health coverage.

In order to ensure universal health insurance coverage, the system of tax credits or vouchers should be designed to finance fully the purchase of a standard package of health insurance benefits for people at the poverty level and to decline gradually with increases in family income. It is essential that this be a gradual reduction, both to ensure the financial capacities of families only slightly above the poverty level (those, for example, with incomes of up to 200 percent of the poverty line) and to minimize increases in marginal tax rates due to the phasing-down of the credits or vouchers as incomes rise. To guarantee the universality of this financing program, and to avoid the political pitfalls of limiting the availability of its benefits to those who meet some means test while at the same time unduly increasing the tax burdens of those who currently enjoy employer-provided health insurance, some minimum amount of credit should be made available to all individuals (equal, say, to one-fifth or one-quarter of the cost of a standard health insurance package). Such a progressive distribution of benefits could resemble the Social Security schedule of wage-replacement retirement benefits.

This kind of universal tax credit financing system for health insurance would have employment effects directly opposite those of an employer mandate. Since low-income workers would come to the job market with their health insurance largely financed,

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they would become less expensive to hire—not, under an employer mandate, substantially more expensive. Because the size of government's contribution to the cost of insurance would diminish with increases in individual or family incomes, the difficulty of trying to target a subsidy appropriately for small businesses would be avoided, as would the regressivity of the existing tax exclusions, which are, as I have noted, more valuable to those with higher incomes.

A revision of the health insurance financing system along the lines suggested here would be compatible with virtually any approach to health care reform that is not employer-based. An individual mandate coupled with tax credits or vouchers would fit nicely with a managed competition strategy, in which individuals would purchase their health coverage through large cooperatives; individuals would simply transfer their tax credits or vouchers, along with any additional cash required, to the cooperative, which could then in turn transfer them to health insurers or providers. Nothing in this scheme of finance would necessarily preclude employers from serving as their employees' purchasing agents or require employees to purchase their insurance from their employers. The transfers of tax credits or vouchers would be straightforward if cooperatives were to purchase health coverage on the basis of per-capita charges, but these credits or vouchers could also be used to finance insurance coverage providing fee-for-service reimbursements of doctors or hospitals. This system of finance would function equally well wherever the levels of individual co-payments or deductibles for medical care were set and whether or not balance-billing were permitted.

What is more, although this may not be so readily apparent, a tax credit or voucher mechanism as outlined here would also be compatible with the development of a single-payer system similar to Canada's. The amounts of the tax credits or vouchers would define the federal government's share in financing coverage for individuals and families and could do so in a progressive manner. The balance of the health insurance costs for individuals and families could be collected from them by the federal government or state governments through existing tax systems or otherwise. Indeed, such flexibility would be advantageous if the particulars of health care reform were permitted to vary state-to-state, as suggested by Jerry L. Mashaw elsewhere in this issue of *Domestic Affairs*. The amounts of the tax credits or vouchers would define the per-capita federal contributions and, if appropriate, could be collected by state governments.

To be sure, the transition to a system of health coverage based on an individual mandate could create difficulties that in the short run might be avoided by trying to patch an employer mandate onto the current system. Moreover, a financing plan centered around tax credits or vouchers might engender opposition from people who are viscerally opposed to any change that seems to funnel money through the government. But if we are bold now, we can move to a rational and stable, yet flexible, system of health care finance well-suited to a modern, mobile labor force—a system in which no one would lose, or even have to change, their health insurance because of job change or job loss.

If, instead, we opt for an employer mandate, we will have simply deferred the need eventually to rationalize the system—and in the meantime, added to the costs of, and thereby jeopardized the rates of, employment. Moreover, we will have failed to address the underlying reasons for the concerns that working

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people now have about the affordability and fragility of health coverage. Moving in the direction of an employer mandate, instead of an individual mandate, would be a big mistake. It is a mistake that we can, and should, avoid.
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Reform and the Physician Work Force

Steven A. Schroeder

Steven A. Schroeder is a general internist and the president of The Robert Wood Johnson Foundation in Princeton, New Jersey.

The vital essence of any health care system—its very energy or life force—is the people who work within it: the physicians, nurses, and others who provide direct care to patients. Moreover, from a financial perspective, physicians are the heart and soul of the U.S. health care system. The reason is simple: Seventy-five percent of our health care spending is the direct result of the decisions they make.

If you consider the differences between buying a new car and "buying" health care, you will have a better understanding of the potency of the physician's role. From the moment a consumer decides to buy a new car until the actual purchase is made, he or she is in total control. The consumer makes the bigger decisions (when to buy the car, how to finance the purchase, and what type of car to buy) as well as the smaller ones (the color, the model, and the degree to which the vehicle is "loaded"). Although a sales person may strongly recommend a Cadillac or a Lincoln,

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Americans are covered now. It does not require shifting private payments to taxes, and does not necessarily involve the government more deeply in the purchase or delivery of health care services.

DISADVANTAGES

Many companies, particularly small firms and those with large numbers of low-wage workers, would be put at a significant economic disadvantage if they were required to provide health insurance to all workers and their dependents, and might even go out of business. For this reason, proponents, such as President Clinton, would offer government subsidies to help small, low-wage firms pay for insurance. In addition, not all Americans are attached to the workforce, and the fact that people lose or change jobs frequently throughout the year makes tying insurance to the workplace administratively complex.

Because the president has proposed an employer mandate as the principal mechanism to pay for health reform, we discuss it in further detail later in this report.

INDIVIDUALS

A recently developed alternative to an employer mandate or a government-run system is to require individuals to purchase their own coverage for themselves and their families, with subsidies for the poor. While such an "individual mandate" for health insurance would be unprecedented, it is an established practice for states to require drivers to carry auto insurance.

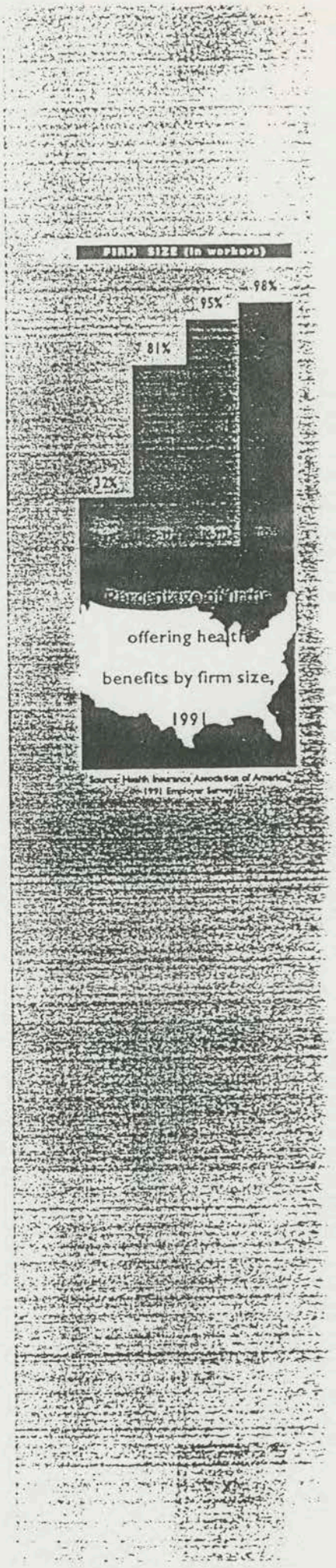
ADVANTAGES

The principal advantage of an individual mandate is hat it would provide universal coverage without the disadvantages of either the government or business-mandate plans.

DISADVANTAGES

There are several disadvantages to this approach. Individual purchase of insurance is administratively more expensive than group purchases, our country has never attempted such a plan before, and that enforcement would be difficult. It is also unclear whether employers who now provide coverage would drop it if individuals were required to purchase plans on their own, which could require even more government subsidies to ensure that coverage is affordable to all.

One alternative to an individual mandate that some advocate is to give poor and moderate income people subsidies to buy insurance if they want it, but not require them to do so. The main question to ask about this alternative is whether the subsidies are adequate to enable people to purchase today's expensive health insurance policies.



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CRITICAL CHOICE #1:
HEALTH INSURANCE FOR ALL AMERICANS?

3 - THE EMPLOYER ANDATE DEBATE

any believe that requiring employers cover workers would be the least ruptive approach, since most nericans already receive coverage ough their jobs. Nearly two-thirds the under-65 population had ployment-based health coverage in 91. And the vast majority of the insured are connected to the work- ce, too. In 1991, 84 percent of the insured were either workers them- es or living in a family in which neone worked full-time with no ri[illegible] of unemployment. The np[illegible]ee Benefit Research Institute imated that requiring businesses th 10 or more employees to provide verage to employees who worked 19 more hours per week in 1990 would ve reduced the number of uninsured m 36.3 million to 14.4 million.

Requiring employers to cover their orkforce is not a new idea — publican President Richard Nixon t proposed it in 1971 as an alterna- e to government-financed national alth insurance. Over the last two ades the idea has been championed those across the political spectrum, m Senator Edward M. Kennedy, Mass., to the American Medical ociation. But the proposal has never [illegible]pted, at least in part because employer mandate for health insur- e has disadvantages as well as antages. Here are the major pros

THE ARGUMENT IN FAVOR

- The chief advantage of requiring employers to provide health coverage to workers and dependents is that it would significantly reduce the number of uninsured Americans. Only 16 percent of the uninsured lived in families in which no one works.

- Many believe that another advantage of an employer mandate is that it could help "level the playing field" between businesses that currently do and do not offer insurance. In our system, most people who need care usually get it, although often in more expensive and inappropriate settings, like hospital emergency rooms. And the cost of care for uninsured, particularly hospital care, is often passed along to those with insurance in the form of higher prices.

- Another politically attractive feature to many in Washington is that an employer mandate does not impose major new financial obligations on the strapped federal treasury. It also avoids the need for the resulting difficult choice between raising taxes or adding to the federal deficit. For this reason, politicians and organizations support requiring employer-based health insurance because its considered the most "politically doable" of the various options for extending coverage to the uninsured. This is in many ways a false advantage, since all Americans end up paying for everyone's health care, whether through taxes, lower wages, or higher prices for products. Nevertheless, in today's political environment, some elected officials see the employer mandate as an alternative to raising taxes.

- An employer mandate builds on the current system, which means less intrusive changes for individuals and businesses than most other proposals — not an insignificant consideration given that health spending accounts for one of every seven dollars spent in our economy and any changes will have a significant ripple effect not only on jobs, but on the way every American lives his or her life.

  Requiring employers to provide health insurance also follows a long tradition of government-mandated employee benefits, starting with the minimum wage and more recently including family leave and advance notification of plant closings.

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THE ARGUMENT AGAINST

- The primary argument against an employer mandate is simple: it will impose new costs on businesses that could result in bankruptcies at worst, and lost jobs, higher prices, and lower wages at best. While the Clinton plan would provide federal subsidies to cushion the blow for small firms and those who employ large numbers of low-wage workers, critics believe that the new costs could still be significant.
- Even if a new health system does successfully curb the growth of medical costs, mandating health insurance is asking much more of employers than any other mandate ever attempted.
- Critics believe that mandating health insurance will have a negative impact on many businesses and their workers, at least in the short run. (In the long run, some say, job losses in some industries could be offset by new jobs created in the health sector, such as for home health aides). Even with promised subsidies for small businesses and larger enterprises with large numbers of low-wage workers (such as courier firms or cleaning services), many businesses will seek to pass along the new costs, either in the form of higher prices to customers, or, more likely, in the form of lower wages and fewer hours for existing workers, and fewer new workers hired.
- Ironically, critics say, the workers most vulnerable to losing wages or jobs because of a health insurance mandate are those who earn low wages and are currently uninsured — the very individuals the mandate is intended to help. That is because not only is the cost of health insurance disproportionately larger the lower wages are, but because employers cannot shift costs back to workers in the form of lower wages if they are already earning a government-mandated minimum.
- Opponents also point out that mandates are administratively complex to enforce. The government will need information from businesses not only to ensure that they are obeying the mandate, but to determine who is eligible for special subsidies. There are operational complexities, too, such as deciding how to cover children in two-worker families, or what to do about a spouse who works part-time. Writes Brookings Institution Economist Henry Aaron, a supporter of mandates, "Employment-based insurance is cumbersome and inefficient in a world in which not everyone works, family units often contain two or more employees of different companies, divorce and cohabitation are common, and workers change jobs or move in and out of the labor force frequently. These realities needlessly inflate administrative costs."
- Finally, note opponents, employer mandates can't completely solve the uninsured problem because a significant portion of the uninsured are not attached to the workforce. Even Hawaii, which has had an employer mandate since 1974, still had about five percent of its residents uninsured in 1987, prompting formation of a new government program which has since reduced the number of uninsured to just under four percent.

No one can say for sure what the effect of an employer mandate would be because it has never been tried before on a national scale. But there is undoubtedly truth on both sides of the argument. A mandate would help many and hurt some. Large employers who currently offer insurance, for example, would probably benefit from reduced shifting of costs. Small employers who insure their workers would probably see lower premiums. But those not currently providing insurance will surely pay more, and even with promised subsidies, firms with thin profit margins could be significantly hurt. The bottom line is that there is no painless way to cure what ails the nation's health system. If we as a society truly want to guarantee continued coverage for those who now have it and extend coverage to the uninsured, we will have to find some way to pay the bill, either through a mandate, higher taxes, or both. The debate is over the fairest and most rational way to proceed.

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CRS Report for Congress

Health Care Reform: Alliances, Purchasing Groups, and Purchasing Cooperatives

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Beth C. Fuchs
Specialist in Social Legislation
Education and Public Welfare Division

February 8, 1994

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HEARING ON ALLIANCES
COMMITTEE OF FINANCE
FEBRUARY 24, 1994

- ON PAPER, HEALTH CARE PURCHASING ALLIANCES SEEM TO BE A GOOD IDEA. THEY APPEAR TO SOLVE MANY OF THE PROBLEMS ENDEMIC TO THE CURRENT HEALTH CARE SYSTEM -- MOST NOTABLY THE WIDE RANGE OF PRICES FOR HEALTH INSURANCE THAT GOES ALONG WITH RISK SELECTION.

- ALTHOUGH THE CONCEPT OF POOLING RISK IS AS OLD AS INSURANCE ITSELF, THE NOTION OF MANDATORY POOLS OR ALLIANCES HAS BECOME A POLITICALLY-CHARGED ISSUE.

- AT THE CORE OF THE DEBATE ARE TWO IMPORTANT ISSUES: ONE IS WHETHER THE U.S. IS WILLING TO REINVENT HEALTH INSURANCE AS A TRUE COMMUNITY ENTERPRISE. THE OTHER IS THE ROLE THAT GOVERNMENT SHOULD PLAY IN CONTROLLING THE HEALTH CARE DELIVERY SYSTEM.

- WHAT IT REALLY BOILS DOWN TO IS WHETHER THE LEVERS OF POWER SHOULD BE PRIMARILY MARKET DRIVEN, OR SHOULD THESE POWERS BE CENTERED IN WASHINGTON AND IN STATE CAPITALS?

- THE SPECIFICS OF THE DEBATE REVOLVE AROUND SEVERAL KEY ISSUES:

  - SHOULD ALLIANCES BE MANDATORY?
  - WHAT SHOULD BE THEIR SIZE?
  - HOW WOULD ALLIANCES FUNCTION?
  - WHAT WOULD BE THE REGULATORY FUNCTION OF THE ALLIANCE?
  - WHAT SHOULD BE THE EMPLOYEE THRESHOLD FOR EMPLOYER PARTICIPATION -- 100, 250, 500, 1,000, 5,000?
  - SHOULD ONLY ONE OR MULTIPLE COMPETING ALLIANCES SERVE A REGION?
  - SHOULD ALLIANCES BE PUBLIC OR PRIVATE INSTITUTIONS?

- FOR EMPLOYERS AND THEIR WORKERS, THE ALLIANCE ISSUE IS ALL-IMPORTANT, FOR BOTH ECONOMIC AND PRACTICAL REASONS. IF THE ADMINISTRATION'S CURRENT PLAN PREVAILS, EVERY EMPLOYER WITH 5,000 OR FEWER EMPLOYEES (ALL, BUT ABOUT 1,000 ORGANIZATIONS IN THE U.S.) WOULD BE REQUIRED TO BUY INSURANCE THROUGH LARGE-SCALE, STATE-BASED REGIONAL ALLIANCES.

- APPROXIMATELY 80 PERCENT OF WORKING AMERICANS, THEN, WOULD BE OBTAINING A HEALTH PLAN THROUGH AN ALLIANCE. EMPLOYERS WOULD PAY ABOUT 80 PERCENT OF THE COST.

- THE ADMINISTRATION ARGUES THAT THE LARGER THE NUMBER OF EMPLOYERS AND THE PROPORTION OF THE POPULATION IN THE ALLIANCES, THE BROADER THE SHARED INSURANCE RISK WILL BE. AS A RESULT, THEY CONTEND, THE HEALTH INSURANCE MARKET WILL BE MORE EQUITABLE.

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- THE ADMINISTRATION ALSO ARGUES THAT SINGLE, MONOPOLISTIC ALLIANCES WILL SAVE MILLIONS IN ADMINISTRATIVE COSTS. IDEALLY THE ADMINISTRATION WOULD LIKE TO SEE A MINIMUM ENROLLEE SIZE IN THE ALLIANCE OF 300,000 AND A MAXIMUM OF ABOUT TWO MILLION.

- HOWEVER, ADMINISTRATION OFFICIALS ALSO ACKNOWLEDGE THAT A CHIEF REASON FOR THE LARGER ALLIANCES IS TO GIVE GOVERNMENT GREATER ABILITY TO OVERSEE THE HEALTH INSURANCE MARKET AND TO IMPOSE THE PREMIUM CAPS AND GLOBAL BUDGETING THE CLINTON PLAN PROPOSES.

- THE ADMINISTRATION'S PLAN MAKES SUCH OVERSIGHT AND REGULATION NECESSARY BECAUSE IT WOULD REQUIRE EMPLOYERS TO IMPLEMENT A STANDARD BENEFIT PACKAGE AND A VARIETY OF OTHER REGULATIONS.

- THE INSURANCE INDUSTRY, ON THE OTHER HAND, ASKS WHETHER ALLIANCES ARE NEEDED AT ALL. THEIR ARGUMENT IS THAT ALLIANCES ARE IRRELEVANT TO CREATING A LEVEL HEALTH INSURANCE PLAYING FIELD. THEY CONTEND THAT THIS CAN BE ACCOMPLISHED THROUGH INSURANCE MARKET REFORM.

- IF INSURANCE MARKET REFORM REQUIRES ALL EMPLOYERS TO TAKE ALL COMERS, TO OFFER A STANDARD BENEFIT PACKAGE, AND TO COMMUNITY RATE, THEN ALLIANCES WOULD BE LEFT TO FULFILL THEIR ORIGINAL MISSION -- TO ALLOW SMALL BUSINESSES TO JOIN TOGETHER SO THAT THEY COULD ACHIEVE GREATER MARKET AND PURCHASING POWERS.

- A COMMON MISTAKE THAT PEOPLE MAKE IS TO THINK THE ALLIANCE IS THE PURCHASING POOL. THE ALLIANCE IS ONLY THE ADMINISTRATIVE ENTITY THROUGH WHICH EMPLOYERS AND CONSUMERS GET TO THE ACTUAL HEALTH NETWORKS. IF THESE HEALTH NETWORKS ARE CAREFULLY RISK ADJUSTED, THEN EQUAL ACCESS AND FAIR PRICING WILL BE ENSURED.

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KEY OPPONENTS TO MANDATORY ALLIANCES

PETE STARK -- WAS QUOTED LAST WEEK AS SAYING, "I DON'T KNOW OF ANY REPUBLICAN OR DEMOCRAT WHO WOULD SUPPORT MANDATORY ALLIANCES. I'VE HEARD A THOUSAND OBJECTIONS AND VIRTUALLY NO SUPPORT. IF I HAD TO SAY ONE THING THAT IS GONE, IT WOULD BE THOSE ALLIANCES."
(PETE STARK WILL BE THE FIRST CHAIRMAN TO MARK UP THE CLINTON BILL)

U.S. CHAMBER OF COMMERCE

HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA)

NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB)

WASHINGTON BUSINESS GROUP ON HEALTH

JACKSON HOLE GROUP (WHICH FORMULATED THE IDEA OF MANAGED COMPETITION)

NATIONAL BUSINESS COALITION ON HEALTH

- THESE GROUPS ARGUE THAT ALLIANCES UNDER THE CLINTON PLAN WOULD BE TOO LARGE AND BUREAUCRATIC, HAVE VAST REGULATORY POWERS, AND BECOME MONOPOLISTIC BUYERS OF HEALTH INSURANCE.

- THESE GROUPS ALSO CHARGE THAT THESE MONOPOLISTIC ALLIANCES WOULD HAVE NO LONG-TERM INCENTIVE TO BE RESPONSIVE TO CONSUMERS SINCE THE ALLIANCE WOULD BE THE SOLE CONDUIT TO INSURANCE FOR MOST BUYERS.

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VOLUNTARY VERSUS MANDATORY ALLIANCES

- BY DEFINITION, VOLUNTARY ALLIANCES WOULD LET EMPLOYERS CHOOSE WHETHER OR NOT TO BE IN AN ALLIANCE. THE PRIMARY REASON TO CHOOSE TO BE OUT OF THE ALLIANCE IS, OF COURSE, ACCESS TO BETTER INSURANCE RATES.

- MANDATORY ALLIANCES WILL ELIMINATE CHOICE. HEALTH ALLIANCES ARE INTENDED TO POOL PURCHASING POWER, NOT TO MONOPOLIZE THE MARKET. IF AN INDIVIDUAL PLAN CAN PUT TOGETHER A MORE ATTRACTIVE BENEFITS PACKAGE THAN THE ALLIANCE, WITHOUT "CHERRY PICKING" THE HEALTHY INDIVIDUALS, THAT SHOULD BE ALLOWED. UNDER THE CLINTON BILL, THIS WOULD NOT BE POSSIBLE.

- MANDATORY ALLIANCES ARE ANTI-COMPETITIVE. THE CONCEPT OF POOLING SMALL BUSINESSES TO PURCHASE COVERAGE HAS MERIT, BUT NOT IF THAT POOL EFFECTIVELY RESTRICTS COMPETITION BY CREATING A MONOPOLY PURCHASER FOR SMALL BUSINESSES.

- COMPETITION IS ALLOWED UNDER VOLUNTARY ALLIANCES. AND COMPETITION KEEPS ALLIANCES HONEST. IF YOU DON'T LIKE A MONOPOLY HEALTH ALLIANCE, WHERE DO YOU GO?

- REPUBLICANS BELIEVE ALLIANCES SHOULD BE VOLUNTARY, PRIVATELY ORGANIZED, AND PRIVATELY FINANCED AND SHOULD HAVE AS LITTLE GOVERNMENT INVOLVEMENT AS POSSIBLE. THE GOAL OF ALLIANCES IS TO POOL MARKET POWER, LEAVING THE ONLY APPROPRIATE ROLE FOR GOVERNMENT AS OVERSIGHT TO AVOID RISK SELECTION OR "CHERRY PICKING".

- MANDATORY HEALTH ALLIANCES PROMOTE CONSUMER MARKETING, NOT COST-EFFICIENCY. THE INTENT OF MANAGED COMPETITION IS TO FORCE COMPETITION BETWEEN PLANS ON THE BASIS OF COST AND QUALITY. HOWEVER, MANDATORY HEALTH ALLIANCES WILL REWARD PLANS ON THE BASIS OF ADVERTISING DOLLARS SPENT MARKETING TO CONSUMERS, NOT HEALTH CARE QUALITY OR EFFICIENCY.

- PLANS SHOULD SUCCEED ON THEIR ABILITY TO PROVIDE COST-EFFECTIVE CARE. IF A BUSINESS CAN FIND MORE COST-EFFECTIVE COVERAGE OUTSIDE THE HEALTH ALLIANCE THEY SHOULD BE ALLOWED TO BUY IT.

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CORPORATE ALLIANCE ISSUE

- THE CLINTON PLAN STATES THAT EMPLOYER PARTNERSHIPS IN THE MANAGEMENT, COST CONTAINMENT, AND QUALITY OF HEALTH CARE ARE AN IMPORTANT PART OF THE PLAN. HOWEVER, THE CLINTON PLAN ACTUALLY DISCOURAGES SUCH PARTNERSHIPS BY PLACING MANY DISINCENTIVES ON CORPORATE ALLIANCES. THESE INCLUDE:
  - INELIGIBILITY FOR THE 7.9% PAYROLL CAP
  - A 1% PAYROLL TAX WOULD APPLY TO ALL CORPORATE ALLIANCES, INCLUDING THE PAYROLL OF PART-TIME EMPLOYEES WHO ARE NOT EVEN PART OF THE CORPORATE ALLIANCE.
  - ALL PART-TIME EMPLOYEES WOULD BE REQUIRED TO LEAVE THEIR COMPANY PLAN AND JOIN THE MANDATORY REGIONAL ALLIANCE.
  - LOW-WAGE INCOME SUBSIDIES DO NOT APPLY TO THE CORPORATE ALLIANCES, ALTHOUGH THEY DO APPLY TO THE REGIONAL ALLIANCE. THE RESULT IS THAT EMPLOYERS OF LOW-WAGE EMPLOYEES MAY BE REQUIRED TO PAY UP TO 95% OF THEIR PREMIUM COSTS.
- IT BECOMES QUICKLY EVIDENT THAT THE ECONOMICS OF FORMING A CORPORATE ALLIANCE WOULD NOT BE FEASIBLE FOR MANY LARGE COMPANIES. SINCE A CORPORATE ALLIANCE IS NOT FEASIBLE FOR MOST EMPLOYERS, THEIR EMPLOYEES WILL BE REQUIRED TO CHANGE HEALTH CARE PLANS, POSSIBLY CHANGING PERSONAL DOCTORS.
- AN IMPORTANT NOTE IS THAT THE FUNDING OF THE CLINTON PLAN WILL BE AFFECTED SINCE THE ADMINISTRATION ESTIMATES THAT $24 BILLION WILL BE RAISED FROM THE 1% PAYROLL TAX ON CORPORATE ALLIANCES. MOST, IF NOT ALL OF THIS WILL NOT BE COLLECTED, SINCE MOST EMPLOYERS OF LARGE FIRMS WILL CHOOSE NOT TO FORM A CORPORATE ALLIANCE.

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STATE INITIATIVES

- LAST YEAR, EIGHT STATES PASSED BILLS TO ESTABLISH VOLUNTARY ALLIANCES. (THE CALIFORNIA PLAN IS DETAILED BELOW.) UNDER MOST OF THESE LAWS, PARTICIPATION IS LIMITED TO FIFTY OR FEWER WORKERS. THESE STATES ARE:

  CALIFORNIA
  FLORIDA
  IOWA
  MINNESOTA
  NORTH CAROLINA
  OHIO
  TEXAS
  WASHINGTON

- MORE STATES ARE EXPECTED TO CONSIDER THE ISSUE THIS YEAR. ONE IS HAWAII, WHICH HAS AN ERISA EXEMPTION. HAWAII COULD BECOME THE FIRST STATE TO ESTABLISH A SINGLE STATEWIDE MANDATORY ALLIANCE.

- HAWAII IS WORKING ON A BILL TO ESTABLISH AN ALLIANCE WHICH AIMS TO BRING ALL TWO MILLION OF HAWAII'S RESIDENTS INTO THE ALLIANCE STRUCTURE.

- HAWAII IS THE ONLY STATE THAT CURRENTLY HAS AN ERISA EXEMPTION TO ALLOW THEM TO ESTABLISH A MANDATORY ALLIANCE.

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CALIFORNIA EXPERIENCE

BACKGROUND

- IN AUGUST, 1992 THE CALIFORNIA LEGISLATURE APPROVED SIGNIFICANT NEW REGULATION OF THE SMALL-GROUP HEALTH INSURANCE MARKET.

- THE LEGISLATURE ADOPTED STRICT UNDERWRITING REFORMS AND ESTABLISHED A STATE-SPONSORED INSURANCE POOL, NAMED THE HEALTH INSURANCE PLAN OF CALIFORNIA (HIPC).

- HIPC BEGAN OPERATION IN JULY, 1993. SINCE THEN, IT HAS BECOME A LABORATORY TO HELP TEST THE HEALTH ALLIANCE CONCEPT IN THE CLINTON ADMINISTRATION'S PROPOSAL FOR NATIONAL HEALTH CARE REFORM.

DIFFERENCE WITH CLINTON

- THE CALIFORNIA ALLIANCE DIFFERS FROM THE ALLIANCES PROPOSED IN THE CLINTON PLAN IN TWO SIGNIFICANT WAYS:
  - IT DOES NOT REQUIRE EMPLOYER PARTICIPATION.
  - IT IS NOT AN EMPLOYER'S EXCLUSIVE SOURCE OF HEALTH INSURANCE. GROUPS CAN STILL OBTAIN INSURANCE FROM CARRIERS THAT DO NOT PARTICIPATE IN THE HIPC.

- THE HIPC IS OPEN TO ALL CALIFORNIA ORGANIZATIONS WITH 5 TO 50 EMPLOYEES. IN JULY, 1994 THE THRESHOLD WILL DROP TO 4 TO 50, AND IN 1995 IT WILL BE 3 TO 50 EMPLOYEES.

- THIS PHASE-IN WAS REQUESTED BY INSURERS WORRIED ABOUT ADVERSE SELECTION IN THE SMALLEST GROUP.

WHAT CAN WE LEARN FROM CALIFORNIA?

- THE CALIFORNIA EXPERIMENT CAN HELP ANSWER THREE IMPORTANT QUESTIONS AS CONGRESS DELIBERATES OVER MANDATORY VERSUS VOLUNTARY ALLIANCES:
  - WILL THE GREATER VOLUME OF PURCHASERS OF INSURANCE IN ONE POOL ACTUALLY RESULT IN LOWER INSURANCE RATES?
  - WILL SMALL EMPLOYERS PARTICIPATE WITHOUT A MANDATE?
  - WILL A NONEXCLUSIVE POOL WORK?

- THIS VOLUNTARY ALLIANCE SYSTEM HAS ONLY BEEN IN EFFECT FOR SIX MONTHS. THEREFORE, RESULTS ARE PRELIMINARY. SO FAR, HOWEVER, IT APPEARS THAT THE ALLIANCE CAN ACHIEVE LOWER INSURANCE RATES.

- IN ITS FIRST SIX MONTHS, THE HIPC ENROLLED 1,900 GROUPS, AVERAGING JUST UNDER TEN EMPLOYEES EACH. ENROLLMENT OF DEPENDENTS RAISES THE NUMBER OF BENEFICIARIES TO AROUND 33,000 IN THE ALLIANCE. TWENTY-TWO PERCENT OF THE 1,900 GROUPS (418) WERE PREVIOUSLY UNINSURED.

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- IN ORDER FOR A GROUP TO ENROLL, HOWEVER, AT LEAST 70% OF THE ELIGIBLE EMPLOYEES MUST PARTICIPATE.

- EIGHTEEN INSURANCE COMPANIES PARTICIPATE IN THE ALLIANCE. INSURANCE RATES FROM THESE COMPANIES ARE 10 TO 15 PERCENT BELOW RATES FOR COMPARABLE PLANS OFFERED BY INSURERS NOT PARTICIPATING IN THE HIPC.

- TWO OF THE STATE'S LARGEST INSURERS, BLUE CROSS OF CALIFORNIA AND CALIFORNIA BLUE SHIELD, DO NOT PARTICIPATE IN THE HIPC. THEY ARE OPPOSED TO THE HIPC BENEFITS THAT EXCEED THEIR NORMAL BENEFIT PACKAGES FOR SMALL GROUPS.

STRUCTURE OF THE PLAN

- EVERY EMPLOYEE MAY CHOOSE FROM AMONG THE PLANS OFFERED IN EACH OF THE SIX REGIONS ESTABLISHED IN THE HIPC, OR MAY CHOOSE A PLAN OUTSIDE THE ALLIANCE SINCE IT IS VOLUNTARY.

- THE PLANS WITHIN THE ALLIANCE OFFER A MODIFIED COMMUNITY RATE WITH ADJUSTMENTS FOR AGE AND GEOGRAPHICS. THE RATES ARE GUARANTEED FOR ONE YEAR.

- THE BENEFITS OFFERED BY THE PLANS WITHIN THE HIPC MUST INCLUDE COVERAGE OF PRESCRIPTION DRUGS. ENROLLEES WHO SELECT AN HMO MAY CHOOSE EITHER A $5 OR $15 COPAYMENT. THOSE WHO CHOOSE A PPO MAY CHOOSE EITHER A $250 OR A $500 DEDUCTIBLE.

- PARTICIPATING EMPLOYERS ARE REQUIRED TO CONTRIBUTE ONLY 50% OF THE COST OF THE LOWEST-COST PLAN IN THEIR REGION. HOWEVER, EMPLOYERS CONTRIBUTED AN AVERAGE OF 80% OF THE PREMIUM WITHOUT A MANDATE.

CURRENT DATA

- SO FAR, 81 PERCENT OF THE ENROLLEES HAVE CHOSEN AN HMO.

- THE HIPC HAS ATTRACTED A YOUNGER POPULATION THAN ANTICIPATED BY THE ACTUARIES.
  - 30% OF ENROLLEES ARE UNDER THE AGE OF 30.
  - 60% ARE UNDER 40.
  - 57% ARE MALE.
  - 43% ARE FEMALE.

- THESE DEMOGRAPHIC PATTERNS SUGGEST THAT THERE WILL BE MINIMAL RATE CHANGES AT THE END OF THE FIRST YEAR.

- WHAT IS ALSO IMPORTANT TO NOTE IS THAT WHILE THE HIPC IS VOLUNTARY, IT DOES NOT SEEM TO BE ATTRACTING A HIGHER PERCENTAGE OF BAD RISK. THIS IS ONE OF THE KEY REASONS THE ADMINISTRATION USES IN ADVOCATING MANDATORY ALLIANCES, ALTHOUGH THE CALIFORNIA PROVES OTHERWISE.

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UNIVERSALITY

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ISSUE #1: UNIVERSAL COVERAGE

1. Should We Require Universal Coverage?

   There are many who believe universal coverage is not necessary. Many believe significant increases in coverage can be made through changes in the insurance market and providing government subsidies for low-income individuals.

2. How Can Universal Coverage Be Achieved?

   The approaches to achieving universal coverage include a single-payer system, an employer mandate, an individual mandate, or some combination of these.

3. Who Should Pay for Universal Coverage?

   Individuals and/or employers?

4. Who Should Receive Subsidies?

   If there is some form of mandate, low-income individuals and/or small businesses will need subsidies to make insurance affordable. Subsidies could take several forms: tax credits, liability caps, vouchers, or premium discounts. Income range for individual subsidies and definition of small business eligible for subsidies need to be determined.

	CHAFEE	GRAMM	LOTT	NICKLES
UNIVERSAL COVERAGE	YES	NO	NO	YES
APPROACH	Individual mandate; Employer must offer insur.	N/A	Employer must offer insur.	Individual mandate
WHO PAYS	Individuals	N/A	N/A	Individuals
SUBSIDIES	Vouchers for individuals with income below 240% of poverty	Tax credits for workers with income below 200% of poverty	Medicaid buy-in for individuals with income up to 200% of poverty	Refundable tax credits for individuals based on medical expenses and income

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OVERVIEW OF REPUBLICAN HEALTH REFORM PLANS

	CHAFEE	GRAMM	LOTT	NICKLES
UNIVERSAL COVERAGE	Individual mandate	NO	NO	Individual mandate
LOW INCOME SUBSIDIES	YES	YES	YES	YES
LIMITATIONS ON FEDERAL $	YES	YES	YES	YES
INSURANCE REFORMS	YES	YES	YES	YES
STANDARD BENEFITS	YES	NO	NO	NO
PURCHASING GROUPS	YES	YES	YES	NO
TAX CODE: Medical Savings Accounts	YES	YES	YES	YES
Increase deduct. for self-employed	YES	YES	YES	YES
Tax cap	YES	NO	NO	Limited credits
Long Term Care Insurance	YES	YES	YES	YES
DIRECT COST CONTROLS	NONE	NONE	NONE	NONE
ANTI-FRAUD AND ABUSE PROVISIONS	YES	NO	YES	YES
ADMIN. SIM-PLIFICATION	YES	YES	YES	YES
CONSUMER VALUE INFORMATION	YES	NO	YES	YES
LIABILITY REFORM	YES	YES	YES	YES
MEDICAL EDUCATION	YES	NO	NO	NO
MEDICAID Capitation	YES	YES	NO	YES
Eliminate DSH	YES	NO	NO	YES
MEDICARE Private Option	YES	YES	NO	Study
Provider Cuts	YES	NO	NO	YES
Means test	YES	NO	YES	NO

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QUALITY STANDARDS	YES	YES	YES	YES
RURAL/INNER CITY PROVISIONS	YES	NO	YES	YES
HEALTH PLAN REQUIREMENTS	YES			YES

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Critical Choice #1: Health Insurance For All Americans?

1.1 - The Universal Coverage Debate

Universal coverage is the guarantee that every citizen have health insurance coverage, so that medical care cannot be denied because of lack of ability to pay. Although some policymakers use the terms interchangeably, universal coverage is not the same as universal access, which seeks to make health insurance available for purchase by every American, but does not ensure that everyone can afford it or is covered.

• What Is Universal Coverage?

Whether a reformed health system has as its goal universal coverage or universal access is the answer to a key societal question: is health care a right or a privilege? If we as a society decide that health care is as much a right as a high school education, then we should guarantee a basic level of health insurance much as we guarantee a basic level of schooling. If, on the other hand, we decide health care is more like a college education, something everyone who wants it should be able to obtain — with financial aid if they can't otherwise afford it — we may wish to opt for universal access.

It must be noted that universal access is not currently available in our health care system. Many people, even working people, are not offered insurance as part of their jobs and cannot afford the premiums for private coverage. Many other people are "uninsurable" and cannot purchase coverage at any price, because they have a "pre-existing" medical condition such as cancer or diabetes. Virtually every reform plan introduced in the Congress includes, at a minimum, requiring insurance companies to sell policies to all Americans, regardless of their health status, and providing the poor with vouchers, tax credits, or other forms of aid to make insurance more affordable.

• Why Is Universal Coverage Important?

Proponents of universal coverage note that it is important not just to those who lack insurance, but also to those who are currently covered. That's because most people who need medical care do ultimately get it, even if they can't pay. Sometimes that care is from a public clinic or hospital, paid for with tax dollars. More often care for the uninsured is financed by what's known as "cost shifting," the practice of a hospital or doctor charging insured patients more to make up for those who can't pay. Cost-shifting can be from the government to private payers, as when Medicaid and Medicare pay less than care actually costs. It occurs from insurance companies to businesses, as premiums rise to cover the cost of care for the uninsured. Cost-shifting even goes on from businesses to their workers, through requiring that they pay a larger percentage of their insurance premiums, higher deductibles and co-payments and even lower wages.

But if the uninsured do sometimes get medical care, people may ask, then why do they need insurance? Because studies have shown convincingly that the care provided to the uninsured is often too late, inappropriate, and more expensive both to them and to society than the care provided to those with health insurance. Because the uninsured get fewer preventive and primary care services than those with insurance, illnesses are often discovered and/or treated at a more advanced stage, thus costing more. The uninsured are also more likely to use hospital emergency rooms to obtain care, which is both more expensive and more impersonal than care obtained from a private physician.

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• WHO ARE THE UNINSURED?

While it is true that many people who are poor lack health insurance, most of the uninsured are not, in fact, poor. More than two-thirds of those who lack insurance live in families with incomes above the federal poverty line. It's also a myth that most of the uninsured are also unemployed. An overwhelming proportion of those without insurance — 84 percent — live in a family in which someone works.

Also untrue is that the uninsured are that way by choice — mostly young healthy people who neither need nor want insurance. In fact, more than half of the uninsured are adults over age 24, and another 22% are children. 93 percent of the uninsured tell pollsters they want coverage. The most common reason the uninsured don't have coverage, they say, is that they simply can't afford it. While affordability is a subjective measure, health coverage for an average family today costs more than $5,000 a year, nearly a seventh of the median family income of $36,812.

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What Is 'Universal' Is Center Of Fight Over a Health Plan

By ROBERT PEAR
Special to The New York Times

WASHINGTON, Feb. 15 — Universal insurance coverage has become the touchstone of the debate over health care. President Clinton threatens to veto "legislation that does not guarantee every American private health insurance that can never be taken away."

But what precisely does universal coverage mean? How would it be administered? Would everyone voluntarily enroll in a health plan? Would the Government force people to buy insurance?

By exalting universal coverage as the paramount goal of a health care plan, the President has made the definition of the term a central part of the political fight developing on Capitol Hill.

Every Legal Resident Protected

Mr. Clinton's plan calls for every legal resident of the United States to have have protection against health care costs at all times. Employers would bear most of the costs for their workers by paying health insurance premiums. Workers and other consumers would also be expected to contribute. The Government would raise new rev[illegible] by increasing tobacco taxes. The Government would subsidize coverage for low-wage workers and the unemployed.

Other proposals before Congress are also intended to provide universal coverage.

Nearly 39 million Americans, representing 15.4 percent of the population, lack health insurance on any given day, acccording to the Employee Benefit Research Institute, a nonpartisan organization whose members include businesses and labor unions. Over the

Continued on Page A11, Column 1

Health Fight Turns on 'Universal Care'

Continued From Page A1

course of a year, as many as 53 million people may be without insurance for a month or more, the institute says.

There are many reasons universal coverage may not equal 100 percent. Finding everyone to be covered is one problem. The Census Bureau tries to count everyone in the country, but by its own estimate it missed at least 1.6 percent of the population in 1990, with larger undercounts in earlier censuses.

Getting people to pay the insurance premiums is another potential problem. Nearly everyone is eligible for Social Security, but many domestic workers are not covered because their employers did not withhold Social Security taxes from their pay as required by law.

Strange as it may seem, the people who run social programs have found that they must make aggressive efforts to induce people to sign up for benefits to which they are entitled, like food stamps and Medicaid. Millions of poor people, homeless people and immigrants do not avail themselves of care for which they are now eligible at community health centers.

Administration officials say the requirement for universal coverage distinguishes Mr. Clinton's plan from others that seek merely to increase access to health care. Mr. Clinton's plan and most of the other health care proposals pending in Congress fall short of universal coverage in one sense: They generally do not cover illegal aliens. The Census Bureau estimates that there are four million such people in the country.

Plan for Access to Insurance

Mr. Clinton would require employers to pay at least 80 percent of health insurance premiums for their workers. Representative Jim Cooper, Democrat of Tennessee, has introduced a bill that would make health insurance easily available to most people. But Mr. Cooper's bill, which has bipartisan support, would not require consumers to buy health insurance or employers to pay for it. So the bill would not guarantee universal coverage.

Mr. Cooper's bill would create large pools of consumers to buy insurance voluntarily, and he estimates that 80 percent of the uninsured would obtain coverage by this means within a few years. Under his bill, a Federal agency would study the remaining uninsured population and advise Congress how to achieve fuller coverage.

Nothing in the Cooper bill would prevent people from delaying the purchase of insurance until they became sick and needed care. But there would be a penalty for those who delayed: Health plans could deny coverage of their existing medical problems for six months. Such consumers might then have to spend more of their own money.

Robert M. Ball, a former Commissioner of Social Security, says: "Universal coverage means that every legal resident of the United States would have protection against health care costs at all times, as in Canada or Britain. That is feasible. There is no reason why anybody should be left out at any time."

But Robert J. Myers, who served as chief actuary of the Social Security Administration from 1947 to 1970, predicted that some people would remain uninsured and "wait till a medical emergency occurs, then go to a hospital and get free care."

Anticipating this possibility, the Clinton plan would establish procedures to

> Almost any plan will leave some people out.

enroll people at the precise moment they sought health care services. As a penalty for their prior failure to obtain insurance, the Clinton bill would have these people pay twice the amount of all the premiums they would have paid if they had enrolled earlier as they were supposed to.

Obviously, Mr. Clinton assumes that most people want health insurance and would voluntarily sign up for it. But under his bill, the enforcement power of the Federal Government would be available if needed to make consumers and employers pay for coverage.

The President's bill says the Secretary of Labor shall provide the regional insurance-purchasing pools with "such technical and other assistance as may promote the efficient collection" of premiums. "Such assistance may include the assessment of civil monetary penalties, not to exceed $5,000 or three times the amount of the liability owed, whichever is greater, in the case of repeated failure to pay," it says.

Under a bill introduced by Senator John H. Chafee, Republican of Rhode Island, every citizen and lawful permanent resident would have to obtain coverage by Jan. 1, 2005.

Under a bill introduced by Representative Jim McDermott, Democrat of Washington, all people would be enrolled in a national health insurance program by 1995. The program would be designed and financed by the Government. Children would be automatically enrolled at birth. Mr. McDermott has proposed a variety of tax increases to pay for this "single-payer" scheme.

The Clinton plan would provide health insurance for the 38.9 million people who have no coverage. At the same time, millions of people who now get coverage through their employers would switch to new insurance purchased through the regional health alliances, which could be either state government agencies or private nonprofit organizations. Companies with more than 5,000 employees could operate their own health plans.

Such sweeping changes would be much different from the gradual process by which Social Security was expanded to cover nearly the entire population over three decades. Social Security was created in 1935, and in the early years of the program, it did not cover agricultural workers, domestic workers or the self-employed.

"We recognized that there was a social need for protection of these people, but we did not know how to administer the coverage," Mr. Myers said. "Our thinking back then was that we wanted to get the system going, keep records and collect taxes, then extend coverage to other groups. In theory, everybody should be covered. But in practice, let's do what's doable. That was our thinking."

In 1950, Social Security was expanded to cover agricultural workers, domestic workers and most of the self-employed, as well as employees of private nonprofit entities like colleges, churches and community hospitals. Coverage became available to clergymen in 1954, and self-employed doctors were not covered until 1965.

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BENEFITS PACKAGE

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DRAFT

ISSUE # : BENEFITS

MAJOR POLICY ISSUES FOR REFORM

1. Covered items and services
   Should the benefit package be the same for everyone in terms of covered items and services; or should a minimum be defined and variation above the minimum allowed?

2. Standardization of cost sharing
   Should cost sharing amounts be the same or should cost sharing be allowed to vary based on type of plan? In general, higher cost sharing is incompatible with health maintenance organizations, but is a necessary cost control mechanism for fee-for-service plans.

3. Definition of the benefit package
   Should details of the benefit package be defined in legislation or should another entity, such as a Commission, make a recommendation to Congress for approval once the legislation has been enacted?

4. Mental health benefits
   Should coverage for mental health services be included in the benefit package? If so, should they be treated the same or differently than medical benefits in terms of cost sharing?

5. Classes of providers
   Should the legislation include language which prohibits discrimination against classes of providers?

6. State law preemption
   Should state laws that mandate coverage for certain items and services or certain provider classes be preempted?

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APPROACH OF REPUBLICAN HEALTH REFORM PLANS

	CHAFEE	GRAMM	LOTT	NICKLES
COVERED ITEMS AND SERVICES	Uniform Package	Variations in benefit packages allowed	Standard, catastrophic and Medisave plans based on actuarial values	Minimum Package - Variations above minimum are allowed
COST SHARING	Standard and catastrophic levels to be defined by Commission	Catastrophic limit not to exceed $3000 per year (indexed)	Standard and catastrophic levels	Variations allowed up to maximum levels
SPECIFICS ON COVERAGE	By Commission	Not applicable	NAIC to set target actuarial values	In Legislation
MENTAL HEALTH BENEFITS INCLUDED	Severe mental illness must be treated same as medical - Other mental health up to commission	Can be an option in a benefit package	Can be an option in a benefit package	Not part of minimum benefit package
PROVIDER CLASSES	All legal providers covered if participants in plan	No mention	No mention	No mention
PREEMPTS STATE MANDATED BENEFITS LAWS	YES	YES	YES	YES

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ISSUE # : STATES' ROLE IN HEALTH REFORM

1. State Solutions

Should there be a national system or should states be responsible for health care reform within their own borders? State-based health care reform would likely create 50-plus health care systems. This would cause headaches for Multi-state employers.

Should States be permitted to "opt out" of a national system? Giving States flexibility to design a system different from a national system could undermine the "universality" of the national system.

2. Implementation/Regulation of National System

If a national health care system is created, States could play a variety of roles in implementing pieces of the national system and play an on-going role in regulating and monitoring compliance within the system. States fear they will be asked to play a large role but not be given the tools necessary to regulate the system, as well as being expected to achieve unrealistic goals. States worry about being responsible for making up the difference if cost containment goals are not met.

3. Financing

What is the role for States? Currently, States contribute about 43 percent of the expenditures for the Medicaid program. Should States be forced to continue such spending through "maintenance of effort" requirements, or be relieved of responsibility? Some proposals divide certain programs financed jointly by the Federal government and the States and create separate programs financed by one or the other. For example, one proposal has the Federal government paying for Medicaid acute care and the states paying for Medicaid long-term care.

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	CHAFEE	GRAMM	LOTT	NICKLES
STATE SOLUTIONS	States can enroll Medicaid beneficiaries in accountable health plans or Medicaid managed care programs	States can enroll Medicaid beneficiaries in private HMOs or establish medical savings accounts	States can enroll Medicaid beneficiaries in accoun-table health plans or Medicaid managed care programs; States can allow low-income individuals to buy-in to Medicaid	No provision
IMPLEMENT /REGULATE NATIONAL SYSTEM	Designate and establish HCCAs	No provision	No provision	No provision
	Certify health plans	No provision	No provision	Certify health plans
	Risk adjustment	States establish insurance pools for individuals with pre-existing conditions	No provision	Risk adjustment

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TOMMY G. THOMPSON

Governor
State of Wisconsin

March 1, 1994

The Honorable John H. Chafee
United States Senate
567 Dirksen Senate Office Building
Washington, D.C. 20510

Dear John:

Thank you for inviting me to attend the Senate Republicans' retreat on the issue of health care reform. Unfortunately, my schedule makes it impossible for me to attend. I would like to take this opportunity however, to point out a number of my major concerns with the President's proposal.

**The employer mandates included in the bill will cost jobs.*

**Mandatory alliances will restrict choice and impose an unnecessary layer of centralized bureaucracy.*

**Global budgets with unrealistic targets will lead to rationing and to a complex bureaucracy to administer them.*

**The maintenance of effort provisions in the bill penalize states that efficiently manage their health care costs. States like Wisconsin, whose costs are increasing at less than the national average, despite the broadest possible coverage, would have to pay an additional amount to subsidize those states who have been less efficient and less generous.*

While your bill provides states with significant flexibility in some areas, I remain very concerned with the provision that caps federal Medicaid payments without a corresponding cap at the state level. This provision is a cost shift to states.

Room 115 East, State Capitol, P.O. Box 7863, Madison, Wisconsin 53707 • (608) 266-1212 • FAX (608) 267-8983

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In Wisconsin, we have significant experience in using managed care for Medicaid participants and have proven that quality of care can be better in managed care than in a traditional fee-for-service setting. Wisconsin has successfully integrated Medicaid recipients into managed care delivery systems serving the general population.
The slow phase-in enrollment for the Medicaid population into the qualified health plans and the exemptions from managed care for special needs populations included in your bill are, therefore, not only unnecessary but could hinder state progress in this area.

The Cooper bill has also been receiving a great deal of attention lately. As you know, the bill would eliminate the acute care Medicaid program and replace it with a fedearally funded program. States would then have to assume responsibility for full funding of Medicaid long term care. This is unacceptable to Governors.

As you know, at the National Governors' Association Winter Meeting, Governors, in a bipartisan manner, adopted a health care reform policy, A Call to Action, which outlines those provisions which Governors would like to see enacted this year. I have attached a copy of our policy. Please feel free to consider it a framework for your discussion.

Again, I am sorry that I will not be able to join you, and I wish you great success in your efforts. I look forward to our continued work together.

Best regards,

Tommy

TOMMY G. THOMPSON
Governor

Enclosure

cc: Governor Campbell
Senator Dole ✓
Congressman Gingrich

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NATIONAL GOVERNORS' ASSOCIATION
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Policy

EC-7. HEALTH CARE REFORM: A CALL TO ACTION

7.1 **Preamble**

The nation's Governors are committed to comprehensive health reform that calls for a federal framework with significant state flexibility, and they will work with Congress and the administration to develop such a system. At the same time, however, the growing demand for affordable quality health care, coupled with the immediate budgetary pressures caused by the Medicaid program, requires immediate action. Virtually every Governor has some health reform initiative in progress. These include comprehensive state-based reform initiatives, programs that assist small businesses in securing affordable health insurance, programs that expand health care coverage to a greater number of uninsured poor, and programs that implement managed care networks for Medicaid beneficiaries. None of these state initiatives are incompatible with national reform; instead, they continue to build a strong policy foundation for reform at the federal level.

7.2 **Federal Barriers to State Health Reform**

As states have moved ahead, their success has been limited by barriers resulting from current federal statutes. The nation's Governors call upon the administration and Congress to immediately remove those federal barriers.

7.2.1 **Medicaid.** By far, Medicaid represents the largest health care expenditure for states. On average, only spending for elementary and secondary education constitutes a larger portion of state budgets. Governors believe that irrespective of any national health reform strategy, Medicaid costs must be brought under control. Should Congress move to limit or cap the federal contribution to Medicaid, a move the Governors adamantly oppose, the Governors believe these changes and other relief will become even more urgent. The Governors recommend the following changes that will contribute to controlling those costs.

7.2.1.1 **Managed Care Waivers.** There is a national trend in health care service delivery toward systems of care. These systems or networks have been shown to provide cost-efficient care while ensuring that the patient has a reliable place from which to seek primary care and to which specialty care can be directed. Although the private sector is moving aggressively toward these networks, the Medicaid program continues to require states, in virtually all cases, to apply for a waiver from fee-for-service care in order to enroll Medicaid beneficiaries in such networks. And while the Bush and Clinton administrations have taken significant steps toward simplifying the application and renewal process, states still must apply for renewals every two years. Moreover, states have been unable to sustain networks where there is a predominance of Medicaid beneficiaries because, under current law, states are permitted only one nonrenewable three-year waiver to have beneficiaries served in a health maintenance organization (HMO) where more than 75 percent of the enrollees in the HMO are Medicaid beneficiaries. This requirement should be repealed.

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If the nation is serious about controlling health care costs, it is essential to give states the opportunity to establish networks in Medicaid (including fully and partially capitated systems) through the regular plan amendment process. Governors recognize the special significance of consumer protections and assurance of solvency in establishing these systems of care and support federal guidance through the regulatory process.

7.2.1.2 **Comprehensive Waivers.** States have begun to look seriously at comprehensive systems of health care where the artificial categorical barriers of Medicaid are removed and where they can establish statewide networks of care for Medicaid beneficiaries. Unfortunately, there are no provisions in the Social Security Act that can be used to establish such programs on an ongoing basis.

Currently, states have been developing these more comprehensive networks through the research and demonstration provisions of the Social Security Act (Section 1115a). Section 1115a, however, was designed for research purposes and has some important limitations. States must demonstrate, through the application process, that they are testing an innovation. The law requires an evaluation that, in some cases, requires control groups. Projects approved under the 1115a process are approved for a limited time period, usually three to five years at the discretion of the administration, and require special statutory changes to go beyond the demonstration period. Finally, these projects must be cost neutral over the life of the project.

Section 1115a is essential to ensure the testing of alternative health and social policies. However, the current statute falls short by requiring statutory changes if a state wants to continue its successful effort. In short, once a state has proven that its research project works, it cannot continue without congressional action. Governors support changes to the Social Security Act so that a state may apply through the executive branch of government for renewable waivers of their innovations. This waiver process should be consistent with the streamlined approaches used by the Clinton administration and states should have to reapply for these waivers no less than every five years.

7.2.1.3 **Boren Amendment.** The Boren Amendment to the Medicaid provisions of the Social Security Act was passed in the early 1980s to give states greater flexibility in establishing reimbursement rates for hospitals and nursing homes and to encourage health care cost containment. Instead, it has led to havoc in the administration of Medicaid programs. Court decisions have interpreted the Boren Amendment to embody a restrictive and unrealistic set of requirements in setting reimbursement rates, and have in effect given judges the power to establish reimbursement rates levels and criteria. Because of these decisions, states remain frustrated in their ability to bring some discipline to their budgets and have been thwarted in their attempts to achieve the original purpose of the amendment.

The nation's Governors believe that any coherent approach to national health reform must address the issue of the Boren Amendment. They believe that a statutory change to this amendment is an important tool necessary to bring Medicaid institutional costs under control. Therefore, the Governors urge the administration and Congress to adopt these or other changes to the Boren Amendment that will give states the relief they need.

Statutory and Regulatory Changes. The Governors agree that standards for establishing adequate reimbursement rates for hospitals, nursing facilities, and intermediate care facilities for persons with mental retardation (ICF/MRs) must be designed to promote access to care for Medicaid patients, quality of services, cost containment, and efficient service delivery. The Governors support a strategy that would replace the current cost-efficiency-based standard in the Boren Amendment with provisions that establish "safe harbor" standards where a state meeting any of these "safe harbor" provisions would satisfy the statute. Standards might include the following.

- The payment rate is equal to the Medicare-based upper payment limit.
- The payment rate is no less than the rate agreed to by the facility for comparable services paid for by another payer (e.g. payment rates for Medicaid patients would not have to be higher than rates paid by any large managed care plans or large business).
- Regarding nursing facilities, the aggregate number of participating licensed and certified nursing home beds in the state (plus resources devoted to home or community-based care for the elderly) is at least equal to a specified percentage of the population age 65 or over.

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- The reimbursement rate is sufficient to cover at least 80 percent of the allowable costs of all facilities in the class in the state in the aggregate, or is sufficient to cover the allowable costs of 50 percent of all facilities in the class in the state.
- The reimbursement rate is equal to a benchmark rate plus inflation no less than the rate of inflation for the overall economy according to a general index (national or state), such as the consumer price index (CPI) or the gross domestic product (GDP-IPD). The benchmark rate would be the approved rate as of the date of enactment of the statute or the current rate approved by the Health Care Financing Administration. This standard is satisfied by a rate methodology currently in effect and approved by HCFA that contains a provision for inflation adjustments.

The Governors also believe that the procedural requirements in the current Boren Amendment must be streamlined. Finally, the Governors support strategies that would reduce or eliminate the costs of prolonged and costly litigation.

7.2.2 **Employee Retirement Income Security Act.** Although the Governors are extremely sensitive to the concerns of large multistate employers, the fact remains that one of the greatest barriers to state reform initiatives is the Employee Retirement Income Security Act (ERISA). ERISA preempts all self-insured health plans from state regulations and subjects those plans only to federal authority. As a result of judicial interpretations of ERISA, states are prohibited from:

- establishing minimum guaranteed benefits packages for all employers;
- developing standard data collection systems applicable to all state health plans;
- developing uniform administrative processes, including standardized claim forms;
- establishing all payer rate-setting systems;
- establishing a statewide employer mandate;
- imposing premium taxes on self-insured plans; and
- imposing provider taxes where the tax is interpreted as a form of discrimination on self-insured plans.

7.2.2.1 **ERISA Flexibility.** Governors call on the administration and Congress to modify the ERISA statute to give states the flexibility they need to move ahead on health reform. This may be done either by establishing the flexibility directly in statute or through the establishment of waiver authority. The flexibility could include a requirement that the state demonstrate broad-based support for the change, such as by passage of state legislation. States must be assured, however, that the flexibility is stable and not time limited.

7.3 **A Call to Action**

The nation's Governors call upon President Clinton and Congress to pass health care legislation this year that includes, at a minimum, the following.

7.3.1 **Insurance Reform.** We support minimum federal standards that result in portability of coverage; guaranteed renewability of policies; limitations on both medical underwriting and preexisting conditions exclusions; and modified community rating that limits the variation in rates that different individuals and groups are charged.

7.3.2 **State-Organized Purchasing Cooperatives.** Through purchasing cooperatives, affordable insurance products will be made available. States and the federal government must work together to ensure that states have flexibility in establishing and operating these cooperatives.

7.3.3 **Core Benefits and Access.** In order to ensure portability of coverage, Governors believe that there must be a core benefits package that is comparable to those that are now provided by the most efficient and cost-effective health maintenance organizations. The cornerstone of this package must be primary and preventive care. All employers must make the core benefits package available to those employees who wish to purchase it. While Governors do not agree on whether employers should be required to pay for any portion of the premium, Governors agree that coverage should be available.

7.3.4 **Tax Deductibility of Health Care Premiums.** Health insurance premiums should be tax deductible to the value of the core benefits package regardless of who pays the premium. Governors do not support

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limiting health benefits; however, policies that afford benefits above the limit should be subject to taxation. The Governors do support tax changes that would correct the inequities now suffered by self-employed individuals. These individuals would be eligible to purchase fully deductible health insurance within the federal limit.

7.3.5 **Low-Income Subsidies.** Low-income families and individuals will require subsidies in order for them to afford health care. Governors support a streamlined eligibility process for these subsidies, and believe that the subsidies must be sufficient to make this goal a reality. Governors also look forward to a system of subsidies that provides low-income families and individuals with a core benefits package that Governors believe will be a more effective method for providing care than the current Medicaid program. This program could be financed partially through revenues resulting from limits on tax deductibility.

7.3.6 **Changes to the Current Medicaid System.** Governors strongly believe that some critical changes to the Medicaid program must be made now to improve the cost efficiency of the program. Specifically:

- States should have the ability to move their Medicaid populations into managed care settings through a plan amendment rather than through a waiver.
- During the phase-in of the new low-income subsidy program, states must have the flexibility to establish new programs that expand eligibility to a larger indigent population. This flexibility would require additional waiver authority under Medicaid.
- In addition, states have been unable to control the costs of reimbursement rates to institutional health care providers as a result of judicial interpretation of the Boren Amendment. States must be given legislative and regulatory relief from these interpretations in order to get better control of these costs.

7.3.7 **Medical Malpractice and Liability Reform.** Another important step in developing a rational health care system is the modification of current medical malpractice and liability statutes. We believe that minimum standards should be set by the federal government. Alternative dispute resolution is among the strategies that should be explored to reduce the amount of litigation in this area.

7.3.8 **Relief from Antitrust Statutes.** More and more Americans are receiving their care through health delivery networks. Establishing these networks requires new approaches to cooperation among providers and businesses that heretofore have been competitors. The current antitrust statutes must be revised to accommodate this new health care environment.

7.3.9 **Relief from the Employee Retirement Income Security Act.** ERISA must be modified to give states the flexibility they need to move ahead on state reform. At a minimum, Congress should enact ERISA waiver authority for states that meet certain criteria for health care reform.

7.3.10 **Federally Organized Outcome and Quality Standards.** If meaningful choices are ever to be made in health care, research must be supported to develop outcomes and quality standards for use by providers and consumers alike. Also, information systems must be developed that include price and quality information for all providers and consumers of health care services in a given geographic area.

7.3.11 **Administrative Simplifications.** The administrative complexity of the current system must be reduced. At a minimum, we must adopt a single national claims form and electronic billing.

We believe that these provisions should be included in any reform strategy. As Governors, we do not vary in our support of these changes, and we urge Congress and the President to act as quickly as possible.

Time limited (effective February 1994-February 1996).
Adopted January 1994.

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INSURANCE REFORM

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APPROACH OF REPUBLICAN HEALTH REFORM PLANS

	CHAFEE	GRAMM	LOTT	NICKLES
GUARANTEED ISSUE	YES	NO	For group market, not individual market	YES
GUARANTEED RENEWABILITY (except for nonpayment or fraud)	YES	YES	Yes - group market, not individual market	YES
PORTABILITY	YES	New COBRA Options Penalty-free IRA withdrawals	YES	YES
PREEXISTING CONDITIONS	Exclusion allowed for 6 months less 1 month for every month of previous continuous coverage None for pregnancy or for newborns	State-run insurance pools to subsidize premiums for those with preexisting conditions	Exclusion allowed for 6 months unless person previously covered within 60 days None for pregnancy or for newborns	Exclusion allowed for 12 months less 1 month for every month of previous continuous coverage
RATING ALLOWED VARIATIONS	Family type, age and administrative costs	Everything except health status (new policies)	Age, gender, geography, family comp. group size, health status	Age, gender, geography, and healthy behavior
LIMITATIONS ON VARIATIONS	Variation on age limited to 2:1	None	High cannot exceed low by more than 50%	
RATING RULES APPLY TO ALL PLANS?	No rating requirements for large employer plans	YES	Applies to small group market only	YES

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	CHAFEE	GRAMM	LOTT	NICKLES
PURCHASING GROUPS	Purchasing Groups	MEWAs(ERISA)	Purchasing Groups	None
EXCLUSIVE OR MULTIPLE?	Multiple	Multiple	Multiple	Not applicable
VOLUNTARY OR MANDATORY?	Voluntary	Voluntary	Voluntary	Not applicable
WHO CAN PARTICIPATE?	Individuals and employers of under 101	Any employers	Any employers	Not applicable
MARKETING	Marketing to small employers must include information on all plans available	No specific provisions	No specific provisions	Agent commissions cannot reflect risk status of enrollees
RISK ADJUSTMENT	States risk adjust all small market plans. Does not apply to large employer plans	No provision	States risk adjust of have risk system for small group market	States risk adjust all health plans

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TAXATION

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ISSUE # : TAXATION OF HEALTH INSURANCE

1. **Employee Exclusion**. Employer-paid health coverage is excluded from the income of employees. This exclusion is the second largest federal tax expenditure. The Joint Committee on Taxation estimates this expenditure to be $287 billion over 5 years.

2. **Employer Deduction**. Employers can deduct the cost of employee health coverage.

3. **Self-Employed Individuals**. A self-employed individual can deduct up to 25% of his or her health insurance premiums. This provision expired on December 31, 1993, but is expected to be extended and increased as part of health reform.

4. **Individual Deduction**. Individuals who itemize deductions can deduct non-reimbursed medical expenses including health insurance premiums that exceed 7.5% of the individuals adjusted gross income.

MAJOR POLICY ISSUES

The fundamental issue for consideration of any health care reform plan is the extent to which the present law tax incentives for employer-provided health care benefits should be retained. The exclusion from gross income provided under present law for employer-provided health insurance is criticized as contributing to the over utilization of health care. The over utilization of health care leads to rising costs.

Alternatively, many argue that an individual taxpayer-based system involving for example, a refundable tax credit for low income individuals combined with an expanded deduction for higher income individuals is a better way to expand coverage and control costs.

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MAJOR SENATE REPUBLICAN BILLS

	CHAFEE	GRAMM	LOTT	NICKLES
EMPLOYER DEDUCTION	Yes, with cap	Yes	Yes	N/A Employers cannot provide plans
EMPLOYEE EXCLUSION	Yes, with cap	Yes	Yes	No
ITEMIZED DEDUCTION FOR HEALTH INSURANCE	Yes, with cap	Yes	Yes	No (tax credit instead)
SELF-EMPLOYED DEDUCTION	Yes, 100% with cap	Yes-national average paid by employers (about 75%)	Yes	No
TAX CREDITS	No	Yes for workers with income below 200% poverty	No	Yes-minimum 25% credit; up to 75% credit based on income and medical expenses
MEDICAL SAVINGS ACCOUNTS	Yes	Yes, for catastrophic and Medicare insurance	Yes, for catastrophic long-term care, and Medicare insurance	Yes
PENALTY FREE WITHDRAWALS FROM IRAs & 401k PLANS TO BUY INSURANCE	No	Yes	No	No

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STATISTICS

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Sources of Health Insurance and Characteristics of the Uninsured

Analysis of the March 1993 Current Population Survey

EBRI
EMPLOYEE
BENEFIT
RESEARCH
INSTITUTE

Special Report

- This *Issue Brief / Special Report* examines the extent of health insurance coverage in the United States, the characteristics of the uninsured population by employment status, firm size, industry, income, location, family type, gender and age, race and origin, and education, as well as how the uninsured population has changed over the last several years.

- Eighty-three percent of nonelderly Americans and 99 percent of elderly Americans (aged 65 and over) were covered by either public or private health insurance in 1992, according to EBRI tabulations of the March 1993 Current Population Survey (CPS). The March 1993 CPS is the most recent data available on the number and characteristics of uninsured Americans.

- In 1992, 17.4 percent of the nonelderly population—or 38.5 million people—were not covered by private health insurance and did not receive publicly financed health assistance. This compares with 36.3 million in 1991 (16.6 percent), 35.7 million in 1990 (16.5 percent), 34.4 million in 1989 (16.1 percent), and 33.6 million in 1988 (15.9 percent).

- The most important determinant of health insurance coverage is employment. Nearly two-thirds of the nonelderly (62.5 percent) have employment-based coverage. Workers were much more likely to be covered by employment-based health plans than nonworkers (71 percent, compared with 40 percent).

- A primary reason for the increase in the number of uninsured between 1991 and 1992 is a decline in employment-based coverage among individuals (and their families) working for small firms. Forty-two percent of the additional 2.2 million individuals without coverage between 1991 and 1992 were in families in which the family head worked for an employer with fewer than 25 employees.

- The number of children who were uninsured in 1992 was 9.8 million, or 14.8 percent of all children. This compares with 9.5 million and 14.7 percent in 1991. The increase in the number and proportion of uninsured children was partially offset by an increase in the proportion of children with Medicaid.

- In 12 states and the District of Columbia, more than 20 percent of the population was uninsured in 1992 (table 3). These states and their uninsured rates were Nevada (26.6 percent), Oklahoma (25.8 percent), Louisiana (25.7 percent), Texas (25.7 percent), the District of Columbia (25.5 percent), Florida (24.2 percent), Arkansas (23.5 percent), Mississippi (22.7 percent), New Mexico (22.5 percent), Georgia (22.4 percent), California (22.2 percent), South Carolina (20.8 percent) and Alabama (20.1 percent).

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SELECTED FIGURES OF CHARACTERISTICS OF THE UNINSURED

(From EBRI Analysis of March 1993 Current Population Survey)

Non-Elderly - 83% have health insurance - of that, 15% had public health insurance

Elderly - 96% are covered by Medicare - of that, 35% have individually purchased Medigap supplemental insurance and another 33% have employer provided Medigap insurance.

- In 1991 - 16.6% of the non-elderly (or 36.3 million people) were not covered by insurance

- In 1992 - 17.4% of the non-elderly (or 38.5 million people) were not covered by insurance

(A primary reason for the increase in the number of the uninsured is a decline in coverage by small firms)

- 92% in families with income over $50,000 have health insurance
- 52% in families with income below poverty line have public insurance
  - 50% Medicaid
  - 2% Medicare, CHAMPUS or CHAMPVA

- Of the 4.2 million increase of uninsured between 1989 and 1992
  - 19% were in families headed by worker in firm of less than 25
  - 21% were in families headed by worker in firm between 25 to 99
  - 14% were in families headed by worker in firm between 100 to 499
  - 21% were in families headed by worker in firm over 500
  - 25% were in families headed by non-worker

- Of the Uninsured
  - 56.7% are working adults
  - 17.8% are non-working adults
  - 25.4% are children

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- Of the Uninsured
  - 60% are families headed by full-year workers with no unemployment
  - 52% are families headed by full-time workers
  - 8% are families headed by full-year, part-time workers

- Only 13% of individuals in families headed by a full-time, full-year worker are not covered by insurance. - But they represent the largest segment (52%) of the uninsured.

- 1/2 of all uninsured workers were either self-employed or working in firms with fewer than 25 employees.

- In 1992 - 88% of the uninsured were in families with an AGI of less than $20,000
  - 53% of the uninsured were in families with income under $20,000
  - 35% of the uninsured were in families with income under $5,000
  - 6% of the uninsured were in families with income over $50,000

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Health Care Fact Sheet

EXPENDITURES	**1980**	**1993***	**2000***
National Total ($B)	$ 250	$ 903	$ 1,613u
Percent of GDP u	9.2	14.6	18.9
Per Capita Amount ('91$) u	$1,761	$3,217	$4,503
National Total (AAC%)	---	10.4	9.8

Expenditure Distribution	**1980**	**1993***	**2000***
Hospital	41%	40%	40%
Physician	17	19	20
Nursing Home	8	8	7
Drugs	9	8	7
Other	25	25	25

Payor Distribution	**1980**	**1993***	**2000***
Private Health Insurance	29%	30%	28%
Patient Out-of-pocket	24	19	17
Federal Government	29	32	36
Other Government/Private	18	19	19

PROVIDERS

Physicians

Active Physicians (1995*)	634,600
Group Practices (GPs) (1991)	16,576
Physicians in GPs (1991)	184,358
Physician Income AAC (1982-91)	6.4%
Malpractice Premiums (1982/1991)	$5,800/$14,900

Hospitals	**1980**	**1993***	**2000***
Total Average Margin	3.8%	4.3%	–
% with (-) Margins	26.2%	24.5%	–
Comm. Hosp. Closures	50	45	39
Comm. Hospitals/Beds (1992)	5,292 / 920,043		
Multi-hospital Systems (1992)	53% of all hospitals, 59% of all beds		

Managed Care	**1988**	**1992**	**AAC**
No. HMOs	643	556	(3.6%)
HMO Enrollment (M)	31	37	4.4%
No. PPOs	691	1,036	10.7%
PPO Enrollment (M)	18	58	33.4

(M)=Millions (B)=Billions (T)=Trillions
u=CBO Data ; *Projected Data; AAC=Average Annual Change
s=Employee Benefits Research Institute Data, 1993 CPS

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INTERNATIONAL	US.	Can.	Ger.	Jap.	U.K.
%Health GDP (1991)	13.4	10.0	8.5	6.6	6.6
%Growth GDP (1991)	2.7	0.9	8.1	6.4	4.7
Per Capita (1991) (US$)	2,867	2,149	2,088	1,800	1,162
Life Expectancy (F)	78.8	80.4	79.0	82.1	78.8
Life Expectancy (M)	72.0	73.8	72.6	76.1	73.2
Infant Mortality (/100)	0.89	0.68	0.71	0.46	0.74
Length of Stay (days)	6.4	11.4	15.2	44.9	20.0
Beds per 1,000	4.7	6.7	10.4	15.8	6.4
Physicians per 1,000	2.5	2.2	3.2	1.6	1.4

INSURANCE COVERAGE

Insured s	1991
Total (M)	251.7
Employment-based	55.6%
Public Program	37.0%
Other Private	7.3%

Uninsured <65 y/o s	1991
Total (M)	38.5
Full-time Emp (Full-year)	52.4%
Part-time Emp (Full-year)	7.8%
Full Year, Some Unemp.	17.4%
Part Year	6.9%
Non-worker	15.6%

% Uninsured by Income, Workers aged 18-64 s	
>$10,000	32%
$10,000-19,999	23%
$20,000-29,999	10%
$30,000-39,999	6%
$40,000-49,999	3%
$50,000 or more	3%

% Uninsured by Family Type Nonelderly Population s	
Total	17%
Married with Children	13%
Married without Children	15%
Single with Children	20%
Single without Children	29%

Expenditures	1987	1991	1992	AAC
Employer Total	$ 128	$ 238	–	16.8%
Per Employee	$ 1,985	$ 3,605	$ 3,968	14.9%

MEDICAID (POOR)

	1990	1993*	1995*	AAC 1990-93
Expenditures (B)	$ 71	$ 145	$ 196	26.9%
Recipients (M)	25	33	36	9.7%

MEDICARE (ELDERLY)

	1993*	1995*	AAC 1995* 1989-93
Expenditures (B)	$ 152.9	$ 191.0	10.6%

(M)=Millions (B)=Billions (T)=Trillions
u=CBO Data ; *Projected Data; AAC=Average Annual Change
s=Employee Benefits Research Institute Data, 1993 CPS

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FEDERAL DEFICIT	Actual 1993	1994*	1995*	1996*	1997*	1998*
Estimated Annual (B) u	$ 255	$ 223	$ 171	$ 166	$ 182	$180
Gross Federal Debt (T) u	4.4	4.7	5.0	5.3	5.7	6.0
Gross Fed Debt Interest (B) s	293	298	311	330	346	263

INFLATION INDEX	1993	1994*	1995*	1996*
CPI-U u	3.0%	2.7%	3.0%	3.1%
Real GDP % Chg u	2.8	2.9	2.7	2.7
Nominal GDP (B) u	6,370	6,730	7,099	7,483

DEMOGRAPHICS	1990	2000*
Total U.S. Population (M)	249.924	274.815

	1993
U.S. Unemployment: u	6.8%

	1980-89	1990-99*
Population Increase:	22.9%	24.9%

Aged Population	1990	2000*	Increase 1990-2000*
Under 65 (M)	218.4	239.9	9.9%
% Total Pop.	87.3%	87.0%	
65 & Over (M)	31.5	34.9	10.6%
% Total Pop.	12.6%	12.7%	
85 & Over (M)	3.1	4.3	39.3%
% Total Pop.	1.2%	1.6%	

AIDS	1993*	1994*	1995*
Cumm. HIV Cost (B)	$ 11.8	$ 13.4	$ 15.2
People with AIDS	203,191	231,469	260,846
AIDS Cases/100,000	USA:18.2		

(M)=Millions (B)=Billions (T)=Trillions
u=CBO Data ; *Projected Data; AAC=Average Annual Change
s=Employee Benefits Research Institute Data, 1993 CPS

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HALEY BARBOUR

Haley Barbour of Yazoo City, Mississippi, was elected Chairman of the Republican National Committee on January 29, 1993. Prior to his election, Mr. Barbour was a practicing attorney and partner in the law firm of Barbour and Rogers, with offices in Mississippi and Washington, D.C.

In 1985, he took a nearly two year hiatus from private law practice to serve Ronald Reagan at the White House. As Deputy Assistant to the President and Director of the White House Office of Political Affairs, Barbour was the President's principal liaison and advisor on political activity nationwide. His initial commission had been as Special Assistant to the President for Political Affairs. Barbour was a Senior Advisor to the George Bush for President campaign in 1988. He also directed the Southern Republican Primary Project, the GOP's successful Super Tuesday program.

Barbour was the Republican nominee for United States Senator in 1982 but lost to the venerable Senator John Stennis, a 35-year incumbent. Since 1984 he has served as Republican National Committeeman for Mississippi.

A seventh generation Mississippian, Barbour is a product of the state's public schools, receiving his law degree from the University of Mississippi in 1973. For thirteen years he was a partner in the law firm of Henry, Barbour, and DeCell of Yazoo City, Mississippi; where he and his family reside.

A long time Southern GOP leader, Barbour served as Executive Director of the Mississippi Republican Party and of the Southern Association of Republican State Chairmen from 1973 to 1976, after having worked in both of the successful Nixon campaigns at the state level.

A Reagan supporter at the 1976 GOP National Convention in Kansas City, he subsequently directed the President Ford campaign in seven states. Since 1976, he has been active in Republican campaigns at the state and national level.

Barbour, 46, is Chairman of the National Policy Forum and is on the Board of Directors of Mobile Telecommunications Technologies, Inc., (Mtel), of Jackson, Mississippi, parent company of Skytel, the country's leading nationwide messaging company and Deposit Guaranty National Bank, Mississippi's largest banking system. He also is a member of the Board of Trustees of the Mississippi Nature Conservancy.

Haley and his wife, Marsha, have two sons. He serves as Deacon in the First Presbyterian Church of Yazoo City, where he has also taught Sunday School.

January, 1994

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STUART M. BUTLER

British-born economist Stuart M. Butler is a Vice-President and the Director of Domestic and Economic Policy Studies at The Heritage Foundation in Washington D.C. He plans and oversees the Foundation's research and publications on all domestic issues. He is an expert on health, urban and welfare policy, the theory and practice of "privatizing" government services, and the politics of the environment.

Butler has authored books and articles on a wide range of issues, from health care to the future of South Africa. In 1981, he wrote Enterprise Zones: Greenlining the Inner Cities(New York, Universe Books), and in 1985, his book Privatizing Federal Spending(Universe) developed a political strategy for reducing the size of government. His book, Out of the Poverty Trap(New York, Free Press, 1987), co-authored with Anna Kondratas, lays out a comprehensive conservative "war on poverty." Most recently, A National Health System for America, co-authored with Edmund Haislmaier and published in 1989 by the Heritage Foundation, lays out a blueprint for a national health system based on free market principles.

In 1981, Butler received the George Washington Honor Medal for his work on urban policy and the Valley Forge Honor Certificate for his book on privatization. In addition, Butler was included in the National Journal's list of the 150 individuals outside government who have the greatest influence on decisions in Washington. The Washington Post says "Butler epitomizes a large segment of the new conservative movement that has become vocal in pursuing its new economic policies at a time when the country seems to be turning away from the old solutions to persistent problems." and The New York Times says he "provided the intellectual underpinnings for the [Reagan] administration's efforts to move [government services] into private control..."

In March 1990 he was appointed a Commissioner on Housing Secretary Jack Kemp's Advisory Commission on Regulatory Barriers to Affordable Housing. He is a frequent guest on television and radio talk shows and is a popular conference and dinner speaker.

Butler was educated at St. Andrew's University in Scotland, where he received a bachelor of science degree in physics and mathematics in 1968, a master's degree in economics in 1971, and a Ph.D. in American economic history in 1978. He was born July 21, 1947 in Shrewsbury, England. He is a British citizen, and married with two daughters.

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IHPS
INSTITUTE FOR HEALTH POLICY SOLUTIONS

Richard E. Curtis

Mr. Curtis is the president of the Institute for Health Policy Solutions, a not-for-profit, nonpartisan organization established in April 1992 to identify, analyze, and develop policies to solve health system problems. He has an extensive background in both public and private health care financing issues as well as in a broad range of policy development, analysis, and technical assistance activities. Areas of expertise include alternative strategies to cover uninsured populations, restructuring the health insurance market, health care financing policy for low-income populations, and health care cost containment. He has spent much of the past two years developing and analyzing alternative strategies for federal, state, and private coalition development of health purchasing cooperatives for small employers. Mr. Curtis has substantial experience in working with the insights and perspectives of individuals from a variety of disciplines to develop alternative policy solutions. Other positions he has held include: working group chairperson for the White House health system reform task force; Director of the Department of Policy Development and Research, Health Insurance Association of America; founding Director, National Academy for State Health Policy; and Director of Health Policy Studies, National Governors' Association (NGA). While at NGA, he also served as Director of the Project on the Medically Indigent for the Academy for State and Local Government, and was a contributing editor to *Business and Health* magazine.

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American Enterprise Institute for Public Policy Research

ROBERT B. HELMS, Ph.D.

Robert B. Helms is a Resident Scholar and Director of Health Policy Studies at the American Enterprise Institute. He has written and lectured extensively on health policy, health economics, and pharmaceutical economic issues.

He is the editor of three new AEI publications on health policy, *American Health Policy: Critical Issues for Reform*, *Health Policy Reform: Competition and Controls*, and *Health Care Policy and Politics: Lessons from Four Countries*.

From 1981 to 1989 Dr. Helms served as Assistant Secretary for Planning and Evaluation and Deputy Assistant Secretary for Health Policy in the Department of Health and Human Services. He holds a Ph.D. degree in economics from the University of California, Los Angeles.

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PROJECT FOR THE REPUBLICAN FUTURE

WILLIAM KRISTOL
CHAIRMAN

WILLIAM KRISTOL

William Kristol is Chairman of the Project for the Republican Future, an independent organization based in Washington, D.C., committed to articulating and advancing a principled Republican governing agenda. From January through October, 1993, he was Director of the Bradley Project on the 90's, a survey of America's social, economic and cultural landscape for the Lynde and Harry Bradley Foundation of Milwaukee, Wisconsin.

From 1989 to 1993, Mr. Kristol served as Chief of Staff to the Vice President of the United States. From 1985 to 1988, Mr. Kristol was Chief of Staff to Education Secretary William Bennett, leaving that position to run Alan Keyes' U.S. Senate campaign in Maryland. Before moving to Washington, Mr. Kristol taught at the John F. Kennedy School of Government, Harvard University, and at the University of Pennsylvania. He received his A.B. and Ph.D. degrees in government from Harvard.

Mr. Kristol's teaching and writing in the fields of political philosophy, American political thought and public policy have appeared in journals such as the Chicago Law Review, the Harvard Journal of Law and Public Policy, Commentary and the Public Interest.

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(title + affiliation)

Mark V. Pauly, Ph.D.

Professor, Health Care Systems, Insurance and Risk Management,
Public Policy and Management, and Economics,
The Wharton School, University of Pennsylvania

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BIOGRAPHICAL SKETCH

Mark V. Pauly, Ph.D.

Mark V. Pauly is the Bendheim Professor, Chairman and Professor of Health Care Systems Department, and Professor of Insurance and Public Policy and Management, at the Wharton School, and Professor of Economics, in the School of Arts and Sciences at the University of Pennsylvania. He served as Executive Director of the Leonard Davis Institute of Health Economics (LDI) from 1984-89 and currently is LDI's Director of Research.

One of the nation's leading health economists, Dr. Pauly has made significant contributions to the fields of medical economics and health insurance. His 1968 article on the economics of moral hazard continues to serve as a benchmark in the medical insurance field concerning the effect of insurance coverage on the use of medical care services. He has analyzed Medicare and Medicaid financing, the impact of methods of paying health care providers on their behavior, and the role of employment-related group insurance.

Dr. Pauly is an active member of the Institute of Medicine, an adjunct scholar of the American Enterprise Institute, and a member of the advisory board of the Washington-based Capital Economics. He has been, in addition, a member of the technical advisory panels to the National Institute of Drug Abuse, the Health Care Financing Administration's Division of National Cost Estimates, and the Advisory Council on Social Security. He sits on the editorial boards of Public Finance Quarterly, Health Services Research, the Journal of Risk and Uncertainty, and the Journal of Health Economics. Dr. Pauly is extensively published, with over 100 journal articles and books in the fields of health economics, public finance, and health insurance. Prior to joining Pennsylvania's faculty, he was a visiting research fellow at the International Institute of Management in Berlin, West Germany where he studied Germany's health care system, and professor of economics at Northwestern University.

He is the author (with others) of a tax credit approach to health reform called "Responsible National Health Insurance" (described in Pauly, et al., "A Plan for 'Responsible National Health Insurance'," Health Affairs, Spring, 1991).

Dr. Pauly is a 1963 graduate of Xavier University. He received his M.A. in 1965 from the University of Delaware, and his Ph.D. in economics from the University of Virginia in 1967.

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January 1994

C. EUGENE STEUERLE
Senior Fellow
The Urban Institute

CAREER BRIEF

Eugene Steuerle is a Senior Fellow at The Urban Institute and author of a weekly column, "Economic Perspective," for Tax Notes Magazine. At the Institute he has conducted extensive research on budget and tax policy, social security, health care and welfare reform. As a member of the International Monetary Fund Fiscal Affairs Advisory Committee, Dr. Steuerle also has undertaken tax assistance missions to China, while the government of Barbados recently undertook a tax reform effort modelled after a report that he co-authored as head of another mission.

Earlier in his career he served in various positions in the Treasury Department under four different Presidents and was eventually appointed Deputy Assistant Secretary of the Treasury for Tax Analysis. Between 1984 and 1986 he served as Economic Coordinator and original organizer of the Treasury's tax reform effort, for which Treasury and White House officials have written that tax reform "would not have moved forward without your early leadership" and the "Presidential decision to double the personal exemption...[is] due to your insightful analysis." A former IRS Commissioner has written "During the past decade, few people have had greater impact on major changes in the tax law and the principal improvements in tax compliance and administration."

Dr. Steuerle's publications include four books, and more than 90 reports and articles, 250 columns and 20 Congressional testimonies or reports. One book, The Tax Decade, was recommended by one historian as "required reading for all who study the development of public policy in the twentieth century." His most recent book (co-authored with Jon Bakija) Retooling Social Security for the Twenty-First Century, was cited by the former Executive Director of the National Commission on Social Security Reform as "undoubtedly the most comprehensive analysis of the very long-range financing problems confronting the Social Security program."

Dr. Steuerle serves or has recently served as an advisor, consultant, or board member to the American Tax Policy Institute, the IRS, the Ways and Means Committee of the U.S. House of Representatives, the International Monetary Fund, the National Commission on Children, and as a member of the Capital Formation Subcouncil of the Competitiveness Policy Council. Previous positions also include Federal Executive Fellow at the Brookings Institution, Resident Fellow at the American Enterprise Institute, and President of the National Economists' Club Education Foundation. He is cited frequently in newspapers and news magazines such as The New York Times, The Washington Post, The Economist, Newsweek, Business Week, The Wall Street Journal, USA Today, The Financial Times, and The Philadelphia Inquirer; and has appeared on TV and radio shows or stations such as CNN, ABC, and NPR.

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EDUCATION

1975 Ph.D., University of Wisconsin
1973 M.S., University of Wisconsin
1972 M.A., University of Wisconsin
1968 B.A., University of Dayton

PROFESSIONAL BACKGROUND

1989-present Senior Fellow, The Urban Institute, and author of a weekly column, "Economic Perspective," for Tax Notes Magazine.

1987-1989 Deputy Assistant Secretary for Tax Analysis, Department of the Treasury. As the nation's highest tax economic official, the DAS directs the Office of Tax Analysis, an office of approximately 50 Ph.D.-level economists whose responsibilities include design and economic analysis of tax proposals, major studies of tax and budget issues, development of elaborate and sophisticated economic models and data files, and estimation of the receipts side of the Budget of the United States Government.

1986-1987 Director of Finance and Taxation Projects and Resident Fellow, American Enterprise Institute for Public Policy Research. Research included studies of the effects of tax reform on the economy, on charitable giving patterns, and on the IRS.

1984-1986 Economic Staff Coordinator, Project for Fundamental Tax Reform (1984-6). Duties here included service as the principal organizer and designer of the Treasury Department's 1984 Report to the President on Tax Reform for Fairness, Simplicity, and Economic Growth, commonly known as the Treasury I study that led to the Tax Reform Act of 1986.

1983-1984 Federal Executive Fellow, The Brookings Institution. Research here included studies of stagflation, tax shelters, tax arbitrage, and the taxation of financial institutions.

1974-1983 Several previous positions were held within the Department of the Treasury's Office of Tax Policy, including Senior Executive Service positions as Deputy Director for Domestic Taxation and Assistant Director. As head of the Domestic Taxation staff, the Deputy Director serves as the U.S. Government's principal economic officer directing studies on matters of domestic taxation.

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OTHER PROFESSIONAL ACTIVITIES

Member, Capital Formation Subcouncil of Presidential/Congressional Competitiveness Policy Council
International Monetary Fund Fiscal Affairs Consultants Committee
Internal Revenue Service Consultants Advisory Panel
Chairperson, Federal Taxation and Finance Committee, National Tax Association
Member, National Academy of Social Insurance
Board of Governors, National Economists Club
Board of Trustees, American Tax Policy Institute
Advisory Committee on Reforming Health Care Financing, National Academy of Social Insurance
Former President, National Economists Club Educational Foundation
Former Member of Board of Directors, Treasury Historical Association
Former Member, Study Panel on Implementation Aspects of National Health Care Reform, National Academy of Social Insurance
Reviewer of articles for American Economic Review and other economics and policy journals

AWARDS OR HONORS RECEIVED

U.S. Treasury Department:	Award for Outstanding Performance, 1979 Award for Outstanding Performance, 1980 Office of the Secretary Honor Award, 1981 Senior Executive Service, 1982 Brookings Federal Executive Fellow, 1983-4 Senior Executive Service Award, 1984 Senior Executive Service Award, 1985 Meritorious Service Award, 1986 Exceptional Service Award, 1989
University of Wisconsin (Madison)	Distinction in Public Finance Special Graduate Fellow Knapp Fellow
U.S. Army	Bronze Star Various Other Service Awards
University of Dayton	Award to the Outstanding Graduate of the College of Arts and Science Graduated Magna Cum Laude Award to the Outstanding Junior in Mathematics Vice-President of the Student Body President of Debate Team President of Honor Society

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MAJOR REPORTS

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China: Evolving Reforms in Tax Administration, with Charles I. Vehorn, Yin-Kann Wen, Washington, DC: International Monetary Fund, October 25, 1990, confidential.

Financing Health and Long-Term Care: Report to the President and the Congress, with B.K. Atrostic, Jerald Schiff, Jim Nunns, and other Treasury staff, Washington, DC: Superintendent of Documents, March 1990.

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ARTICLES

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"Trends in the Distribution of Non Wage Benefits and Total Compensation," with Gregory Acs, final report for the U.S. Department of Labor, December 1993.

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"Economic Effects of Health Reform," testimony before the Committee on Ways and Means, U.S. House of Representatives, December 15, 1993.

"The Taxation of Social Security Benefits," testimony before the Committee on Finance, U.S. Senate, May 4, 1993.

"Finance-Based Reform of Health Policy," statement presented before the Subcommittee on Health, House Committee on Ways and Means, February 4, 1993.

"Tax Expenditures," testimony before the Senate Committee on the Budget, February 3, 1993.

"Long-Term Economic Implications of the Federal Budget Deficit," testimony before the Subcommittee on Deficits, Debt Management and International Debt, Senate Finance Committee, June 5, 1992.

"Enterprise Zones," testimony before the Senate Finance Committee, June 3, 1992.

"Tax Proposals for Fiscal Year 1993," testimony before the House Committee on the Budget, February 11, 1992.

"Tax Policy: Health Insurance Coverage," statement before House Committee on Ways and Means Retreat, April 19-21, 1991.

"Taxation and the Family," testimony before the Select Committee on Children, Youth, and Families, April 15, 1991.

"Social Security Taxation," testimony before the House Committee on Small Business, March 15, 1990.

"Tax Proposals for Fiscal Year 1991," testimony before the House Committee on the Budget, February 27, 1990.

"Social Security Taxation," testimony before the Senate Committee on Finance, February 8, 1990.

"Capital Gains and Tax Reform," testimony before the House Committee on Small Business, November 1, 1989.

"Taxation of Life Insurance Companies," testimony before the Subcommittee on Select Revenue Measures, Committee on Ways and Means, October 19, 1989.

"Saving and Investment," testimony before the Joint Economic Committee of the U.S. Congress, June 21, 1989.

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"Pension Portability," testimony before the Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, July 12, 1988.

"Low Income Housing Tax Credit," testimony before the Subcommittee on Select Revenue Measures of the Committee on Ways and Means, U.S. House of Representatives, March 1988.

"Normalization Requirements for Public Utility Property," "Indian Fishing Rights," and "Federal Income Tax Treatment of Housing Allowances for Individuals Employed by or Assigned to the U.S. Mission to the United Nations," Testimony before the Subcommittee on Select Revenue Measures of the Committee on Ways and Means, U.S. House of Representatives, December 1987.

"Indian Enterprise Zones" and "The Treatment of Charitable Contributions of Debt of Developing Nations," testimony before the Subcommittee on Taxation and Debt Management, Senate Finance Committee, U.S. Senate, November 1987.

"Sulfur and Nitrogen Emissions Tax Act of 1987," testimony before the Subcommittee on Ways and Means, U.S. House of Representatives, September 1987.

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SAMPLE OF OTHER PRESENTATIONS AT CONFERENCES OR MEETINGS

"Universal Coverage: Is Exact Equality in Health Care Possible?", seminar for Senior Congressional Staff, U.S. Congress, February 25, 1994, panel with Senator Jay Rockefeller and Uwe Reinhardt, sponsored by the Alliance for Health Reform.

Health Care and Social Policy," Congressional Quarterly Conference on FY95: The President's Budget in Perspective, Arlington VA, February 24, 1994.

"Economic Effects of Health Reform," American Enterprise Institute Conference on Budget-Regulatory Aspects of the Clinton Health Care Plan, Washington, DC, February 22, 1994.

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"Employer and Individual Mandates to Purchase Health Insurance," Robert Wood Johnson Foundation and Woodrow Wilson School of Public and International Affairs, Princeton University Conference on Universal Coverage: How Best to Achieve It? Princeton, NJ, January 29, 1994.

"Health Care Reform: Introduction and Overview," Committee for a Responsible Federal Budget, U.S. Congress, January 28, 1994.

"Mandating Universal Coverage: Employer or Individual," retreat for Senior Congressional Staff sponsored by the Alliance for Health Reform, Annapolis, Md, January 7, 1994.

"Advances in Distributional Analysis: Other Dimensions of Distribution," discussant at American Enterprise Institute Conference on Distributional Analysis of Making Tax Policy, Washington, DC, December 17, 1993.

"The 1993 Tax Reform Act: What's Next," National Tax Association 86th Annual Conference on Taxation, Minneapolis, MN, November 7-10, 1993.

"Financing and Administering Health Care Reform," St. Olaf's College, Northfield, MN, November 5, 1993.

"Child Allowances and Marriage Tax Penalties," The Communitarian Network Conference on the Future of the Family, Capitol Hill, Washington, DC, November 3, 1993.

"EITC: Prospects and Problems," American Tax Policy Institute Conference on Earned Income Tax Credit, Washington, DC, October 22, 1993.

"Tax Expenditures and the Budget," General Accounting Office and American Society of Public Administration panel on Tax Expenditure, Crystal City, VA, October 15, 1993.

"Tax Evasion," International Monetary Fund, Washington, DC, October 7, 1993.

"The Inevitable Reform of Social Security," National Academy on Aging Executive Seminar on Policy Responses to Demographic Change: The Implications of Population Aging, Washington, DC, September 30 - October 1, 1993.

"Implications of Alternative Methods of Health Care Finance," American Enterprise Institute Conference on Prescription for the Nation's Health: Where Will the Numbers Lead Us? Washington, DC, September 23, 1993.

"Taxes, Benefits, and Equity Within and Across Generations: The Social Security System and Beyond," American University, Washington, DC, September 22, 1993.

"Financing Health Care Reform," IBM Executive Meeting, Washington, DC, July 12, 1993.

"Comments on a Value-Added Tax," Tax Analysts Conference, Washington, DC, July 16, 1993.

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"Budget and Taxes," Congressional Quarterly Conference, Washington, DC, April 25, 1993.

"The Budget and the Economy," Urban Institute Roundtable, Washington, DC, April 14, 1993.

"Possibilities for Health Reform," University of Wisconsin Robert M. LaFollette Institute of Public Affairs, Madison WI, April 13, 1993.

"Changing the Tax Treatment of Health Insurance," American Enterprise Institute Health Policy Roundtable, Washington, DC, March 1, 1993.

"Tax Policy Changes in the President's Budget," Congressional Quarterly Conference on FY94: The New President's Budget and Policy Agenda, Washington, DC, February 25, 1993.

"The Deficit and Debt," U.S. Catholic Conference Committee on Domestic Policy, Washington, DC, January 26, 1993.

"How Our Tax and Transfer Systems Treat Children," National Governors' Association, Washington, DC, January 7, 1993.

"Reducing Family Poverty: Tax-based and Child Support Strategies," Family Impact Seminar, U.S. Capitol, Washington, DC, December 4, 1992.

Chair, National Tax Association Finance and Taxation Committee Meeting, "Tax Policy in An Election Year, Salt Lake City, UT, October 12, 1992.

"Measuring Future Income Security and Health Care Expenditures for the Aged and Disabled," Social Security and Medicare Public Trustees, Washington, DC, October 5, 1992.

"Credits for Children" and "Child Support Enforcement," National Commission on Children, September 23, 1992 (for PBS satellite affiliates).

"Enterprise Zones," It's Your Business (TV program), September 9, 1992.

"Tax Policy in An Election Year," The American Accounting Association annual meeting, Washington, DC, August 10, 1992.

"Income Support Policies: The Difficult Choices," National Academy of Sciences Retreat, Forum on Children and Families, Racine, WI, July 27, 1992.

"Pensions -- Is the Tax Expenditure Worth It," Association of Private Pension and Welfare Plans, Washington, DC, June 16, 1992.

"A Balanced Budget Amendment," Financial Executives Institute, Washington, DC, June 11, 1992.

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"Current Tax Legislative Process," and "The Unfinished Agenda for Tax Reform," American Bar Association Section on Taxation, Washington, DC, May 14, and 15, 1992.

"The Uses of Charitable Statistics," New York, Indiana and Duke Universities Conference on Charitable Statistics, Washington, DC, May 8, 1992.

"Tax Policy: Where Are We Going and Where Have We Been," American Association for Budget and Program Analysis, National Press Club, Washington, DC, April 23, 1992.

"All the Ways to Make Work Pay," Chair, National Academy of Social Insurance, Washington, DC, January 30, 1992.

"Taxation of Social Security Benefits," Committee to Preserve Social Security, Washington, DC, January 27, 1992.

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STANLEY B. JONES

Born: July 27, 1938

Education: B.A. Dartmouth College, 1960, Magna Cum Laude with high distinction in Philosophy, Phi Beta Kappa.

Danforth Graduate Fellowship to Yale for graduate study in Philosophy and Religion, 1960-63

Current Position:

Consultant in Health Policy

Advise insurers, employers, and providers on competitive private health insurance markets, and the potential roles of health insurance in containing costs and improving the accessibility and quality of health care.

Previous Positions:

1986 to 1989

Founder and President, Consolidated Consulting Group and Vice President, Consolidated Healthcare, Inc.

Recruited and directed staff in analytic studies of costs and market requirements of multiple choice health insurance systems, long term care insurance, and other aspects of private health insurance product design, marketing and rating.

1978 to 1980 & 1983 to 1986

Founding partner in consulting firm of Fullerton, Jones & Wolkstein - Health Policy Alternatives

Analyzed impact on private clients of federal legislative and regulatory proposals, and prepared alternative proposals regarding private health insurance, Medicare and Medicaid, and health services and health professions education.

1980 to 1983

Vice President for Washington Representation, Blue Cross and Blue Shield Associations

Coordinated policy studies and advocacy activities of the Blue Cross and Blue Shield system regarding

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proposals for federal legislation and regulation.

1977 to 1978

Program Development Officer, Institute of Medicine, National Academy of Sciences

Developed studies, conferences and other projects relevant to current public policy issues in health insurance, health professions education, disease prevention and health promotion, health science policy, and health services.

1971 to 1977

Member of professional staff and then Staff Director, Subcommittee on Health, Committee on Labor and Public Welfare, United States Senate

As Staff Director, planned and coordinated subcommittee legislative activity on national health insurance proposals, and programs of the Public Health Service Act, Community Mental Health Centers Act, and the Food, Drug and Cosmetic Act.

1969 to 1971

Chief, Planning Systems Branch and then Director, Office of Management Policy, Health Services and Mental Health Administration, Department of Health, Education and Welfare

Directed staff in studies of federal grant programs and development of regulations authorized by portions of the Public Health Services Act.

1964 to 1969

Coordinated data processing and computer systems conversion activities of the Division of Research Grants and served as staff to the Associate Director of Division of Computer Research and Technology, National Institutes of Health, Department of Health, Education and Welfare.

1963 to 1964

Participated in National Institutes of Health "Management Intern Program".

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Other Recent Professional Activities

Member, Institute of Medicine, National Academy of Sciences, 1980 to present, serving as:

Chairman, National Academy of Sciences Panel on Long Range Planning For Disability Research, 1989
Chairman, Invitational Workshop on Utilization Management, 1987
Chairman, Ad Hoc Committee on Education of Health Professionals, 1987
Member, Board on Mental Health and Behavioral Medicine, 1980-86
Member, Robert Wood Johnson Fellowship Board, 1980-86

Member, District of Columbia General Hospital Commission, 1985-87

Member, Robert Wood Johnson Review Committee for Program to Promote Long-Term Care Insurance for the Elderly, 1988

Fellow of Institute of Society, Ethics and the Life Sciences, The Hastings Center, 1978 to 1989.

Frequent public speaking and teaching engagements on health insurance and health legislation.

Papers:

"Multiple Choice Health Insurance: The Lessons and ?Challenge to Private Insurance," Inquiry, Summer, 1990.

"Outcomes Measurement: A Report From The Front," Ron Geigle & Stanley B. Jones, Inquiry, Spring, 1990.

"Many Will Be Hurt: Another View of Mandating," Bulletin of the New York Academy of Medicine, Jan. - Feb., 1990.

"Perspective: Can Multiple Choice Be Managed?," Health Affairs, Fall, 1989.

" What Distinguishes The Voluntary Hospital in An Increasingly Commercial Health Care Environment?" Stanley B. Jones, Merlin K. DuVal, Chapter 8 of In Sickness And In Health, Edited by J. David Seay and Bruce C. Vladeck, McGraw-Hill, 1988.

"Competition or Consciences? Mixed-Mission Dilemmas of the Voluntary Hospital," Stanley B. Jones, Merlin K. DuVal, Michael Lesparre, Inquiry, Summer 1987.

"Moglichkeiten und Grenzen Einer Markwirtschlichen Steuerung des

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Gesundbeits - und Krankenhauswesens," ("Possibilities and Limitations of a Marketplace Mechanism for Health and Hospital Systems"), Arzt und Kranken, August 1982.

"Existing Federal Programs as Models for Compensation of Human Subjects," Compensating for Research Injuries, V.2, Report of President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, June, 1982.

"Labor's New Approach to National Health Insurance," National Health Policy, What Role for Government, Proceedings of a Conference on National Health Policy at Stanford University, March 28 and 29, 1980, Hoover Press Publication 265.

"Improving the Financing of Health Care for Children and Pregnant Women," Report of Select Panel on the Promotion of Child Health, Department of Health, Education and Welfare, 1981.

"The Consumer Choice Approach to National Health Insurance," NCHSR Research Proceedings Series, Effects of the Payment Mechanism on the Delivery of Health Care, October, 1977.

"Publicly Funded Plan: The Most Equitable and Cost-Effective," Journal of the American Hospital Association, March, 1976.

Community Activities

Member of Vestry & Candidate for Holy Orders in the Episcopal Church - Ministry in health and health policy.

Organizer and Board Chairman of Good Shepherd Interfaith Volunteer Caregivers, a program providing services for the frail elderly in Shepherdstown, W. Va.

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February, 1993

Robert M. Teeter

Mr. Teeter is president of Coldwater Corporation, a consulting and research firm that provides services in the areas of strategic business planning, marketing, public affairs and policy analysis. He served as chairman of the Bush-Quayle '92 Committee and in 1988, was senior advisor to the Bush for President Committee.

Prior to establishing Coldwater Corporation, Mr. Teeter was with Market Opinion Research for over twenty years, during which time he held several management positions. He was president of the company from 1979 through 1987.

His clients include a variety of businesses, public organizations and trade associations. In addition, he serves on the Board of Directors for Browning-Ferris Industries, Detroit and Canada Tunnel Corporation, Durakon Industries and United Parcel Service.

***

Mr. Teeter participates in numerous civic activities and has been particularly active in the field of education. In 1989, he was appointed to the President's Education Advisory Committee. He is a member of the Board of Trustees for Albion College, a Director of the Gerald R. Ford Library and serves on the National Advisory Committee to the College of Engineering at the University of Michigan.

Mr. Teeter received his Masters degree from Michigan State University and his Bachelor of Arts Degree from Albion College.

Mr. Teeter and his wife Elizabeth have two children and live in Ann Arbor, Michigan.

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ARNETT & CO. 1133 CONNECTICUT AVE., N.W., SUITE 700 WASHINGTON, DC 20036 PHONE: 202-296-5431 FAX: 202-457-6566

Grace-Marie Arnett
Health Policy Consulting
Arnett & Co.

Grace-Marie Arnett has operated her own consulting firm in the Washington, D.C., area for ten years. She specializes in health policy consulting and has written extensively on reform issues. She is a frequent guest on radio and television programs and speaks regularly to audiences throughout the U.S. She also assists businesses, agencies, and associations in analyzing health care reform, developing position statements, and planning communications programs.

She has advised a presidential commission studying health policy issues and currently is working with other policy experts in developing alternative health care reform proposals based upon a market approach.

She has had articles published in the *Washington Post*, *The Wall Street Journal*, and in a number of daily newspapers throughout the country as well as in the *National Review* and other periodicals.

Before starting her own consulting firm, Ms. Arnett served as **executive director** of the **Washington Psychiatric Society**, a professional association of psychiatrists in the Washington, D.C. area. The early part of her career was spent in **journalism and politics.** During this time, she wrote news and analytical articles focusing on tax policy, politics, and other domestic issues, and covering Congress, the White House, and the administrative agencies. She won numerous **awards** for her work as Washington correspondent for the Copley News Service and as a feature writer for the Albuquerque Journal. She also served as **Washington correspondent** for CBS radio affiliate KMOX and for the Fort Worth Star-Telegram.

She has been **press secretary** to **Sen. Pete V. Domenici**, deputy press secretary to the **President Ford Campaign** in 1976, and a media consultant to the **Republican National Committee.**

Ms. Arnett received the Marion Chase Memorial **Award** for public service presented by the **D.C. Mental Health Association** in 1989. She received the award for continuing service to the patients and professionals of the nation's capital from the **District of Columbia Chapter of the Washington Psychiatric Society and the Medical Society of the District of Columbia** in 1986. And she received the outstanding achievement award from the **Washington Psychiatric Society** in 1984.

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PROJECT FOR THE
REPUBLICAN FUTURE

BOARD OF DIRECTORS
WILLIAM KRISTOL, *CHAIRMAN*
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THOMAS L. RHODES

March 2, 1994

MEMORANDUM TO REPUBLICAN LEADERS

FROM: WILLIAM KRISTOL

SUBJECT: HEALTH CARE: THE PRINCIPLES OF CONSERVATIVE REFORM

Tomorrow in Annapolis, Senator Chafee will convene a retreat designed to bring clarity and unity to the Republican position on health care reform. We wish him well. But before his conferees get too absorbed in the details of compromise among provisions of competing larger "plans," we think they should keep in mind two overarching substantive and political truths.

First, notwithstanding the inevitable insider's fixation on the shifting fortunes of Clinton-Cooper-Chafee-Michel-Nickles-Gramm-and-so-on, there are now -- and always have been -- only two meaningful positions on health care. One holds that the American health care system is fundamentally crippled and defective, and must be replaced by something newly designed and administered in Washington. The other holds that problems in the health care system can be solved directly, without undoing American medicine's basic delivery structures, and without threatening the incalculable benefits those structures now provide. Radical overhaul on the one hand, or conservative reform (in the best and broadest sense of that phrase) on the other. The choice is that simple and that stark. And the proper and principled Republican option is obvious.

How the Tide is Turning. The second truth about health care is this: public opinion and the momentum of the current political situation increasingly favor conservative reform. Popular support for the Clinton health care scheme is evaporating; everyone knows that. Last week's CBS News poll showed a 46-39 percent plurality of respondents disapproving of the president's handling of health care; a similar plurality said the Clinton plan is "not fair" to "people like me." Indeed, most strikingly, the CBS poll now ranks health care as the president's worst issue. In short, health care, a centerpiece of the Administration's political strategy, is fast becoming an albatross for the president -- and an opportunity for Republicans.

It's important that Republicans understand why this is so. The answer is not that the Clinton plan's legislative details have alarmed certain business and interest groups, or that the plan's

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budget numbers don't add up. The answer is that the American people are not persuaded -- and, indeed, are increasingly doubtful -- that any radical overhaul of the health care system is either safe or necessary. A *Time*/CNN/Yankelovich poll of two weeks ago asked whether the state of our health care system was a "crisis," or a "problem, but not a crisis." By a clear majority, 51 to 43 percent, their choice was "problem." (And 5 percent said there was "not a health care problem" at all!) Even universal coverage, the question that has made some Republicans particularly nervous, turns out to be something less than an unambigous popular favorite. True, 49 percent of Time respondents say government should guarantee it. But a full 41 percent already say only access should be guaranteed -- which insurance reform and a low-income voucher would go far to provide -- and this result comes before Americans have been offered any clear explanation of the federal regulation, monitoring, and administration that mandated universal coverage would require.

Radicalism in Retreat. Read carefully, the health care news out of Washington these days is a picture of radical overhaul in retreat. A long series of Democrats told the *Washington Post* last week that their constituents were nervous to the point of opposition about sweeping government redirection of health care. Freshman Rep. Tom Barlow of Kentucky told the Post that his voters "know we've got to do something, but they don't want to take a giant leap into a national program." Senator David Boren reported much the same thing from Oklahoma: "They're not saying it's not a problem. They're not saying: Don't do anything. But they're saying: Be cautious. Be real cautious." Rep. Jim Slattery of Kansas told *Congress Daily* this week that "there isn't overwhelming political support for Clinton" -- or for Cooper. And Dan Rostenkowski, acknowledging that he is viewed by some Democrats as "the skunk at the party" for his realism, told *USA Today* last week that he would advise the President to sign a package of meaningful conservative reforms this year -- and declare victory.

Clinton-Cooper Plan stalwarts hate such talk. But there is now more and more of it, and it means that there is an opportunity to advance a serious legislative alternative to a radical, government-planned overhaul of health care. Now is the time to lay out a set of bipartisan, consensus proposals to address the real problems of health insurance and financing. Republicans have nothing to gain from any further delay in developing the basis for a principled bipartisan compromise.

If it is hope for winning with a purely "Republican" health care bill that's holding things up, it is time that hope yielded to reality. As long as Democrats control Congress, no strictly Republican bill will pass, and Republicans should not begrudge the president his signing ceremony -- so long as the legislation he signs is not pernicious. If it is fear of public reaction against conservative reform that gives Hill Republicans pause, that fear is misguided and unnecessary; the public supports such reform and opposes the radical alternative, as many (if not most) Congressional Democrats have already concluded in private. And if some Republicans (in Annapolis or elsewhere) are inclined to pursue bipartisan compromise along radical rather than conservative lines, they should be strongly discouraged. Health care is not an issue on which Republicans should snatch defeat from the jaws of victory.

For the use of Senator Chafee's Annapolis conferees, we provide an outline below of bipartisan legislation to achieve principled conservative health care reform.

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ESSENTIAL COMPONENTS OF SENSIBLE HEALTH REFORM

Health Insurance Should Be Renewable and Portable

- Individual and group health plans should be made renewable without premium increases due to pre-existing conditions of those already covered by a policy.
- Individuals who already have health insurance should, if they change jobs or move, be permitted to enroll in similar plans without facing premium increases due to health status.
- Individuals who work at small companies should be allowed to continue their insurance coverage for a transitional period after they leave their job; existing COBRA legislation should be extended to cover businesses with fewer than 50 employees.

Health Insurance Should Be More Affordable and Accessible

- Individuals and the self-employed should be able to deduct the full cost of their health insurance from their personal income tax -- the same tax advantage enjoyed by those who now get health coverage from their employer.
- Employers should be able to offer medical savings accounts -- essentially tax-free medical IRAs -- in conjunction with a catastrophic health care plan.
- Small businesses should be allowed to pool together to buy group insurance for their employees without facing cumbersome federal and state regulations and mandates.
- Individuals should be able to obtain health insurance through nonbusiness organizations such as churches, unions, or fraternal organizations.

Low-Income Families Should Receive Assistance to Purchase Health Care Insurance

- Working heads of households who do not earn enough to afford a family insurance plan should receive a government voucher to help defray the costs. The voucher could be made available on a sliding scale up to a family of four earning, say, $23,000 a year -- approximately 160 percent of the poverty line. Similar results could be obtained by designing a tax-credit for this group of Americans. Funding for this proposal could be found in currently proposed Medicare cuts and by redirecting federal payments already made to states for hospitals treating low-income individuals.

The Health Care System Should Be Simpler and Less Litigious

- Federal and state health care programs should standardize their forms and set a timetable for reducing the amount of paperwork they generate.
- The first steps of medical malpractice reform should be instituted: for example, effectively eliminating pain and suffering awards if an early offer is made to have the defendant assume the full economic cost of malpractice claims. The bipartisan Gephardt-Moore bill of the 1980s proposed a similar reform.

States Should Be Able to Reform Their Medicaid Programs

- The federal government should create a fast-track regulation waiver process for states that wish to administer their Medicaid programs in different ways. Priority should be given to states that intend to use voucher systems to give Medicaid patients greater access to private health care or create cost-saving managed care systems such as those in Massachusetts or Wisconsin.

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Conservative Reform vs. Radical Reorganization

Republicans must be aware that the sensible and eminently achievable reforms described above are always at risk of being hijacked and transformed into intrusive government plans to control the nation's health care. That result must be avoided. The merit of these ideas is that they respond, in a measured way, to genuine concerns about the current system. But equally important, they attempt to make our health care system simpler, giving Americans more control over their insurance and greater flexibility over the treatment decisions they make about their own health care.

Of course, even President Clinton has tried to disguise his plan as a set of six simple principles, rarely acknowledging the vast and intricate regulatory regime it would establish. That's why we believe that any serious attempt at basic health care reform should meet two straightforward tests:

> First, no reform should undo our present system or force Americans to abandon the way they now purchase health insurance and receive medical services.
> Second, whatever changes are introduced, they should not establish any new government function or use government authority to limit the amount of medical care available to individuals.

If Republicans hew to these two principles while pursuing straightforward, targeted health care reform, they will quickly see how many of the most important current Congressional enthusiams lead in the wrong direction.

Employer mandates and price controls -- the pillars of the Clinton plan -- would establish an assortment of new governmental powers to control the most basic features of our health care system. Mandatory health alliances, central to both the Clinton and Cooper plans, would prevent small employers from making their own insurance arrangements and would install a centralized, monopolistic, and bureaucratic regime to allocate health care. A standard benefits package, common to Clinton, Cooper, and some Republican plans, would give political appointees (and the interest groups that lobby them) control over what kind of health care benefits Americans are entitled to receive. The individual mandate to purchase health care, found in both the Nickles and Chafee bills, is an expansion of federal authority over private decisionmaking. The community rating system proposed in several plans, which prevents insurers from discriminating among clients on the basis of their medical history, would destroy the essential character of insurance and prevent a company from offering price incentives to policy holders who take positive steps to maintain their health. Federal government control over the number of medical students trained in various specialties, central to the Clinton and Cooper visions, would involve an unacceptable level of government management in our health care system.

Such proposals have no place in sensible health care legislation.

A Word About Tax Caps and Tax Exclusions

There also exist other proposals that, while appealing in principle, raise questions of politics and prudence. Limiting tax-exempt health benefits is the most prominent example. Proposals to end the tax-exempt status of employer-provided health benefits or cap the amount employers can deduct from their taxes have been around for decades. Such measures would sensitize consumers to the true cost of their health care, creating more efficiency and generating cost-savings in the system.

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But the practical consequences of such policies cannot be ignored. Both the Cooper and Chafee plans would ultimately force employers to seek the lowest cost health plan in a region in an effort to avoid the tax penalty or, in the case of Senator Chafee's plan, would impose a significant tax increase on large numbers of Americans who decided to stick with the insurance plans they now rely on. Whatever public policy rationale could be offered for such measures, it is beyond dispute that they would have a tumultuous effect on the health insurance arrangements Americans have made for themselves. We believe that advocates of changing the tax exclusion rules governing health care benefits might instead consider proposing a tax cap on only the most extravagant employer health plans -- perhaps those costing 150 percent of the national average health package. This step, though small, would nevertheless introduce a degree of price sensitivity to the system and, at one end of the spectrum, encourage some employers and their employees to make health insurance decisions based on real costs.

The True National Consensus

Despite all the editorials, speechmaking, and political posturing, the current debate is not about "universal coverage," "cost containment," "managed competition," or "the third-party payer system." Health care reform, to most Americans, means adding security, flexibility, and affordability to an insurance system that is now too often a source of anxiety. The best way to address that anxiety is through insurance portability, pre-existing conditions, tax equity, small business pooling, medical savings accounts, paperwork reduction, medical malpractice reform, and assistance for low-income families. The consensus on these issues is so broad that it defies reason that Congress has not yet agreed on a basic package of reforms.

The greatest current obstacle to passage of such a package is the Administration's insistence on establishing a national health care entitlement, replete with government regulations, controls, and penalties. Republicans should recognize the leadership opportunity that exists for those willing to challenge the premise of the White House's proposal with an alternative vision of principled reform. Such measured steps will be criticized by more liberal Democrats as inadequate, of course. So what? The vast majority of Americans (and, we suspect, most Congressional Democrats) would enthusiastically welcome such reform. All that remains now is for Republicans to embrace and make the case for it.

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cc Fred Thompson
Baker

PROJECT FOR THE
REPUBLICAN FUTURE

BOARD OF DIRECTORS
WILLIAM KRISTOL, *CHAIRMAN*
VIRGINIA GILDER
MICHAEL S. JOYCE
THOMAS L. RHODES

February 10, 1994

MEMORANDUM TO REPUBLICAN LEADERS

FROM: WILLIAM KRISTOL WK

SUBJECT: Defeating the Coming Clinton-Cooper Compromise

Attached is a third political strategy memorandum on the debate over health care reform. The good news is that the president's plan has been further wounded in recent weeks. The bad news is that the logic of the current situation points toward eventual Clinton-Cooper compromise legislation -- legislation that would be bad for health care and for the nation.

We argue in this memo that Republicans can help avert this outcome. We can do this, first, by intensifying our assault on the Clinton plan and its underlying premises, which are shared by the Cooper proposal. This assault will require a mobilization of public opinion across the country. All polls tell us that the more people learn about the president's plan, the more likely they are to reject it. It is therefore essential that Republicans, business groups, and conservative organizations engage in media, direct mail, and other "voter contact" efforts now in order to expose the perils of the president's plan. The course of public opinion over the next several weeks is crucial to shaping a desirable legislative outcome.

Second, the Republican leadership on Capitol Hill needs to complement these grassroots efforts to discredit both Clinton and Cooper by moving more aggressively to advance a set of proposals that address America's health care problems. This set of principled, targeted reforms should not be simply another "Republican alternative"; rather it should be put forward explicitly as the basis for future bipartisan compromise -- a "Moynihan-Dole" bill, say -- that serves as the fundamental alternative to Clinton-Cooper. Such a bill would build on past bipartisan efforts while forging a new path toward greater choice and control for individuals and the doctors who treat them. And it would have the added virtue of appealing to all who are increasingly doubtful about the president's bill, including those who, while retreating from Clinton, may have taken temporary refuge with Cooper.

As in the past, we would be grateful for your thoughts about this assessment of the health care debate and the recommendations that accompany it.

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HEALTH CARE: DEFEATING THE COMING CLINTON-COOPER COMPROMISE

"[Y]ou should realize our bills are very similar. The White House bill and my bill have a lot in common, and we're very proud of that.... I want the White House to win." Rep. Jim Cooper (February 4, 1994)

"[I]n some ways I think that Jim Cooper is being extremely helpful to the process, extremely helpful to the process." Sen. Jay Rockefeller (February 4, 1994)

"[I]n broad outline the Clinton and Cooper proposals are more alike than either side at times finds it convenient to acknowledge." The Washington Post (February 7, 1994)

Jim Cooper, Jay Rockefeller, and the *Washington Post* know something that many people in Washington (including, we fear, many Republicans) do not: that while the Clinton Administration's health care legislation may be in trouble, its project of reform by sweeping government dictat is, unfortunately, still alive.

The new conventional Washington wisdom about health care has it that the Clinton plan is in trouble, its current momentum stalled and its future prospects threatened by the emergence of Representative Jim Cooper's "moderate alternative." This week's *Time* goes so far as to suggest that Clinton's plan might be "DOA." Evidence for this theory is deceptively obvious. The president has been on the defensive since before his State of the Union message, which included a veto threat he apparently deemed necessary to protect legislation he had introduced just two months earlier. That speech failed to move poll numbers as intended; public support for the plan remains below levels recorded early last fall. And there have been signs of White House fear and weakness ever since.

Concerned about potential political support for less radical reform than his, the President has offered surprising (if ultimately unsuccessful) concessions in a bid for support by the National Governors Association. His aides have responded somewhat hysterically to a series of critical television ads -- and to an article in *The New Republic* that convincingly detailed their plan's likely ill effect on American medical services. Tuesday's Congressional Budget Office pronouncement raises further serious questions about the plan's financing and budget effect. And last week saw a new rush of business objections to the Administration's health care proposal: tough Congressional testimony by the Chamber of Commerce, a declaration of opposition by the National Association of Manufacturers, and an outright endorsement of Cooper by the Business Roundtable.

The Clinton-Cooper Phony War. It's true that the Clinton health care legislation, as written, is made weaker by the fresh strength of the Cooper bill. And the harsh reaction to this development by the White House and its allies seems at first glance to support the notion that large ideas are at issue in a Clinton/Cooper tug of war. But large ideas are not in fact at issue; Clinton and Cooper are instead, as the Congressman correctly claims, "first cousins in this debate and ... hoping for a family reunion this year." Both Democratic proposals involve a radical federal regulatory rearrangement of the financing and delivery of American medical services. In this respect they constitute not two political positions on health care, but only one. Clinton's health plan is by no means "dead on arrival."

The fact that Clinton and Cooper now thoroughly dominate the Washington health care debate, and thus threaten permanently to circumscribe its acceptable parameters, should alarm Republicans. Neither bill is compatible with conservative principle, and Republicans therefore have no business cheering for either side of the Clinton/Cooper controversy -- much less "participating constructively" in its resolution, despite the disingenuous advice we now receive from editorialists. Any conceivable

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Clinton-Cooper compromise legislation would represent an unprecedented government encroachment on the authority of individual citizens to make basic decisions about their daily lives, in this case about their very health. Republicans ought not be reluctant to defend such individual rights and oppose a Clinton-Cooper compromise that threatens them.

The health care debate is at a watershed. The Cooper bill is currently ascendant not because "managed competition" has any broad-based, intrinsic appeal, but rather, we suspect, because its Congressional and business supporters see no other politically realistic vehicle with which to register their opposition to Clinton. Republicans must now make clear that Cooper is not a meaningful departure from the Clinton vision, and must make a principled case for the real alternative solution to America's health care problems: sensible, straightforward reforms that would make insurance more stable and affordable. Those reforms have enjoyed bipartisan support in the past; they can earn such support again this year.

Unless we are prepared to oppose Clinton-Cooper vigorously and propose our own reforms intelligently, the ultimate success of Clintonism, broadly understood, will be virtually certain. The White House can meet Jim Cooper well more than half way in the public and private compromise negotiations now underway, and the president will still be able to sign the terrible result into law.

UNDERSTANDING THE COOPER BILL. Managed competition, the core of the Cooper bill, shares with the president's proposal the vision of a government-directed remaking of American health care delivery and financing. Though it comes in free-market guise, the Cooper bill would undo the medical system we now take for granted -- just as radically and completely as would the Clinton plan.

True, Cooper avoids a mandate that employers pay for their employees' health care. That has been its central attraction for business groups. But a closer examination of the bill reveals other ways in which employers would be drawn into a web of state-administered health care machinery. Firms with fewer than 100 employees (about 93 percent of all businesses), for example, would be required to register with regional Health Plan Purchasing Cooperatives, forward information about all their full- and part-time employees, and deduct from paychecks the cost of health care premiums, whether or not the firms were providing health care coverage.

Each of these purchasing cooperatives would be required to make available "accountable health plans" that offer a standard set of benefits determined by a vote of Congress. Proponents of the Cooper bill point out, correctly, that under their plan consumers might still choose plans whose benefits exceed the government's established standards. But the Cooper bill is essentially designed to limit individual choice by pushing consumers into the lowest-priced health plan in their region. Through the introduction of a tax deduction cap, both individuals and employers would be permitted to deduct only the cost of the lowest priced plan in their region. Anything beyond that would be subject to the top corporate rate. Businesses that today offer their employees generous health plans would effectively be forced either to accept the government's more austere benefit limits or face stiff economic penalties.

This is a remarkably coercive use of the tax code. The federal government would first decide what type of health insurance should be in a employee's benefit package, and then, in effect, penalize all those who choose what the Cooper bill deems "excess" health coverage. Cost savings would presumably emerge from the competition among these minimum benefit plans to become the lowest bidder in any given region. The Cooper bill advances these measures in the name of cost containment. But they are tantamount to an arbitrary government restriction on how much money goes into the health system. To retain the tax deductible status of the health plan under which they work, doctors, nurses, and hospital administrators would be driven primarily by budget priorities. The ability of patients to obtain high quality service and a full range of treatment options would invariably be compromised.

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In most regions, the only plans able to meet government-set standards for certification as "accountable health plans" would be health maintenance organizations (HMOs). Representative Cooper's candor on this point has been widely overlooked. "My guess," he has said, "is that fee-for-service medicine will be discouraged and mostly die out." Alain Enthoven, one of the authors of the managed competition model, has made the same prediction: "We doubt that [private-practice doctors] would generally be compatible with economic efficiency." Seeing a specialist when you like, seeking a second opinion, choosing your own family physician -- all these things would be as rare under Cooper as under Clinton.

Surviving health plans would be further hampered by the Cooper requirement that no plan charge enrollees different rates for any reason other than age. While ostensibly designed to guarantee access to health insurance, this Cooper version of "community rating" would effectively prevent a plan from offering different premiums based on health status or medical history. Under Cooper's system, in other words, the individual who quits smoking or takes preventive health measures would be treated the same, for insurance purposes, as a smoker or someone with a debilitating disease. And both would likely wind up in the same "lowest price" accountable health plan.

For the health consumer in America, life under the Cooper plan would look very much as it would under the president's: standardized medicine, impersonal systems of care, and hospitals and doctors judged by economic efficiency standards. "Cost containment" would become the mantra of American medicine, and all incentives in the system would be geared toward cutting corners and trimming service. Doctors operating in an accountable health plan would be required to report on procedures, treatments, outcomes, patient background, expenses and other "necessary" medical information; health plans would withhold payment to any doctor who does not provide such requested data. The number of specialists trained each year would be decided and alloted by a panel of government experts.

Above everything, the Cooper system shares the president's fixation with a complex architecture of national health care bureaucracy that regulates, monitors, and coordinates virtually every aspect of the doctor-patient relationship. Like the president, Cooper would establish Health Cooperative Boards in each region. He would also create a Health Plan Standards Board to establish standards for every health plan; an Agency for Clinical Evaluations to oversee federal medical research; and a Benefits, Evaluation, and Data Standards Board to manage a national health data system. The entire structure would be governed by a Health Care Standards Commission of five presidential appointees -- an independent agency that would function as a Supreme Court of Health. While steps may be taken to shield them, all these organizations would be subject to immense pressure from politicians, interests groups, and professional health industry lobbyists. Vital decisions about experimental drugs or even routine medical procedures would become political questions. The quality of treatment patients receive, the options available to them, and the advancement of medical practice would all become tertiary concerns.

The Republican Responsibility. The Clinton health care plan and its Cooper "cousin" are together a gigantic leftward social policy gamble by the Democrats, one that should be impossible to win given everything the United States has learned over the past 25 years about the failures of big-government liberalism. The White House had no right to expect anything but fierce opposition to the proposal -- from American business, which has a legitimate and necessary interest in protecting itself from government, and from Republicans, who have a comparable but even more important interest in defending both private American relationships (like that between patient and doctor) and those non-governmental institutions that remain basically sound and successful (our health care system most definitely among them). But such an opposition has not emerged, not so far at least. And if it doesn't, soon, the Clinton gamble may well pay off -- despite the fact that it pursues a misguided answer to a misconceived problem, and does so from premises a justly skeptical America has long since rejected.

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For its part, the Republican Party in Congress has limited options. It can remain fractured, with various Members attached to various proposals, and hope for the best. But the best won't happen; Clinton-Cooper will pass, and the Republican Party will have been passively complicit in its passage. The Party might instead decide to play the inside legislative game of Clinton-Cooper-Chafee, working the subcommittee hearings and the committee markups, and trying somehow to influence the final bill on the margins. Clinton-Cooper passes that way, too, and Republicans will be actively implicated.

There are those Republicans prepared to argue that such a result involves no compromise of conviction. DavidDurenberger, for example, Cooper's only Republican cosponsor in the Senate and a cosponsor also of the very similar Chafee bill, says that "Republicans already have a winning strategy and that strategy is managed competition," which he calls a "comprehensive vision" consistent with "Republican principles." Senator Durenberger is wrong. Managed competition is not a Republican principle. It is massive social regulation, precisely the kind of thing the Republican Party should exist to oppose, and for Republicans to acquiesce or participate in its enactment would bring us no credit, and much shame.

The only honorable and realistically successful path for Republicans, then, is that outlined by Senator Dole in his calm and intelligent State of the Union response, and restated last Wednesday in a speech by RNC chairman Haley Barbour: advancing specific solutions to the problems of health care coverage, affordability, and cost that most Americans agree exist while at the same time defending our medical system's unparalleled benefits -- and making clear that those benefits are under attack by the White House. Republicans should not be deterred from this position, as some appear to have been in recent days, by press criticism and isolated polling statistics. The criticism comes from advocates of the Clinton-Cooper position. And public opinion, which political parties are formed to help shape and change, is already overwhelmingly hostile to any health care reform that would, as Clinton-Cooper will, limit the availability of medical services. Senator Dole and Chairman Barbour are making a correct argument in principle. And a winnable one.

A STARK CHOICE. There is already widespread public nervousness over the Clinton-Cooper program. New York Representative Charles Schumer, for example, reflecting on his trip home during the last Hill recess, expressed this fear quite starkly to *The New York Times*: "How are we going to explain to a majority of my constituents, who have worked hard and invested in a [health] plan that they're not terribly unhappy with, that they should jump into the abyss of the unknown?" He was talking about the Administration's legislation, of course, but the same question can and should be asked of Cooper. And when it is, Cooper's supporters -- many of whom have joined his bill for purely tactical, anti-Clinton purposes -- will be eager for an alternative to the coming Clinton-Cooper compromise.

It is the Republican Party's duty to speak for Charles Schumer's Brooklyn constituents and the silent majority of Americans who want reform but whose medical care would be badly damaged by the radical experimentation of the Clinton-Cooper health care proposals. Republicans must reframe the health care debate and offer these Americans a clear choice: a crisis-driven Clinton-Cooper "jump into the abyss," on the one hand, or real solutions to existing problems that give individual citizens, not government, more control over their health care. What is needed is not yet another "Republican plan"; instead, the Republican Hill leadership should put forward a proposal that can be the basis of effective bipartisan legislation.

The political damage recently sustained by the Clinton health care plan suggests that a Clinton-Cooper compromise will be forced on the White House sooner rather than later. It would be useful to get the principled alternative -- a proposal that might eventually become the "Moynihan-Dole" bill, for example -- on the table just as fast. This is a sound strategy for Republicans, and for the country.

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Dole

United States Senate

DAVE DURENBERGER

February 28, 1994

Dear Republican colleague:

I look forward to our retreat this week to discuss the Republican role in health reform.

After 3 1/2 years of Thursday breakfast meetings, a substantial majority (19) of our Senate Republican task force has agreed on a direction for health reform which is also setting an example for others.

This letter expresses concern about those Republican political strategists who call our work "the kind of thing the Republican Party should exist to oppose."

By linking managed competition to the Clinton plan, William Kristol implies that the 26 Republicans supporting the Cooper-Grandy bill in the House and the 19 Republican Senate cosponsors of the Chafee bill bring "shame" to the Republican party.

We Republicans are not novices on these issues. Many of us have been working together on health reform since we defeated Carter's hospital cost containment bill in 1979. Senators Chafee, Dole, Packwood, Danforth, and Roth among others have a long track record of health legislation.

Conservatives like Kristol are correct on several points.

They are right in observing that we need catastrophic coverage and better risk pooling mechanisms. Like everyone else, they recognize that we need basic insurance reform so that policies can be more equitably priced and available to working people.

They are also right to say that in a number of local markets, experiments in voluntary pooling and greater efficiency in delivery systems have ameliorated price increases.

However, in the Senate Republican task force we concluded that we can't wait for episodic and fragmentary reform at the state level while ignoring more comprehensive reform at the national level.

Over 3 1/2 years, the task force has addressed the problems in the system and, most of all, the issues involved in change. For pragmatic, strategic, and policy reasons, we've chosen the principles embodied in HEART (Chafee-Dole).

To Mr. Kristol's chagrin, that puts us in league with Cooper (Breaux-Durenberger) and with the system reform elements buried in the Clintons' 1300 page bill.

Pragmatic Reasons for Reform Now:

State-by-state reform is occurring and Democrats in every state are rising to the regulatory bait in their health care markets. From Lawton Chiles in Florida, to a host of candidates from Oregon to Minnesota to Vermont, state governments are plowing forward with government controls over health care systems.

COMMITTEE ASSIGNMENTS:
FINANCE
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Bob Dole's comments at the Finance Committee hearing last week illustrated the perverse effect of state-by-state regulation over local medical markets.

If we do nothing at the national level, we risk a patchwork of conflicting and highly regulatory health systems with significant adverse effects on multistate businesses, interstate health care networks, and local markets such as Utah and Minnesota that are impeded by profligate spenders in other states. ERISA preemption WILL NOT survive state pressures in the absence of federal reform.

Strategic Reasons for Reform Now:

President Clinton will compromise anything to get universal coverage. Why not take advantage of his singleminded goal?

Republicans know that our federal entitlement programs and our tax policy are the real sources of medical inflation. Pete Domenici's leadership on the Budget Committee has brought this issue to the forefront of the debate. We also know employer mandates won't achieve universal coverage.

We have a rare opportunity to change the federal reimbursement systems that are threatening to break the federal treasury and penalize every effort at efficiency in local markets. Republicans believe in making markets work--not replacing markets with government control. We must not bow to Clinton's call for universal coverage without ensuring coverage policy reform.

Policy Reasons for Reform Now:

From a policy perspective, we have an opportunity to reset the rules to make the medical markets work. That is where real long-lasting cost containment can be accomplished.

For 40 years, national policy paid for anything and everything and sheltered private citizens from the economic consequences of their medical spending. We have created a monster of consumption. We need to change the signals for both the public programs and the private market to pay for results not services.

When we do, it is imperative that the savings accrue to the consumers who are buying more wisely and to the efficient providers of care. Savings should not absorbed through taxes and transferred to less efficient markets. Good behavior must be rewarded not taxed.

The problem for conservatives is that they can't seem to see the dysfunction in medical markets. Its true that we have the best health care services and technology in the world. But we don't have the best health care system.

The problems extend beyond the small group market, although we agree these reforms will alleviate some of the inequities for small business buyers.

A closer look at Kristol's analysis in his most recent memo, "Defeating the Coming Clinton-Cooper Compromise" illustrates my point.

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Purchasing Groups

By attacking alliances (also known as purchasing groups or cooperatives) as a "web of state administered health care machinery," he misses a central tenet of functioning markets. Buyers must have information on which to make informed choices and sufficient market power to exercise those choices. Group buying can also result in administrative efficiency.

EFFICIENCY, CHOICE, INFORMATION, and POWER conferred by member-controlled buying groups will make the medical market work better. That's the goal of purchasing cooperatives. Those goals will not be achieved by the Clinton alliances, but will be under the structures proposed in the Chafee and Cooper bills.

Accountable Health Plans

An accountable health plan fully integrates financial, managerial, and clinical aspects of health care. They must be accountable to their members for their cost and effectiveness as well as patient satisfaction.

Insurance reform changes the way that insurance plans are priced and sold. An accountable health plan changes the insurance "product."

Conservatives have used scare tactics to imply that our intention is to drive out fee-for-service medicine. That decision will be made by consumers in the marketplace--not by politicians.

Once people are able to select a health plan on the basis of price and quality, they MAY choose a fee-for-service plan or they may not. If fee-for-service cannot compete, it will be because people believe they get more value for their health care dollar in other systems of care. That is the essence of CHOICE not the elimination of it.

Tax Policy

Kristol also implies that choice will be limited by the imposition of a cap on the tax exclusion for health care expenditures. Such a limit, he argues, is a "remarkably coercive use of the tax code." After 16 years of service on the Finance Committee, I find that characterization laughable.

ALL tax policy is designed to create incentives for certain kinds of behavior BY taxpayers. As we all know, the mortgage interest deduction is designed to encourage and reward home ownership. This is one of thousands of such examples in the code.

Our present tax policy fuels consumption by insulating people from the economic consequences of their medical spending. It rewards overspending and penalizes constraint.

All the proposed tax caps do is limit the amount of spending consumers can do with tax free dollars. Nothing in this approach inhibits an individual from buying more health care than the tax cap shelters. You just can't do it with pretax dollars.

Kristol calls the tax cap an arbitrary restriction. Its no more arbitrary than the limits on the deductibility of business lunches. Businessmen can still eat (and presumably eat well). They just can't do it at our expense!

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Information

Finally a word about the role of information in a functioning health care system. Markets don't always produce information, yet they cannot function without it. That is basic economics.

Information is the tool of accountability. We cannot hold doctors, hospitals, health plans, or government accountable without information. When we have better information on medical outcomes, we will get better health care and make better choices.

Government's role in reporting requirements and uniform data systems is not new nor does it presage government control. Air travelers can rely on safety and on-time data to use their personal dollars to choose an airline. This assists the private market rather than replaces it.

Kristol counts up the institutional arrangements in Cooper and Chafee, then bemoans them as too bureaucratic. If he looked more closely at our present HHS infrastructure, he would see that these bills streamline what we already have and facilitate the orderly analysis of information necessary for quality improvement. We can't support a 1990s health care system on a 1960s infrastructure.

Choice:

We all use the same vocabulary, but speak different languages. Nowhere is that more apparent than in the use of the word "choice." Thematically, the conservatives have hammered home the point that managed competition deprives consumers of choice. Choice implies that we know what we're doing, getting and paying for. That simply is NOT the case in our present system.

The purpose of system reform is to guarantee consumers that they can choose a health plan based on accurate information about its price and its quality -- that is real choice.

And, that is why it is not accurate to say that Americans have the best health care system in the world. Because it's only potentially the best.

Republican Reform

A recent New York Times poll found that people trust Democrats not Republicans to improve health care by a margin of 59 to 20. Clinton has squandered his political advantage because his plan is a complex tangle that the American people cannot understand.

As Republicans we can take advantage of the desire for reform among Americans to reshape the debate and to work with like-minded colleagues on both sides of the aisle.

But, Republicans can't do it by "assaulting" Clinton, Cooper, and, by implication, Chafee-Dole. Republicans cannot do it by blocking comprehensive reform, riding a limited insurance reform horse, and expecting the President and the people to embrace it. Without the support of the public and the support of the President, Republicans cannot win anything.

The goal of our retreat is unity. Accusing some of us of bringing shame and dishonor on the party because we propose solutions based on a long tradition of Republican health reform activity is counterproductive.

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I prefer that we invest in the debate on reform, arm ourselves with a good understanding of the present system and a vision of where we want the system to go in the future.

Republicans must assure Americans that they understand the problem and are committed to genuine and meaningful reform.

So far, we're losing 59-20.

Chafee-Dole tries to get us back in the game.

I look forward to getting the job done in this session of Congress.

Sincerely,

Dave Durenberger
United States Senator

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PROJECT FOR THE
REPUBLICAN FUTURE

WILLIAM KRISTOL
CHAIRMAN

December 2, 1993

Honorable Robert Dole
Republican Leader
United States Senate
Washington, D.C. 20510

Dear Leader,

Thought you might be interested in this.

Sincerely,

William Kristol

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BOARD OF DIRECTORS
WILLIAM KRISTOL, *CHAIRMAN*
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MICHAEL S. JOYCE
THOMAS L. RHODES

December 2, 1993

MEMORANDUM TO: REPUBLICAN LEADERS

FROM: WILLIAM KRISTOL

SUBJECT: Defeating President Clinton's Health Care Proposal

What follows is the first in what will be a series of political strategy memos prepared by The Project for the Republican Future. The topic of this memo is President Clinton's health care reform proposal, the single most ambitious item on the Administration's domestic policy agenda.

These four pages are an attempt to describe a common political strategy for Republicans in response to the Clinton health care plan. By examining the president's own strategy and tactics, this memo suggests how Republicans might reframe the current health care debate, offer a serious alternative, and, in the process, defeat the president's plan outright.

Nothing in these pages is intended to supplant the many thoughtful analyses of the Clinton health care plan already produced by Republicans and others, analyses which have done much to expose both its glaring weaknesses and immediate dangers. In fact, this memo borrows heavily from articles and papers prepared by conservative public policy think tanks, the Republican National Committee, House and Senate Republicans, and the dozens of superb critiques that have appeared in newspapers and magazines. Nor is this an attempt to prescribe legislative tactics for defeating the Clinton bill; for that we defer to our Republican leaders in the Congress. Instead, it is an effort to assess the current political climate surrounding the health care debate and to provide a winning Republican strategy that will serve the best interests of the country.

The Project for the Republican Future was founded last month to help shape a Republican vision and advance an agenda for governing. It seeks to frame a new Republicanism by challenging not just the particulars of big-government policies, but their very premises and purposes. In the coming months, we will prepare and circulate other memos on critical issues of politics and policy. We welcome your reactions to this memo so that we can further refine a Republican strategy, and we encourage your thoughts on future subjects for consideration.

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PROJECT FOR THE REPUBLICAN FUTURE: A POLITICAL STRATEGY FOR HEALTH CARE

I. THE CURRENT SITUATION

Just after President Clinton introduced his health care plan in September, opinion polling reflected strong public support for it. That support has now sharply eroded. A late September *Washington Post*/ABC News poll, for example, had national respondents approving the plan by a 56 to 24 percent margin; the same poll in October had approval down to a 51 to 39 percent margin; and a mid-November *Post*/ABC poll now shows bare plurality support for the plan of 46 to 43 percent.

To some extent, these results follow a predictable pattern of Clinton Administration policy initiatives, which have tended to open well on the strength of the president's personal advocacy, and then to falter as revealed details make plain his attachment to traditional, big government, tax-and-spend liberalism. Faced with forceful objections in the past, the Administration has generally preferred to bargain and compromise with Congress so as to achieve any victory it can. But health care is not, in fact, just another Clinton domestic policy initiative. And the conventional political strategies Republicans have used in the past are inadequate to the task of defeating the Clinton plan outright. That must be our goal.

Simple Criticism is Insufficient. Simple, green-eyeshades criticism of the plan -- on the grounds that its numbers don't add up (they don't), or that it costs too much (it does), or that it will kill jobs and disrupt the economy (it will) -- is fine so far as it goes. But in the current climate, such opposition only wins concessions, not surrender. The president will lobby intensively for his plan. It will surely be the central theme of his State of the Union Address in January. Health care reform remains popular in principle. And the Democratic Party has the votes. After all, the president's "tax fairness" budget, despite unanimous Republican opposition and rising public disapproval, did pass the Congress.

Any Republican urge to negotiate a "least bad" compromise with the Democrats, and thereby gain momentary public credit for helping the president "do something" about health care, should also be resisted. Passage of the Clinton health care plan, in any form, would guarantee and likely make permanent an unprecedented federal intrusion into and disruption of the American economy -- and the establishment of the largest federal entitlement program since Social Security. Its success would signal a rebirth of centralized welfare-state policy at the very moment we have begun rolling back that idea in other areas. And, not least, it would destroy the present breadth and quality of the American health care system, still the world's finest. On grounds of national policy alone, the plan should not be amended; it should be erased.

But the Clinton proposal is also a serious *political* threat to the Republican Party. Republicans must therefore clearly understand the political strategy implicit in the Clinton plan -- and then adopt an aggressive and uncompromising counterstrategy designed to delegitimize the proposal and defeat its partisan purpose.

II. THE CLINTON STRATEGY

"Health care will prove to be an enormously healthy project for Clinton ... and for the Democratic Party." So predicts Stanley Greenberg, the president's strategist and pollster. If a Clinton health care plan succeeds without principled Republican opposition, Mr. Greenberg will be right. Because the initiative's inevitably destructive effect on American medical services will not be practically apparent for several years -- no Carter-like gas lines, in other words -- its passage in the short run will do nothing to hurt (and everything to help) Democratic electoral prospects in 1996. But the long-term political effects of a successful Clinton health care bill will be even worse -- much worse. It will relegitimize middle-class dependence for "security" on government spending and regulation. It will revive the reputation of the party that spends and regulates, the Democrats, as the generous protector of middle-class interests. And it will at the same time strike a punishing blow against Republican claims to defend the middle class by restraining government.

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The 80-80 Split. The president intends to convince the American middle class to buy into this new government dependency by overcoming their skepticism with fear. Poll numbers explain his tactics. A large majority of Americans consistently reports that it believes our country's health care system, writ large, to be dysfunctional; 79 percent of respondents to a Princeton Survey Research Associates/*Newsweek* poll in late September, for example, said the American health care system needed fundamental change or a complete rebuilding. Popular discomfort with American medicine as a "system" is Clinton's opportunity. But the same polls contain the key to Clinton's vulnerability, as well. The vast majority of Americans are pleased with the care this system now provides them personally; 80 percent of respondents to a late September Yankelovich/*Time*/CNN poll said they were "somewhat" or "very" satisfied with their own medical services.

So the president advances a promise of "universal" health care coverage as a solution to the problem of the uninsured, but his plan must win the approval of a middle class most members of which are generally happy with the health care they have. He cannot plausibly claim that his plan will make the middle class even happier with their present care. That argument, at least, is already lost. Respondents to a mid-November CBS/*New York Times* poll say, by a two-to-one margin, that the Clinton plan is more likely to degrade than enhance the quality of their own medical care, and by an almost six-to-one margin that their personal medical expenses are more likely to go up under Clinton than down.

The Administration's only option, then, is singlemindedly to focus on the fears many middle-class Americans have about health care as an abstract "system" that might someday threaten them. The Administration's public pronouncements ignore all basic, practical questions about how their health plan will actually affect the quality and flexibility of American medical care. And its spokesmen encourage the notion that radical change involving a sacrifice of quality and free choice is necessary for health "security."

III. A REPUBLICAN COUNTERSTRATEGY

The president makes his pitch to the 79 percent of Americans who are inclined to agree that "the system" isn't working, hoping to freeze health care debate on the level of grand generalization about structural defects. He is on the side of the angels rhetorically -- denunciations of the status quo, easy moralism about his own alternative, rosy predictions of a utopian future in which security is absolutely guaranteed. Republicans can defeat him by shifting that debate toward specific, commonsense questions about the effect of Clinton's proposed reforms on individual American citizens and their families, the vast majority of whom, again, are content with the medical services they already enjoy.

Republicans should ask: what will Bill Clinton's health care plan do to the relationship most Americans now have with their family doctor or pediatrician? What will it do to the quality of care they now receive? Such questions are the beginning of a *genuine* moral-political argument, based on human rather than bureaucratic needs. And they allow Republicans to trump Clinton's security strategy with an appeal to the enlightened self-interest of middle-class America.

The Republican counterstrategy involves pursuing three distinct tasks: 1) deflating the exaggerated fears of systemic health care collapse that Democrats have encouraged; 2) clarifying and publicizing how the Clinton reform plan would alter and damage the quality and choice of medical treatment most Americans now take for granted; and 3) pointing out that incremental and meaningful solutions to problems of health security -- solutions that do not require scrapping the current structure of American medicine and experimenting with something invented in Washington -- are already available and politically within reach.

Deflating Fear. Genuine, yet remediable problems do exist in the American system of medicine, but the rhetoric surrounding the president's health plan deliberately makes those problems sound apocalyptic. "Fear itself" does not trouble the new New Dealers; indeed, they welcome it as a powerful tool of political persuasion. Mrs. Clinton, in particular, routinely describes a nation of individual lives teetering on the brink, each only an illness or job switch away from financial ruin. The text of the president's Health Security Plan and vir-

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tually all the public remarks on heath care made by his advisors are filled with images of a health care system spawning little else but frustration and tragedy. It is a brazen political strategy of fear-mongering, conducted on a scale not seen since the Chicken Little energy crisis speeches of President Carter.

Fanning the flames of public unease is a purely political tactic for the Democrats, and it deserves to be exposed as such. For while public concern about health care is undoubtedly real, the president's deliberate campaign of fright seems designed less as a response to the public and more as a justification for his own far-reaching, grand reforms. Republicans should scrupulously avoid endorsing the president's depiction of a nation beset by fear over health care, which provides him cover for the war-time, centrally-planned, emergency-style measures that characterize his alarmist overhaul of our medical system. Republicans should instead painstakingly debunk that account, and remind the nation, point by point, that it currently enjoys the finest, most comprehensive, and most generous system of medical care in world history.

Raising Questions About Medical Quality and Choice. The most devastating indictment of the president's proposal is that it threatens to destroy virtually everything about American health care that's worth preserving. Under the plan's layers of regulation and oversight, even seeing a doctor whenever you like will be no easy matter: access to physicians will be carefully regulated by gatekeepers; referrals to specialists will be strongly discouraged; second opinions will be almost unheard of; and the availability of new drugs will be limited.

So while there are now countless valid criticisms of the Clinton plan's various aspects, the most politically effective ones focus on how the proposal would fundamentally change the quality and kind of medical service that Americans cherish and expect. This means an assault on the Clinton plan's two central tenets: mandatory, monopolistic health alliances and government price controls. Hand in hand, these two cornerstones of the president's plan will establish a system of rationed medical care.

Under Clinton's plan, the alliances will submit annual budgets to a national health board, thereby creating pressure to save money and trim service wherever possible. That means tightly regulated managed health care for most people, with an emphasis on efficiency over quality. Those who can afford huge premiums may be able to see a private fee-for-service doctor, though fee schedules will make it difficult for most independent physicians to stay in business. In time, the family doctor tradition will disappear. And avoiding this result by purchasing health insurance outside the alliances will be either impossible or criminal. The chief effect of price controls -- the linchpin of the president's cost-containment theory -- will be a rigid national system of pre-set budgets and medicine by accountants. There is no reason to believe that such a system won't follow the pattern that price controls have established in every other area: rationing, queuing, diminished innovation, black markets, and the creation of a government "health police" to enforce the rules.

Though the president and his surrogates deny all this, the basic building blocks of his proposal permit no other result. Republicans should insistently convey the message that mandatory health alliances and government price controls will destroy the character, quality, and inventiveness of American health care.

Advocating Security Without Upheaval. The initial appeal of the president's proposal is its promise of lifelong, universal security, defined in standard Democratic terms as a federal entitlement benefit. But this promise can also be restated as the plan's most glaring weakness: it mistakes federal spending and regulation for individual security. In exchange for his government-program security, Americans must accept a massive uprooting of the entire U.S. health care system, with disruptive and deleterious consequences.

As both a political and policy matter, the best counter-strategy to Clinton's offer of security requires resisting the temptation to compete with the president in a contest of radical reforms. Allaying public concern about health security can be achieved by addressing a few basic problems directly -- and without unravelling the current system. The easiest way to do that is by pursuing the short list of reforms for which there is already a

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national consensus. Relatively simple changes to insurance regulation, for example, can eliminate the barriers to health insurance for people with pre-existing medical conditions. The unemployed or people whose employers do not provide health insurance should be able to deduct the full cost of their premiums. The federal government could target its health spending to provide clinics in rural areas and inner cities where access to health care remains a problem. Long-overdue reforms to medical malpractice law would help lower insurance rates across the board. And a simplified, uniform insurance form would reduce paperwork, another unnecessary irritant of the current system. All these small steps would make health insurance less costly and health care easier to obtain.

Even where national health budgeting is concerned, there exist opportunities for significant reform that do not involve Great Society-scale upheaval. States might be permitted to operate Medicare and Medicaid programs through managed care, for example, rather than through now-mandated fee-for-service plans -- and thereby realize huge cost savings in their own budgets. (The Democratic governor of Tennessee recently applied for, and received, the necessary waiver of federal regulations to pursue just such a reform.) In fact, there are all sorts of cumbersome and costly health care mandates and regulations now imposed on states; they should be lifted to allow governors to allocate their federal programs in the most efficient way. The potential savings from Medicare and Medicaid -- the engine of our escalating federal deficit -- are enormous.

These are hardly revolutionary or even visionary proposals. In fact, variations of these reforms have been floating around the Congress for some time. Their simplicity and their lack of big-government "sophistication" stand in stark contrast to the extensive controls, reorganizing, standardization, and rationing that are at the heart of president's Health Security Plan.

IV. LAYING GROUNDWORK FOR THE FUTURE

These may only be intermediate measures. A more ambitious agenda of free-market reforms remains open for the future: medical IRAs, tax credits and vouchers for insurance, and the like. But Republicans must recognize the policy and tactical risks involved in near-term advocacy of sweeping change, however "right" it might be in principle. The Clinton plan's radicalism depends almost entirely for its success on persuading the nation that American medicine is so broken that it must not just be fixed, but replaced -- wholesale and immediately. And it would be a pity if the advancement of otherwise worthy Republican proposals gave unintended support to the Democrats' sky-is-falling rationale.

The more modest Republican reforms discussed earlier would have the virtue of cooling the feverish atmosphere -- fostered largely and deliberately by the Administration -- in which health care is currently discussed. And they offer a potentially much larger benefit to the Republican Party as a model of future conservative public policy: a practical vision of principled incrementalism. The character of Republican opposition to the president's health care plan, properly pursued, has broad implications. The party's goal, in health care and in other policy areas, should be to make the case for limited government while avoiding either simple-minded bean-counting, on the one hand, or Democrat-like utopian overreach on the other. The target of Republican policy prescriptions must be the individual citizen, not some abstract "system" in need of ham-fisted government repair. If we can, in this way, provide a principled alternative to the paternalistic experimentalism that consistently underlies Democratic ideas of governance, Republicans will be poised to claim the moral high ground in this and future debates.

The first step in that process must be the unqualified political defeat of the Clinton health care proposal. Its rejection by Congress and the public would be a monumental setback for the president, and an incontestable piece of evidence that Democratic welfare-state liberalism remains firmly in retreat. Subsequent replacement of the Clinton scheme by a set of ever-more ambitious, free-market initiatives would make the coming year's health policy debate a watershed in the resurgence of a newly bold and principled Republican politics.

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United States Senate

DAVE DURENBERGER

January 19, 1994

Dear Colleague:

Last month you received a memorandum from William Kristol from the Project for the Republican Future on the subject of "defeating President Clinton's Health Care Proposal."

Kristol proposes an unqualified political defeat of the Clinton proposal -- a "monumental setback for the president."

After the fall, Republicans would offer a short list of "more modest" reforms of insurance, malpractice and paperwork. A more ambitious Republican agenda (tax credits, medical IRAs, etc.) would be saved for the future. He dubs this "principled incrementalism."

I don't doubt the sincerity of his effort. However, Kristol offers neither a winning political strategy nor a policy position that serves the best interests of the United States.

We do have a crisis in health care in this country. The Clinton Administration has wrongly characterized the problem as a crisis of access. It is NOT an access problem, it is a COST problem. If costs continue to escalate at current rates, health care expenditures will break the bank and our own best efforts at access.

It is essential that we accomplish reform of the health care delivery system in order to control costs. The ONLY way to do that is to change the incentives for the delivery of care. The market-based reforms embodied in the Managed Competition Act (S. 1579) and the Republican HEART proposal (S. 1770) will accomplish the necessary system reform.

Kristol perpetuates the unfortunate tendency to polarize the health reform debate around terms like comprehensive VERSUS incremental. It is a false dichotomy.

The Clinton proposal is fatally flawed, NOT because it is so-called comprehensive. It is flawed because it buries markets in a tangle of regulation and bureaucracy.

What Kristol offers is also flawed, but not because it is incremental. His modest recommendations are necessary and are embodied in the managed competition proposals. They are flawed because they offer no vision for the future. Managed competition doesn't do it all, but it gives us a sense of direction--a comprehensive vision that includes ALL the necessary first steps to get us there.

Kristol cautions Republicans not to compete with the President in a contest for radical reforms. By this, I assume he is warning us away from the middle ground embodied in S. 1770 and S. 1579. I would remind him that Senate Republicans are not neophytes on this issue:

- Many of the Senate authors have devoted much of their careers to health policy.

- John Chafee has led the Republican Task on Health through years of meetings to increase our knowledge of these complicated issues.

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- I introduced a market-based reform bill in 1979. So did then Senator Dick Schweiker and then Congressman Dave Stockman.

- Republicans labored hard during the 1980s to reform Medicare, including Prospective Payment legislation, TEFRA risk contracts, and the Catastrophic bill.

- Republicans invented small group insurance reform. Republicans built bi-partisan leadership for Medicare Catastrophic.

- We led the defeat of President Clinton's Hospital Budget regulation.

We must keep in mind that ALL our efforts at health reform in the last decade have been bipartisan. Republican principles are not sacrificed by working collaboratively with Democrats. My cosponsors on S. 1579--Senators Breaux and Lieberman--share our commitment to market-based reforms. The efforts of John Chafee, Jim Cooper (D-TN) and Fred Grandy (R-IA) in the House to build a mainstream coalition that is bipartisan and bicameral exemplifies our commonalities.

I urge you NOT to fall into the trap of negativity and denial. That approach has failed Republicans politically in the past and will fail us again in the future. As a party, we do not need health care as an unresolved issue in 1996.

I am not suggesting that we must embrace the seriously flawed Clinton bill. I am strongly opposed to it in its present form. But, I believe that if we stand firm on the market-based principles of managed competition, and stand side-by-side with Democrats who share those principles, we can prevail.

President Clinton can't do reform with the liberal left. He can't do it with Democrats only. He can't do it without a significant group of Republicans. We can't do reform - incremental or comprehensive - without the President. Let's persuade him the MCA/HEART is the reform.

I believe that these reforms are in the best interests of the country. I also believe they are in the best interests of the Republican party because they are grounded in limited government and sound markets.

To Mr. Kristol, I simply say that Republicans already have a winning strategy and that strategy is managed competition. To my Republican colleagues who have signed onto the HEART bill, I say lets stick to our principles. There is too much to lose if we do not.

Sincerely,

David Durenberger
United States Senator

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