Mon, Sept 30

JOHN H. CHAFEE
RHODE ISLAND

United States Senate
WASHINGTON, DC 20510-3902

September 26, 1991

The Honorable Robert Dole
United States Senate
Washington, D.C. 20510

Dear Bob:

Just a quick reminder that the Republican Task Force For Health Care Retreat will be held this Monday, September 30, from 1:00 p.m. to 6:00 p.m. at the Library of Congress, Madison Building.

We will meet in the West Dining Room, which is on the sixth floor, Room 621. There is a house phone located outside of the room so that we will be able to make and receive telephone calls. The telephone number of the house phone is 707-9374.

It should be a very informative afternoon. Hope to see you there!

Sincerely,

John

John H. Chafee
United States Senator

Monday - Sept. 30

REPUBLICAN HEALTH CARE TASK FORCE
RETREAT
SEPTEMBER 30, 1990

A. WELCOME
John H. Chafee, Chairman

B. HEALTH CARE COST IMPLICATIONS -- FUTURE:
Deborah Steelman, Chair, Advisory Council on Social Security

C. STATE INNOVATIONS/NGA ACTIVITY:
Mike Castle, Governor of Delaware

D. PREVENTION AND DELIVERY
Secretary Sullivan

E. DISCUSSION OF PROPOSED PLANS:
Richard Darman

F. WHAT IS THE PUBLIC THINKING?
Linda Duval, American Viewpoint
Bill McInturf, Public Opinion Strategies

G. DISCUSSION, STRATEGY PLANNING

REPUBLICAN HEALTH RETREAT

SEPTEMBER 30, 1991

WE ALL OWE A DEBT OF GRATITUDE TO JOHN CHAFEE FOR BRINGING US TOGETHER TODAY, AND OVER THE LAST FEW MONTHS.

AS MANY WILL POINT OUT TODAY, THE AMERICAN HEALTH CARE SYSTEM IS CAPABLE OF DELIVERING THE HIGHEST LEVEL OF CARE IN THE WORLD. BUT COST AND ACCESS ISSUES ARE PREVENTING US FROM MAKING THE SYSTEM MORE EFFECTIVE.

OUR DISCUSSIONS OVER THE PAST MONTHS HAVE IDENTIFIED A NUMBER OF BASIC ACTIONS THAT VIRTUALLY EVERY BUSINESS AND HEALTH CARE GROUP WOULD AGREE COULD SLOW RUN-AWAY HEALTH CARE COSTS, AS WELL AS EXPAND ACCESS TO CARE FOR ALL AMERICANS.

MANY PLANS

INCORPORATING THESE

SUGGESTED CHANGES HAVE

BEEN OFFERED BY REPUBLICAN

MEMBERS, MYSELF INCLUDED.

SOME OF THESE

PROPOSALS CALL FOR

COMPREHENSIVE REFORM

WHILE OTHERS ARE

INCREMENTAL. I BELIEVE THIS

DIVERSITY TO BE USEFUL. IN MY VIEW, THE LAST THING WE NEED IS ONE MASSIVE PLAN THAT EVERYONE CAN SHOOT AT FOR THE NEXT 13 MONTHS BEFORE THE ELECTION.

WHAT WE CAN DO IS TRY TO REACH CONSENSUS WITH THE ADMINISTRATION, IF POSSIBLE, ON A BROAD SET OF

PRINCIPLES THAT WE CAN EACH INTERPRET IN OUR OWN WAY -- TO MEET OUR OWN NEEDS.

THE WAY I SEE IT, THERE ARE BASICALLY TWO WAYS OF SOLVING THE COST AND ACCESS PROBLEMS -- THE EASY WAY -- THE WAY THE DEMOCRATS SUGGEST, BY TAXING THE EMPLOYER -- OR

THE RIGHT WAY -- THE WAY THAT WE, AS REPUBLICANS BELIEVE IS MORE RESPONSIBLE AND WON'T RAVAGE THE ECONOMY. FUNDAMENTALLY, WE BELIEVE IN A PRIVATE SECTOR, MARKET DRIVEN SOLUTION.

LET'S NOT FORGET, THE U.S. HAS AN OUTSTANDING

HEALTH CARE SYSTEM FOR THE 87 PERCENT OF THE POPULATION COVERED BY HEALTH PLANS. WE DON'T HAVE LONG WAITING LISTS. WE DON'T RATION CARE. WE HAVE THE BEST TRAINED HEALTH CARE PROVIDERS IN THE WORLD. BUT POLL AFTER POLL TELLS US THAT THE AMERICAN PEOPLE ARE CONCERNED,

PARTICULARLY ABOUT COSTS, AND WANT US TO DO SOMETHING. IN FACT, I HEARD ABOUT IT AT EVERY TOWN MEETING I ATTENDED IN KANSAS. ITS MIDDLE AMERICA WHO SUDDENLY CAN'T AFFORD TO GET SICK -- NOT JUST THE URBAN POOR.

WHEN LOOKING TO REFORM THE SYSTEM, WE MUST CONTINUE TO NURTURE AND PROTECT OUR STRENGTHS. TAXING THE EMPLOYER OR ADOPTING A NATIONAL SYSTEM, LIKE CANADA'S, IS NOT WHAT WE NEED. WHAT WE DO NEED IS RESPONSIBLE, REPUBLICAN ACTION THAT WILL IMPROVE ACCESS AND CONTAIN COSTS.

HOPEFULLY, TODAY'S DISCUSSION WILL HELP US IDENTIFY THE STRENGTHS AND WEAKNESSES OF OUR SUGGESTIONS.

REPUBLICAN HEALTH CARE TASK FORCE
RETREAT
SEPTEMBER 30, 1990

A. WELCOME
John H. Chafee, Chairman

B. HEALTH CARE COST IMPLICATIONS -- FUTURE:
Deborah Steelman, Chair, Advisory Council on Social Security

C. STATE INNOVATIONS/NGA ACTIVITY:
Mike Castle, Governor of Delaware

D. HEALTH CARE REFORM: CURRENT OUTLOOK
Secretary Sullivan

E. DISCUSSION OF PROPOSED PLANS:
Richard Darman

F. WHAT IS THE PUBLIC THINKING?
Linda Duval, American Viewpoint
Bill McInturf, Public Opinion Strategies

G. DISCUSSION, STRATEGY PLANNING

AMERICAN VIEWPOINT

American Viewpoint, Inc.
300 North Washington Street
Suite 505
Alexandria, Virginia 22314
(703) 684-3325
(703) 684-9295 - FAX

PROFESSIONAL STAFF

LINDA DiVALL, President

As American Viewpoint's founder, Linda DiVall has been recognized by CAMPAIGNS AND ELECTIONS as one of the top six rising stars in the Republican Party. She is well known and highly respected in the political community for her expertise in assessing the dynamics behind voters' time of decision-making in political campaigns. Additionally, she has been deeply involved with assisting the Republican Party in formulating solutions to the gender gap, as well as analyzing the implications that the abortion issue presents to Republican coalition-building efforts.

Linda is a frequent source of the national press. Her views have been sought by a number of groups including the Cabinet, the Republican Conference of the U.S. House of Representatives, the National Press Club, the National Women's Political Caucus, the Radio and Television News Directors Association, and various trade associations and political organizations. Linda has been a guest commentator for all of the major networks, CNN, and C-Span, and has appeared on CBS' "Face the Nation," ABC's "This Week With David Brinkley," "Nightline," and "Good Morning America," and NBC's "The Today Show." She has been a contributing writer to political publications such as PUBLIC OPINION and CAMPAIGNS AND ELECTIONS, and has been featured in numerous magazine and newspaper articles.

In the 1988 election cycle, Linda served as a pollster and senior advisor to the campaign of President George Bush. Under her direction in the 1990 cycle, American Viewpoint served as the pollster to three U.S. Senate races and three gubernatorial races, including John Engler's upset victory in Michigan. Linda has worked with CBS as part of its Super Tuesday and Election Night news teams during the last two election cycles, and in 1990 was Lesley Stahl's analyst for all gubernatorial campaigns.

In April 1990, Linda participated as one of the first teams of political consultants sent to Romania to assist the non-Communist parties in the May elections in that country. In September 1991, she was a participant in a four-day seminar in Moscow designed to assist new republic leaders in training on democracy, party building, coalition building, and analyzing and interpreting public opinion.

Linda began her career in survey research in 1974 with the Republican National Committee, and in 1977 was selected to serve as the Committee's first research director of its Local Elections Division. In the six years Linda spent with the NRCC prior to founding American Viewpoint, she originated its national survey research program, was given sole responsibility for planning and implementing its district, national, and national media survey research programs, and also served as Director of Coalition Development.

Linda is an Illinois native and an honors graduate of Arizona State University.

PUBLIC OPINION STRATEGIES

WILLIAM D. McINTURFF

William D. McInturff is currently a partner of Public Opinion Strategies, a leading political and public affairs research firm.

Previously, Bill served as senior consultant to The Wirthlin Group, a national polling firm, where he directed numerous political studies at national, statewide and congressional levels. In 1990, he managed polling for three successful statewide campaigns, including the come-from-behind victories of Maine Governor Jock McKernan and Arizona Governor Fife Symington. Since 1988, Bill has polled for 12 congressional races, winning seven.

His public affairs research experience is extensive, emphasizing environment, healthcare, community image, crisis management and opinion leader studies. Bill has directed major research programs for International Paper, ALCAN, Wheelabrator Technologies, the Aluminum Association, the American Paper Institute, and the National Basketball Association, among others.

He is a leading practitioner and authority on applying survey research, computerized list development, and phone/mail/direct contact programs for campaigns, grassroots lobbying and initiative/referenda campaigns, and authored the Republican National Committee's "The Complete Guide to Voter Programs," now in distribution nationally.

Bill's experience managing sophisticated direct voter contact programs includes a grassroots lobbying program for a major Fortune 100 company, a national referendum campaign for the National Cattlemen's Association, and as consultant to the Bush-Quayle '88 campaign's voter persuasion and get-out-the-vote effort. For the National Association of Realtors in 1990, he designed and directed a $750,000 independent expenditure program on behalf of now-U.S. Senators Larry Craig (R-ID), Hank Brown (R-CO) and Bob Smith (R-NH), as well as other Members of Congress.

He is founder and creator of "POLITICAL INTELLIGENCE," a new voter tracking system that in 1990 monitored the impact of specific voter contact upon key U.S. Senate and gubernatorial races in California, Illinois, Texas, Florida, Michigan and Oregon. Heading into 1992, the results provide a unique database for analyzing the impact of political party and special interest group efforts upon outcomes of elections.

Bill also developed DATS (Database Analysis Targeting System), which translates phone bank identification data into a survey tracking format to monitor a campaign more closely. Still in development is a project integrating voter identification data by zip codes to enable more precise campaign media buys to key undecided constituencies.

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Other senior management and strategic experience with the Republican Party includes: service in 1985-86 as the RNC's Director of Voter Programs and Director of Party Development, 1983-84 service as National Director of Field Operations for the National Republican Congressional Committee (NRCC), and 1981-82 service as the NRCC's Northeast Regional Campaign Director, responsible for GOP assistance to 43 U.S. House races in Connecticut, Rhode Island, New Jersey, and Pennsylvania. He has managed both a statewide and a congressional race, and in 1980 served as Western States Field Representative for the George Bush for President campaign.

Prior to entering politics, he served as president of a professional recruiting and consulting firm, specializing in the field of materials management.

He is a graduate of Boston University, a former adviser to the Graduate School of Campaign Management at the University of Florida, and a contributor to several campaign and political publications. He has appeared on a variety of television programs discussing current political events and the status and activity of political parties. He is Contributing Analyst to the *Campaign Hotline* and writes a monthly column on public opinion trends for the magazine *Campaign*.

In 1988, he was selected one of the "Top 50 Rising Stars" of the Republican Party by *Campaigns & Elections* magazine.

DEBORAH STEELMAN
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(202) 637-5890

EXPERIENCE

LAW OFFICES OF DEBORAH STEELMAN
Attorney-at-Law
September 1987 - present

Established practice in the fields of employee benefits, health care, and environment. Client services include regulatory, legal, and legislative guidance. A partner at Epstein, Becker, and Green prior to opening independent practice in January 1991. Currently serving as the Chair of the Advisory Council on Social Security whose charter includes a review of U.S. health care financing and retirement policy.

GEORGE BUSH FOR PRESIDENT CAMPAIGN
Director of Domestic Policy
1988

Developed and managed the domestic policy strategy for the George Bush for President Campaign, and represented then Vice President Bush in an official capacity regarding domestic issues within the public and media.

OFFICE OF MANAGEMENT AND BUDGET
Associate Director for Human Resources, Veterans and Labor
Washington, D.C.
January 1986 - June 1987

Reviewed over $460 billion in annual Federal expenditures contained in the budgets of the Departments of Health and Human Services, Labor, Education and the Veterans Administration, and 19 independent agencies.

THE WHITE HOUSE
Deputy Assistant to the President and
Director of Intergovernmental Affairs
Washington, D.C.
January 1985 - January 1986

Worked on behalf of the President with the nation's Governors, legislators and local officials.

ENVIRONMENTAL PROTECTION AGENCY
Director, Office of Intergovernmental Liaison
Washington, D.C.
September 1983 - January 1985

Managed state and local relations for Administrator William D. Ruckelshaus.

UNITED STATES SENATE
Legislative Director to Senator John Heinz (R-PA)
Washington, D.C.
March 1982 - September 1983

Managed legislative program centered around Finance, Banking, Energy and Aging Committee assignments.

MISSOURI DEPARTMENT OF NATURAL RESOURCES
Deputy Director
Jefferson City, Missouri
January 1981 - March 1982

Served as counsel to the Department, and managed the governmental and public relations staff.

ATTORNEY GENERAL JOHN D. ASHCROFT
Campaign Manager
Jefferson City, Missouri
1980

Managed the Attorney General's campaign in 1980, in which he was reelected by 64.3% of the vote. In 1984, General Ashcroft was elected Governor of Missouri.

OFFICE OF THE PUBLIC DEFENDER
Assistant Public Defender
Kansas City, Missouri
1979

EDUCATION

Bachelor of Arts, 1976, University of Missouri
Phi Beta Kappa
Magna Cum Laude

Juris Doctor, 1978, University of Missouri
Moot Court Board
Editor, Urban Affairs Section, Urban Lawyer

Member, Missouri Bar
Member, District of Columbia Bar

AFFILIATIONS

Appointed by Secretary Bennett to the Advisory Council on Student Financial Assistance, 1988; elected to Vice Chairman by the Council members.

1989-90, Appointed by Secretary Sullivan to Chair the Quadrennial Advisory Council on Social Security.

C-28. HEALTH CARE REFORM

28.1 Preface

The health of our nation depends on the health of our people. Although the United States leads the world in health care spending, even basic care is beyond the reach of many. Our people and our nation suffer the consequences.

The nation is struggling to find consensus about how to build a health care system that will improve the health of our citizens. Changing the way we finance and deliver medical care alone will not achieve this goal. Individual people need to learn to make healthy lifestyle choices. Further, health status is influenced by a host of other critical social and economic factors -- income, housing, nutrition, and the environment -- sometimes beyond individual control.

The Governors have significant responsibility for the policies, programs, and resources that address these factors. Yet precious resources Governors want to invest in education, housing, nutrition, and family support are being consumed by the spiraling costs of medical care.

The cost statistics are familiar. Total health spending has grown from less than 6 percent of the gross national product (GNP) in 1960 to about 12 percent in 1990. If current trends continue, it will reach 17 percent of GNP by the year 2000. Yet despite the extraordinary amount spent on health care, access to health insurance and health care is uneven. Roughly 16 percent of non-elderly American people have no health insurance at all. An even greater percentage have inadequate access to routine primary and preventive care services.

Real per capita health spending has risen dramatically in the United States, far outpacing that of other major industrialized nations. The cost is a particular concern because U.S. health status is not conspicuously superior, and by some measures, it is clearly inferior to trading partners like Canada, Germany, Great Britain, and Japan, who spend substantially less on health care.

As a result of the failing of the health care system, many of the nation's most vulnerable citizens do not receive the health care they need, especially our children -- the nation's future. In many ways, our youngest citizens are suffering the most. Children are more likely to be uninsured than any other age group, the nation's infant mortality rate lags behind that of twenty other developed nations, only two-thirds of pregnant women receive sufficient prenatal care, and too few preschoolers are fully immunized.

America has become increasingly concerned about losing its competitive advantage in the world marketplace. Historically, health care in the United States has been provided through private insurance funded by employers. Today, spiraling health care costs have placed some U.S. industries at a competitive disadvantage in the international marketplace, and have priced insurance coverage beyond the means of small businesses and individuals.

Clearly, the nation's health care system is in trouble. The system costs too much and provides too little. Moreover, there are increasing questions about the value of what is purchased. Far from a seamless web of services, the "system" is a patchwork of policies, programs, and payors.

Purposeful change is in order.

28.2 The Governors' Goal

The Governors believe the nation needs to have a system that makes health care affordable and available for all Americans. Further, the health care system must have sufficient controls in place to ensure the cost-effective delivery of care. The National Governors' Association shall, as soon as possible, call for a meeting with the President and Congress to begin immediate work with the Governors to achieve this system.

The system should include a continuum of services that begins with education and prevention, includes cost-effective community-based interventions, focuses on the early and routine provision of primary care, provides appropriate acute care services, and accommodates rehabilitative and long-term institutional care. Entry into this system should occur at the most appropriate level for each individual and the services should effectively and efficiently address his or her needs.

28.3 A Strategy for Reform

There is growing consensus on the nature and extent of the health care problems that confront the nation. There is little consensus on the solutions. To forge that consensus, the nation's Governors call for both steps toward a new national framework for the health care system and a period of accelerated and comprehensive state action.

The Governors believe a way to achieve national consensus is to develop comprehensive, statewide health care reforms, including reform efforts by commonwealths and territories, that maximize preventive public health programs and experiment with medical care payment programs to reduce overall medical costs. This will allow the nation to evaluate the results and effectiveness of various approaches to achieving affordable care for all.

States and the federal government should work together and with the private sector, where appropriate, to:

- Accelerate comprehensive, statewide approaches to expanding access and containing costs;
- Overcome the market failures in the health care system;
- Restructure the public programs that support the most vulnerable citizens; and
- Forge a national consensus for a health care system.

28.4 Steps Toward a National Framework

The short-run goal is the implementation of comprehensive state reforms. Ultimately, however, the nation must agree on a system that makes health care affordable and available for all Americans.

28.4.1 **Step 1: Provide the Means to Accelerate Statewide, Comprehensive Solutions.** The nation's Governors recommend that the federal government work with states to facilitate and accelerate the development of comprehensive, statewide reforms to expand access and control costs. Most states have already begun to demonstrate discrete approaches to controlling costs and expanding access to health care. However, only Hawaii currently has a statewide system in place.

Approaches to cost control that states may want to test include:

- Implementing a managed competitive approach that could include strategies such as developing statewide systems for getting price and quality information to consumers; eliminating state-mandated insurance benefits and anti-managed care legislation; and deregulating providers;
- Creating an all-payor system including strategies such as instituting a statewide global budget for the allocation of capital resources and establishing a program to partially subsidize private insurance for unemployed individuals who are not eligible for Medicaid; and
- Instituting uniform electronic billing systems to reduce administrative overhead.

Approaches to expanding access that states may want to try include:

- Building on the current system and instituting a statewide "pay or play" system for expanding access to employees of small businesses;
- Creating a statewide purchasing board to help small businesses purchase basic health insurance for their employees;
- Providing subsidies to small businesses that are purchasing health care insurance for the first time; and
- Expanding the role of community-based primary care providers through programs to recruit and retain health professionals in underserved areas, and to strengthen local community health centers and other sources such as school-linked health care.

Some states may want to pursue policies that address the access needs of specific populations, including:

- Ensuring that all children have access to affordable and adequate insurance coverage and comprehensive health care services;
- Expanding small business insurance coverage; and

- Focusing on the needs of the uninsured populations that are currently below poverty but not eligible for Medicaid.

Most states will want to maximize the preventive health (physical, developmental, and mental) programming in their public health programs to reduce the need for more expensive medical care. Such programs may include immunization, well-child care, nutrition, prenatal care, injury prevention, environmental health, communicable disease programs, early diagnosis and treatment of chronic illness and disability, and special health promotion programs designed to lower the insurance costs for small employers.

Integral to both the state and national approaches is the assumption that the organization and delivery of services should be closest to those who receive services and that any national health care system will still rely on states to organize and administer the delivery of services. Consequently, states are perfect laboratories for testing a wide range of approaches.

Specifically, the federal government should assist states in the following ways.

28.4.1.1 **Modernizing the Federal Approach to Management.** The federal government shall immediately eliminate the requirement for states to submit waivers for enhancing and restructuring their Medicaid programs for services or reimbursement systems that have proven their worth. States desiring to test new approaches should be given the authority through a streamlined process, with the federal partnership emphasis on outcomes and not process. States must be permitted flexibility in administering Medicare, Medicaid, grant programs, and other health funds. This flexibility must be a component in a mutually agreed upon state system that increases access to health care and lowers the administrative costs associated with cumbersome federal requirements. In return, the states agree to be accountable for our performance. For example:

- Revise the present federal audit and disallowance policy to prohibit federal practices that heavily penalize states for violations of obscure federal policy that constitute no harm to patients, and even include cases where federal policy itself is not clear.
- Improve the approach to managed health care, to facilitate the ability of states to enroll Medicaid recipients in systems of coordinated health care.
- Offer as optional services such programs as home- and community-based care for AIDS patients, the handicapped, the elderly, and the developmentally disabled. These programs have been proven effective and should no longer require waivers or other administrative exceptions.
- States that choose to test an all-payor system approach to cost control would need to have the authority to include Medicare funds in their system.
- States that want to use Medicaid resources as the basis of a larger program need the ability to restructure Medicaid within this effort.
- States need the flexibility to shift funds from expensive medical care to cost-effective preventive health programs.
- States struggling to increase access in rural areas may need to have waivers of staffing pattern requirements and facility regulations in rural hospitals.
- States, recognizing that meaningful reforms will require start-up costs, must be able to negotiate waivers that share financial risk with the federal government over an extended period of time.

28.4.1.2 **Coordination.** Streamline federal executive and congressional approval of state waiver requests required for state reform efforts. Expedite permanent status approval for state waivered programs once their effectiveness has been adequately demonstrated.

28.4.1.3 **ERISA.** Provide waivers to override ERISA preemptions -- and clarify conditions through other statutes -- that enable states to increase access to care as part of an approved state approach. For example, states that want to use a "pay or play" system for employers need to be able to ensure that employers who claim ERISA preemption from state law are, in fact, offering health care coverage to their employees. States that want to use a statewide, employer-based reinsurance approach to access for the uninsurable would need a waiver to ensure the participation of all employers in the state.

28.4.1.4 **Investment.** Invest significant funds in statewide reform efforts. This investment, supplemented by the more efficient use of existing resources, would support strategies, including:

- Direct and indirect subsidies to small businesses to assist in purchasing insurance for their employees;
- Data systems and evaluation efforts;
- Tax credits for professionals serving in underserved areas;
- Upgrades in emergency medical service systems;
- Subsidies of infrastructure development in rural areas for telecommunications systems for isolated facilities; and
- Program planning and design.

28.4.2 **Step 2: Overcome Market Failures in the Health Care System.**

28.4.2.1 **Develop a "Critical Decisions" Information Base.** To support a wide array of cost control strategies, the Governors recommend an enhanced federal effort to develop and disseminate health care information.

Specifically, the Governors recommend that the federal government:

- Augment current federal efforts to organize and support biomedical, psychosocial, and developmental research, technology assessment, the effectiveness of alternative medical strategies, and the relationship between medical procedures and health outcomes. This kind of systematic information could assist physicians in establishing acceptable medical practice guidelines and reducing both defensive medicine and medical tort liability.
- Begin to develop benefit guidelines, based on the results of effectiveness and outcomes research and state experience. Benefit guidelines would inform decisions about the range of effective medical services that should be available to all people, and assist in the development of different kinds of cost-effective insurance packages. These benefit guidelines could then apply to self-insured businesses as well as those who insure through a commercial carrier.
- Develop a systematic way to capture and report line-item health care expenditures by state. National baseline information is needed to assess whether efforts to control costs are successful.

28.4.2.2 **Reform the Health Insurance Market.** A number of insurance industry practices seriously impede the ability of small businesses and individuals to find affordable insurance coverage. Most of these practices allow the industry to compete by shifting risk. These practices include the redlining of certain businesses, which precludes them from being eligible to purchase insurance; experience rating, which primarily affects small businesses; medical underwriting, which makes many people with existing medical conditions uninsurable; and enrollment, disenrollment, and reenrollment procedures, which price small businesses out of the market.

Therefore, the Governors will:

- Provide for the establishment of national uniform minimum standards for state health insurance reform. The minimum standards should restrict or prohibit the use of certain rating techniques and factors, assure availability, renewability, and continuity of coverage, and encourage broader and more equitable sharing of risk. These minimum standards should be developed by state officials, including the National Association of Insurance Commissioners (NAIC), in consultation with representatives of affected small businesses, insurers, and consumers. States should adopt and implement legislative or regulatory changes that meet or exceed the minimum standards.

28.4.2.3 **Enhance Opportunities for Primary Care Practice.** The medical education system is not preparing the providers that are needed for a health care system with a focus on preventive and primary care. Therefore, the Governors recommend that the federal government:

- Provide incentives for students and mid-career health professionals to serve in primary care professions, particularly in rural and underserved areas;
- Greatly expand the National Health Service Corps;

- Reorient existing subsidies through the Public Health Service Act and the Social Security Act to give priority to graduate medical education in family practice;
- Expand Public Health Service Act support for graduate training of mid-level health professionals, such as certified nurse-midwives and nurse practitioners; and
- Continue to aggressively pursue physician payment reforms that encourage entry into primary care-related fields.

28.4.2.4 **Undertake Medical Tort Reform.** Reform of the medical tort system should be undertaken with a view toward achieving high-quality and appropriate care. Ideally, the medical tort reform will reduce the cost of defensive medicine and provide appropriate levels of compensation for patients injured by medical negligence.

28.4.3 **Step 3: Restructure the Public Role.** Any national health care system will contain a continued public sector role in the financing and delivery of services to the poor, children, the elderly, and people with disabilities. The Medicaid program is the vehicle currently used to provide such care.

Medicaid, enacted into law as a part of the Social Security Act Amendments of 1965, was originally designed to pay for health care services for Aid to Families with Dependent Children (AFDC)-eligible women and children and to the aged, blind, and disabled covered by federal Supplemental Security Income (SSI).

Today, Medicaid struggles to serve a widely diverse population with a broad array of services. It has become not only impossible to effectively administer, but also prohibitively expensive.

The Governors believe that the Medicaid system is broken. It has become a rigid and overly complex program. Its institutional bias prevents states from providing preventive and primary care in settings most appropriate for its clients, and eligibility for the program is dominated by arcane rules that penalize clients, providers, and administrators.

Therefore, the Governors envision a long-term strategy that would use public resources in a more efficient and effective manner than is currently possible through Medicaid.

28.4.3.1 **The Long-Term Vision.**

The Elderly and People with Disabilities: There is general recognition that the needs of the elderly and people with disabilities go beyond health care and include a social service component and long-term care. The Governors believe that the elderly and people with disabilities must have access to medical and other appropriate services they need to enhance quality of life and prevent unnecessary institutionalization.

The program should provide a continuum of services ranging from basic preventive and primary care to rehabilitative, maintenance, social support, and other long-term care services, and be fully integrated with other programs that provide services to the elderly and people with disabilities.

The Social Security/Medicare programs provide the obvious framework for such a program. However, serious attention must be paid to the programmatic, service, and financing implications of such a substantial change.

Public Program for Low-Income People: Existing Medicaid resources should be used to fund a new public program to provide health care for individuals with incomes below a certain level of poverty and/or individuals who do not receive health insurance through their employment. This new public program should be designed to specifically address the health care needs of the non-disabled population from birth through age sixty-four.

The program should:

- Provide for eligibility based solely on income, and not be tied to welfare or AFDC;
- In establishing income eligibility levels, recognize economic variations among states, such as per capita personal income and cost of living, instead of using a uniform national standard such as the federal poverty income level;
- Include a service package of preventive, primary, and acute care services;
- Be managed at the state level and freed from unnecessary and cumbersome administrative constraints so that states can integrate the program into other state delivery systems;
- Emphasize the use of managed care;

- Reinvest funds saved from the transfer of program responsibility for the elderly and disabled into expanded eligibility for the public program;
- Be closely coordinated with other public health and social service programs so that the range of services needed by the eligible population are more readily available and accessible; and
- Include outreach strategies to assist in bringing hard-to-reach populations into care.

Congress, the administration, and the Governors should form a working group to examine the feasibility and desirability of moving toward a national system of comprehensive services for the elderly and people with disabilities. This working group should include in its charge an examination of financing options, taking into account the private insurance market and individual responsibility.

The working group should also undertake an examination of the establishment of eligibility criteria, a service package, and a financing mechanism for the public program for low-income people.

28.4.3.2 **Short-Term Realities and Recommendations.** Financing is the major obstacle to achieving consensus on the best long-term use of current Medicaid resources. The options, therefore, are for each side to try to shift a disproportionate burden to the other or to work cooperatively to develop a way to achieve a rational system over time.

Therefore, in the short term, the Governors make the following recommendations.

- Until newly structured public programs are in place, states should be allowed to maintain their complete authority to raise funds to match federal Medicaid dollars without restriction from the federal government.
- As a first step toward creating a comprehensive program of health care for the elderly, all qualified Medicare beneficiaries (QMBs) should be fully covered under Medicare.
- States should be allowed wide latitude in creative uses of the existing Medicaid program in the context of an approved state health care reform prototype.
- The federal government should encourage increased access in Medicaid through state reform strategies rather than new mandates. Medicaid mandates are the result of a health system that is fragmented and additional mandates only further fragment the system.
- Commonwealths and territories, whose Medicaid funds and FMAP are currently capped, should be included in these strategies to the extent their fiscal condition allows them to participate in the new public program.
- States should share in the savings resulting from innovative approaches to the delivery and financing of health care.
- Repeal the so-called Boren amendment.

28.4.3.3 **Catastrophic Coverage.** There are millions of Americans who have health insurance but still face catastrophic out-of-pocket health costs -- typically considered to be more than 10 percent of a person's income. This includes low-income people, as well as those who need services not covered by or exceeding the coverage limits of their insurance.

Therefore, the Governors recommend further study on the efficacy of establishing a national catastrophic program.

28.4.4 **Step 4: Evaluation and Accountability.** The Governors realize that there is a need to develop more information on the effects of the comprehensive reforms they undertake. They also realize that states that initiate comprehensive reforms will need considerable flexibility of existing programs balanced by mutually agreeable accountability. The Governors believe that the evaluation and information dissemination necessary for these should be a joint federal-state activity.

28.5 A Call to Action

Building a health care system that truly enhances health will require a strong federal-state partnership. The Governors are committed to meeting the challenge of reforming the health care system. States are uniquely positioned to demonstrate the ways in which this goal can be achieved.

To build the experience needed to develop an informed national consensus, the federal government should help states demonstrate different approaches to achieve universal access to affordable health care. The states should demonstrate and evaluate creative, comprehensive approaches to health care reform in both the public and private sectors. The results of these prototypes will inform the debate on a national strategy.

The nation's leaders must act now. The health of a nation and its people is at stake.

Adopted August 1991.

DONATED FUNDS , DEDICATED TAXES, AND INTERGOVERNMENTAL TRANSFERS

The nation's Governors call upon Congress and the Administration to protect state revenue raising authority to match federal Medicaid funds.

States currently use donated funds, dedicated taxes, and intergovernmental transfers to achieve the historic purpose of the Medicaid program. The funds enable states to expand access to pregnant women and children, to increase payments to hospitals that serve a disproportionate number of poor patients, and to meet federal Medicaid mandates to both additional populations and services.

Currently, Medicaid is a vital program that serves nearly 27 million low-income people -- half of whom are children. The U.S. Department of Health and Human Services' interim final regulations would force states to make dramatic cuts to Medicaid, education or other services, or raise additional taxes.

State options for financing Medicaid costs are limited. In the current economic climate, with enacted state budgets cut by $8 billion and state taxes increased by $10.3 billion, Governors must retain the right to receive matching federal payments for funds raised through donations, dedicated taxes, and intergovernmental transfers.

Furthermore, states have the constitutional authority to determine state taxing policy. The proposed regulations violate that authorization and contradict current Medicaid statute and regulation.

Nationally, health care inflation is increasing at a rate twice that of general inflation. Medicaid cost growth is reflective of the systemic problems in our nation's health care system. The Governors believe strongly that Medicaid budgetary problems can only be solved in the context of comprehensive health care reform.

Therefore, the Governors call upon the Administration and Congress to rescind the interim final regulation and to protect states' use of donations, dedicated taxes, and intergovernmental transfers to continue to fund their Medicaid programs. Further, the Governors call upon the Office of Management and Budget to stop publishing regulations contrary to the law and intent of Congress.

* based upon Policies C-27 and C-28

Key components that form the basis for the NGA policy.

* Individuals have the ability and responsibility to determine their health status through their lifestyle choices.

* Too many Americans lack adequate health care. Young children in particular need access to primary and routine care to assist in their school preparedness.

* Although there is consensus on the problems related to health care in America, there is no consensus on the solution.

* To craft a solution to the health care reform, numerous demonstration projects need to be planned, implemented, and evaluated before a national solution can be crafted.

* Solving the health care dilemma will require a true partnership between states, Congress, the Administration, health care providers, and private industry.

Three specific areas of the NGA policy speak to the need to work in partnership with Congress and the Administration, state demonstration, restructuring the public role, and cost containment/financing.

STATE DEMONSTRATION:

NGA Policy:

The Governors believe a way to achieve national consensus is to develop comprehensive, statewide health care reforms, including reform efforts by commonwealths and territories, that maximize preventive public health programs and experiment with medical care payment programs to reduce overall medical costs. This will allow the nation to evaluate the results and effectiveness of various approaches to achieving affordable care for all.

States and the federal government should work together and with the private sector, where appropriate, to:

* Accelerate comprehensive, statewide approaches to expanding access and contain costs;

* Overcome the market failures in the health care system;

* Restructure the public programs that support the most vulnerable citizens; and

* Forge a national consensus for a health care system.

Steps States Can Take To Encourage Demonstration:

* Eliminate state-mandated insurance benefits. -- Many states have legislated over the years a lengthy list on health services that insurers must include in their coverage. Examples include: invitrofertilization and hair transplants.

* Work to ensure anti-managed care legislation is not passed in the Statehouses. Many states, including Delaware, have been solicited by health care providers (primarily dentists, social workers and psychiatrists) to pass anti-HMO legislation. Since managed care is one of the only delivery systems that has shown significant cost containment, it is not in our best interest to allow this restrictive legislation.

* Assist in deregulating providers. Physicians and other health care providers are currently precluded from discussing costs of their care among themselves. Implemented as a strategy to prevent price fixing, the regulation also does not permit physicians and providers to work together to determine appropriate costs.

Steps Congress Can Take to Encourage State Demonstration:

* Create a new waiver process that reflects a true state/federal partnership. Existing waiver authority is too cumbersome and has significant restraints that deter demonstration and experimentation. Home and Community based waivers and managed care waivers require cost savings or budget neutrality in the first year and the waiver approval is only good for two or three years.

States would like to be able to go to Congress and ask for a five year waiver. We don't want to be limited to cost savings or budget neutrality in any one year. However, we are willing to agree to specific outcomes over five years, including cost neutrality and/or cost savings, but we need the flexibility of time to show the positive results that we all seek. In addition, states interested in comprehensive reform should be allowed to include Medicaid and Medicare, ERISA preemptions and other health related federal grant programs in one application that goes through one review process. Currently, each funding program requires a separate waiver and review process.

Attached are projects in the planning stage in South Dakota, Hawaii, and Florida that require extensive waiver authority. Attached are state projects that will require extensive waiver authority.

* Begin to develop benefit guidelines, based on the results of effectiveness and outcomes research and state experience. These guidelines would become the basis for determining which health services have the most important impact on health status and could serve as the basis for developing cost-effective insurance packages.

RESTRUCTURING THE PUBLIC ROLE:

NGA Policy:

Any national health care system will contain a continued public sector role in the financing and delivery of services to the poor, children, the elderly and people with disabilities. The Medicaid program is the current vehicle used to provide such care.

The Elderly and People with Disabilities: There is a general recognition that the needs of the elderly and people with disabilities go beyond health care and include a social service component and long-term care. The Governors believe that the elderly and people with disabilities must have access to medical and other appropriate services they need to enhance quality of life and prevent unnecessary institutionalization.

The program should provide a continuum of services ranging from basic preventive and primary care to rehabilitative, maintenance, social support and other long-term care services, and be fully integrated with other programs that provide services to the elderly and people with disabilities.

The Social Security/Medicare programs provide the obvious framework for such a program. However, serious attention must be paid to the programmatic, service and financing implications of such a substantial change.

Public Program for Low-Income People: Existing Medicaid resources should be used to fund a new public program to provide health care for individuals with incomes below a certain level of poverty and/or individuals who do not receive health insurance through their employment. This new public program should be designed to specifically address the health care needs of the non-disabled population form birth through age sixty-four.

Steps States Can Take To Encourage Changes In The Public Program:

* Implement broad-based state demonstrations that will provide increased access for the low-income population.

* Work with Congress and the Administration to develop a financing mechanism that supports long-term care for the elderly and disabled.

Steps Congress Can Take To Reshape The Public Program:

* Support state waiver requests that will increase access for the low-income population.

* Work with the Administration and states to develop a strategy for funding long-term care for the elderly and disabled. Neither the states nor the federal government has the financial resources to pay for the growing numbers of individuals that require long-term care. It is essential that we develop and support a funding mechanism that individuals contribute to over their lifetime, like Social Security, that will pay for this cost.

COST CONTAINMENT:

NGA Policy:

The cost statistics are familiar. Total health spending has grown from less than 6% of the gross national product in 1960 to about 12% in 1990. If current trends continue, it will reach 17% of GNP by the year 2000. Yet despite the extraordinary amount spent on health care, access to health insurance and health care is uneven. Roughly 16% of non-elderly Americans have no health care at all. An even greater percentage have inadequate access to routine primary and preventive care services.

Strategies to reduce the cost of health care without jeopardizing the quality of care:

* Reduce Administrative costs;
* Implement Tort Reform;
* Reign in prescription drug costs;
* Use paraprofessionals where possible;
* Limit access to expensive technology;
* Limit access to medical specialists.

MEDICAL FINANCING

NGA Policy:

Until newly structured public programs are in place, states should be allowed to maintain their complete authority to raise funds to match federal Medicaid dollars without restriction from the federal government.

OBRA'90 extended the option to states to continue using voluntary donations to match federal Medicaid dollars to fund Medicaid mandates and expanded health care services. It also restated a state's right to impose provider based taxes to serve as the state match for federal Medicaid funding. Recent HCFA regulations severly hamper a state's ability to secure funding for federal Medicaid match. While a small number of states may have gone beyond the intent for the use of voluntary donations, prohibiting all donations will have the unintended effect of eliminating the charitable contributions from organizations like Easter Seals that have for years been used to provide services for eligible populations. In addition, restraining a state's right to use provider taxes as a match for federal Medicaid dollars infringes on our state's right to tax.

Unfortunately, the increasing number of Medicaid mandates have made it difficult for states to find the state match rate without increasing their revenue. While everyone would like to assure access to health care for our low income populations, it would be better implemented as a state option rather than a mandate.

Building a health care system that truly improves access to health care while maintaining quality and containing costs will require a strong federal-state partnership and commitment. The governors are ready to meet the challenge of reforming the health care system.

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Possible Exceptions for Health Care Reform: Washington State

The state of Washington is contemplating major reform of its health care system in the upcoming legislative session. Most of this reform may be done entirely by the state under its own jurisdiction and powers. There are, however, a number of issues that will be less successful, liable to legal challenge, or impossible without federal cooperation.

The complete agenda for health care reform is not yet completed. There are a number of highly probable proposals that need highlighting.

1. "Pay or Play:" As a mechanism to increase coverage for employed people, a pay or play proposal may be forthcoming. While no similar program has been implemented and the outocme of a legal challenge is unknown, it is clear that a challenge will be made to this program if it is instituted. Given the uncertainty of the situation due to ERISA, clarification is necessary.

   This clarification may be accomplished either by making a specific exemption from the ERISA statute or by establishing a special legal status for state reform efforts that include pay or play provisions.

2. Medicare: A cost containment mechanism, such as an all-payer mechanism, will require the participation of Medicare. It will need to include both in- and out-patient services. It may be a combination of both RBRVS and DRG's as well as a uniform utilization management program (both price and volume). Assurances to access would be part of this exception.

   Also, we are developing plans to simplify the administrative structure in our system. Medicare should be part of that simplification and standardization.

3. Medicaid: The reform could proceed with the current Medicaid program, but it would be greatly enhanced by a reform of the Medicaid program along the lines of the policy adopted by the NGA in August 1991.

   Specifically, to more completely fill the gaps in the current system, Medicaid would be melded into a broader public program that would provide coverage for all poor and near poor individuals, and small businesses that are without access. Poor people would receive services with little or no cost. There would be a sliding scale for those above poverty. Categorical limits would be removed and the program would be delinked from Welfare.

New Jersey

The developing strategy to reform health care financing and delivery includes two components that need federal legislative support in order to be successful. First the State is interested in making major expansions of its home- and community-based service delivery system for the elderly and disabled. Current Medicaid waiver authority is too restrictive, especially with respect to budget neutrality on a year by year basis and with respect to the numbers of persons who can be served. New Jersey also needs an exemption from the ERISA preemption of state insurance regulation in order to implement comprehensive health insurance reform to improve the availability of affordable health insurance.

Florida

In order to implement comprehensive reform, the state needs federal statutory changes to allow waiver of current federal statutes. Current waiver authority available for Medicare and Medicaid are not sufficient. Current waiver authority is too restrictive, fragmented, procedurally cumbersome, and unstable.

Specifically:

- An exemption from the current ERISA preemption is needed to allow the state to regulate all insurers and ensure the participation of all employers in comprehensive reform.

- An exemption from the threat of lawsuits on payment and utilization review of providers similar to Medicare.

- Waiver of Medicare and Medicaid rules and regulations to allow the implementation of a single claims payment system to reduce administrative costs for all purchasers.

- Changes to current Medicaid "Freedom of Choice" waiver authority to allow the state greater opportunity to implement managed care programs.

- Waiver of Medicare rules to allow the state to include Medicare participation in hospital cost control initiatives.

- Additional federal financial assistance needed for the state to maintain Medicaid at the current levels required by federal law by enhancing federal payments for Medicaid cost increases above increases in state revenue.

- Additional federal matching payments to allow the state to add non-categorical eligibles to its Medicaid program.

Hawaii

The attached materials show the accomplishments made by the State of Hawaii in reforming its health care financing and delivery system and suggests in general terms proposed policy changes that will require federal support.

There are other proposal under consideration that can only be accomplished through amendments to the ERISA language that pertains to Hawaii's exemption from the ERISA preemption. ERISA was enacted in 1974. The provisions relating to Hawaii have not been amended, though there have been massive changes in health care costs and delivery systems.

For example, Hawaii's ERISA exemption applies only to employees, not dependents. Expanding the exemption to cover dependents would allow Hawaii much more flexibility in making health insurance available to children.

Second, employers in Hawaii can impose only very limited cost sharing requirements on employees -- 1.5% of income. While this protects low income workers it may be inequitable for high income workers and employers. Amending this provision would allow the state to consider more equitable costs-sharing while maintaining protections for low-income workers.

Separate from ERISA, Hawaii is considering a long term care financing strategy that would involve establishing a program for people to contribute to an account that would be used to pay for their long term care expenses. Federal support that would make this type of program viable include: allowing interest from these accounts to be exempt from federal tax; and, providing funds to assist the state in establishing and implementing the program. A program of this type could save state and federal Medicaid dollars in the long run.

South Dakota

A main priority for South Dakota is to maintain and improve access to primary care in rural areas. South Dakota's rural health care delivery system would benefit from the following type of authority to waive Medicare statute and regulations.

Alternative models of care are being explored within the state to keep a level of primary care available with an community or region. For many South Dakota hospitals, the EACH/PCH grant program offered by HCFA as a way to maintain access to health care services may not be located close enough to a PCH facility to form a rural health network required as a condition of participation to be an EACH/PCH.

Rural hospitals would instead benefit from the development of a different, flexible category which could waive staffing, facility or other inpatient care requirements allowing a rural hospital to transition into an alternative delivery model without sacrificing Medicare reimbursement as part of the transition.

COMPREHENSIVE HEALTH REFORM: A FEW INTRODUCTORY OBSERVATIONS

(1) The Administration has advanced initiatives to: increase prevention and personal responsibility; reduce infant mortality; reduce subsidies for the rich; reform malpractice; increase R&D; limit overpriced fees; reduce fraud; and encourage experimentation by States. Yet, valuable though these initiatives be, they do not fully address the "access" and "cost" problems.

(2) There are several proposals for small group market reform (Appendix 1). These could address a significant portion of the "access" problem.

(3) But small group market reforms do not amount to "comprehensive" reform. To meet the political system's current definition of "comprehensive", a plan seems to have to: (a) provide access to affordable health insurance coverage for all (or almost all) Americans; and (b) control the growth of health costs.

(4) There is need to address the cost issue -- even without the "access" issue. (See Darman, Senate Finance Testimony, 4/16/91.)

(5) But the political system seems to be enforcing a political bargain upon itself: trading cost control for access and vice-versa. As a practical matter, all comprehensive plans buy otherwise unpopular disciplinary measures with increased access, and pay for increased access (at least partly) with increased disciplinary measures.

(6) In thinking about "comprehensive reform," there are literally thousands of complex technical issues. But before getting to those, there are two rather basic quasi-philosophical issues that should be addressed:

(a) In financing increased "access," who should bear the burden of financial responsibility for:

- the poor (now a combination of: charity, cross-subsidy, States, and Feds);
- those employed who are not now offered affordable insurance (now principally: charity and family resources);
- the aged (now principally Medicare, regardless of income);
- those in need of long-term care (now principally: families and State-Federal Medicaid).

NOTE: Few plans start from (or end up with) a particularly coherent set of answers to this question.

(b) In seeking to control costs, does one wish to rely more upon:

- o governmental budgetary caps (Canada, Europe, Russo et al., Medicare physicians payment system);
- o expanded direct regulation (Medicare, Democrats, many States);
- o incentives or requirements for "managed care" (HMOs, PPOs, etc.); and/or
- o increased consumer choice in the context of:
  - -- greater cost-sharing; and/or
  - -- greater involvement in plan selection in a competitive marketplace.

NOTE: The specific answers to these questions will tend to determine the character (or existence) of the role for private doctors, providers, and insurers. They will also determine who will do the "rationing" and how.

(7) Addressing the "access" problem inescapably means shifting tens of billions of dollars (per year) of health care financing. It is important to note: the total cost to the government [or even to the system as a whole] does not necessarily have to go up [by much]. Under most plans, however, it would likely go up substantially. What happens to both the distribution of the financial burden -- and to the total -- depends upon answers to the philosophical questions noted above, and the selection of financing options from among those listed at Attachment 1, "Generic Financing and Savings Options."

(8) Proposals to finance universal access via savings in "administrative costs" generally come up way short. (See Appendix 2, "Administrative Costs and Savings.") The more substantial "administrative cost" saving proposals involve eliminating (or substantially displacing) the private insurance industry. They thus raise practical and ideological issues that go far beyond "administrative efficiency."

(9) Although there is an abundance of comprehensive reform plans, most plans have serious problems -- even without taking basic ideological issues into account. For example:

- o The Russo plan (by its own account) raises business taxes by $23 billion per year; raises the top corporate rate from 34 to 38%; raises personal income taxes by $12 billion per year; raises the top personal rate to 38%. At that, it still comes up short by more than $100 billion per year (preliminary OMB estimate) unless one assumes equivalent savings from reduced reimbursement to providers.

- The Mitchell plan relies on an "RFK Stadium" approach to uniform rate-setting -- a cumbersome, unworkable, approach to national price controls. It also involves an unpredictable, unstable, and therefore unworkable floating employer tax.

- The pure form of refundable tax-credit plans involve difficult problems of risk segmentation.

- And so on . . . . (See Appendix 3.)

(10) Before refining details, it is probably wise to settle on one of the 3 basic conceptual alternatives for comprehensive reform: "Play-or-pay" vs. "Canadian-style" vs. "Pro-competitive." To assist in assessing this basic choice, see Attachment 2, "Comprehensive Health Plans: Major Conceptual Alternatives."

Attachment 1: Generic Financing and Savings Options

Attachment 2: Comprehensive Health Plans: Major Conceptual Alternatives

Appendix 1: Small Group Market Reform Proposals

Appendix 2: Administrative Costs and Savings

Appendix 3: Comprehensive Reform Plans

GENERIC FINANCING AND "SAVINGS" OPTIONS AVAILABLE TO FUND POSSIBLE "ACCESS" INITIATIVES

(1) Reduce defensive medicine and malpractice insurance costs via enactment of malpractice reform.

(2) Reduce utilization via:

- (a) improved prevention strategies;
- (b) greater co-insurance; and/or
- (c) increased "managed care"; and/or
- (d) greater use of practice guidelines and more efficient protocols; and/or
- (e) [aggregate expenditure caps].

(3) Stop Medicaid abuses by, e.g.:

- (a) ending states' donor-and-tax "match" scams;
- (b) ending spend-down avoidance schemes.

(4) Reduce prices (or price growth) for service delivery by:

- (a) tightening reimbursement schedules/systems; and/or [expanding aggregate expenditure caps];
- (b) encouraging superior operations research techniques (via incentives and/or requirements);
- (c) increasing competitive discipline; and/or
- (d) reducing administrative burdens and/or functions.

(5) Via small group market reforms, reduce the cost of insurance for (and thereby increase premium payments by) small business employees/employers who do not now have affordable options.

(6) Cap or eliminate the tax deduction/exclusion for premium payments.

(7) Recapture windfalls from any new access system that would otherwise accrue to:

- o state and local government;
- o insured low income workers and/or their employers;
- o hospitals and doctors.

(8) Means test Medicare (or "reduce subsidy for the rich"); and/or [phase in eligibility-at-67 for Medicare -- to parallel Social Security.].

(9) [Other -- Note: Democrats tend to raise employer taxes (for pay-or-play); raise HI wage base (above $125,000 annual income); establish an individual and corporate "universal health coverage surtax" (as in Rosty); and/or increase corporate and personal income tax rates (as in Russo).]

COMPREHENSIVE HEALTH PLANS: MAJOR CONCEPTUAL ALTERNATIVES

PLAN/CHARACTERISTIC:	"PLAY-OR-PAY"	"CANADIAN"	PRO-COMPETITIVE
Access for All (including poor)	Yes	Yes	Yes (w. individual mandate and **sufficient financing***)
Net New Mandated Employer Spending or Employer Tax	**Yes***	No (serious adaptation issues -- **Yes*** w. Russo)	No
Comprehensive Governmental Price Regulation	Yes (in Mitchell and Rosty Plans)	Yes	No
Continued Major Role for Private Insurance Companies	Yes	**No***	Yes
Income Tax Exclusion for Employer-paid Premiums (or tax equivalent)	Unlimited	Unlimited	**Capped or Eliminated***
Refundable Tax Credit for Low Income (to cover health insurance)	No	No	Yes
Treatment of Small Business	**Play-or-Pay* (w. credits)**	Universal plan (some new pay)	tax benefit equalization; [and regulatory reforms; market pooling]
Treatment of Medicaid [NOTE: Medicare is generally left alone.]	Replaced w. new program (for all not in "play")	Replaced by single universal plan	Replaced, either immediately or over time
"States as Laboratories"	No	No	Possible
Consumer Choice	Medium	Low	Higher
Governmental "Rationing" Potential	Low (could grow)	**High***	Low

* Politically sensitive (negative)

Summary of Small Group Market Reform Proposals*

	1. H.R. 1565 (Johnson)	2. S. 700 (Durenberger)	3. S. 1227 (Mitchell)	(H.R. 3205) Rostenkowski	5. Enthoven
Implementation	Federal preemption unless state meets Federal std. Federal regulation enforced thru tax code. NAIC to have opportunity to develop regulations.	Federal preemption unless state applies for waiver to operate its own program.	Federal preemption unless state meets Federal standard. Federal regulation enforced thru civil penalties and Federal excise tax.	Federal preemption unless state meets Federal stds. Fed. regulation enforced thru excise tax. Small employer carriers must register with the Secretary	Health benefit tax subsidy for small business workers, would be available only for coverage purchased thru an accredited Health Insurance Purchasing Corp.
Guaranteed Issue (must cover all groups & not exclude any member)	Yes	Yes	Yes	Yes	Yes, for coverage purchased thru a HIPC.
Guaranteed Renewability	Yes	Yes	Yes	Yes	Yes, for coverage purchased thru a HIPC.
Exclusions for Preexisting Conditions	Limited	Limited	Limited	Limited	None allowed.
Limits on Premiums					
Across blocks of business	Premiums may not differ by more than 20%.	Same as (1)	Same as (1)	No variation allowed.	Not specifically addressed.
Across demographic (age/sex) categories	Unlimited variation permitted.	Same as (1)	Premiums may vary by up to 10%	Premiums may vary by up to 33%	Unlimited variation permitted.
Within demographic categories	Premiums may not vary by more than ±25% from midpoint.	Premiums may not vary by more than ±20% from midpoint.	After phase-in, no variation in premiums allowed	No variation allowed within demographic categories.	No variation allowed within demographic categories.
Limit on premium increases	To be established by NAIC	% increase for new business plus adjustment for change in benefits	Selective rate increases based on group experience would be prohibited.	Renewal rates must be the same as that for a new issue.	n/a
Enforcement	Actuarial certification. Monitoring by state insurance commissioner.	Same as (1).	Same as (1)	Actuarial certification.	HIPCs would monitor insurers compliance with contract terms.
Reinsurance	States can design their own system. Federal back-up provided.	Not addressed.	Encouraged, but not required.	Not addressed.	n/a
Core Benefit Plan	Covers hospital, physician & preventive services. Scope can be modified.	Covers hospital, physician, diagnostic, ambulance, prenatal & DME services.	Covers hospital, physician, diagnostic, preventive & mental health.	Covers all Medicare services including: hospital, physician, diagnostic, preventative & mental health.	Basic coverage
Other	Employers must offer basic coverage but needn't pay. Prohibits mandated benefits & restrictions on selective contracting.		After phase-in, employers must provide minimum benefits or pay tax. Subsidies provided to assist small business with costs.		A HIPC is a non-profit corporation controlled by small business members for group purchasing of health insurance. States would certify one (or more) per area.

* The Heritage and AEI/Pauly proposals are not included in this table because of their different approach to market reform.

Total Administrative Costs, Administrative Savings, and Added Benefit Costs

(Preliminary Staff Estimates, in billions of 1991 $)

	U. S. Current		Adopt Canada		OMB Staff Estimates		
	GAO	OMB Staff Estimate	GAO	OMB Staff Estimate	Russo	Kerrey	Mitchell
Current Administrative Costs							
Insurance Administrative Costs	$43	$39	$9	$9 - $22	$9 - $22	$25 - $30	$30-$35
% of National Health Expenditures	5.8%	5.3%	1.2%	1.2 - 3.0%	1.2 - 3.0%	3.4 - 4.1%	4.1 - 4.8%
Hospital Administrative Costs	$43	$37	$25	$23 - $26	$23 - $26	$28-$33	$30-$35
% of National Health Expenditures	5.8%	5.0%	3.4%	3.1 - 3.5%	3.1 - 3.5%	3.8 - 4.5%	4.1 - 4.8%
% of Total Hospital Spending	15.1%	12.9%	8.7%	8.0%-9.1%	8.0%-9.1%	9.8 - 11.5%	10.5 - 12.2%
Physician Practice Expenses	$70	$75	$55	$70 - $72	$70 - $72	$70-$72	$71-73
% of National Health Expenditures	9.5%	10.2%	7.5%	9.5 - 9.8%	9.5 - 9.8%	9.5 - 9.8%	9.6% - 9.9%
% of Total Physician Spending	47.1%	50.5%	37.0%	47.1 - 48.5%	47.1 - 48.5%	47.1 - 48.5%	47.8 - 49.2%
Total Administrative Costs	$156	$151	$89	$102 - $120	$102 - $120	$123 - $135	$131-$143
Administrative Savings	---	---	$67	$31 - $49	$31 - $49	$16 - $28	$8-$20
New Administrative and Benefit Costs							
Administrative Costs for Newly Covered	---	---	($2)	($4)	($4)	($4)	($15)
Benefit Costs for Expanded Coverage							
Newly Insured	---	---	($17)	($12-$20)	($12-$20)	($12-$20)	($12-$20)
Currently Insured Utilization Adjustment	---	---	($45)	($40-$90)	($100-$160)	($40-$70)	($0-$5)
Net Savings/(Costs)	---	---	$3	($7-$83)	($67-$153)	($28-$78)	($7-$32)
Financing Costs and Gap							
Financing Needed	---	---	$0	($7-$83)	($67-$153)	($28-$78)	($7-$32)
Financing Provided	---	---	$0	$0	($40)	($29)	$0
Loss of Tax Revenue from Insurers	---	---	$0	($2-$4)	($2-$4)	$0	$0
Financing Gap	---	---	$0	($9-$87)	($109-$197)	($57-$107)	($7-$32)

Notes:

(1) Plans vary: only Mitchell and Kerrey retain patient cost sharing; only Russo and Kerrey cover long term care and prescription drugs; only Russo covers vision and dental care; and Canada has no cost sharing, does not cover long term care or prescription drugs, and provider payment rates are significantly lower than current U.S. rates.

(2) To realize administrative savings, provider payments must be reduced by amounts identified.

(3) Financing gap to be closed by additional reductions in provider payments, new or higher taxes, or increased premiums.

30-Sep-91

Summary of Comprehensive Health Reform Proposals Now Being Debated

	Heritage	AEI/Pauly	Enthoven (3/91 Draft)	H.R. 1565 (Johnson)
General Approach	Pro-competitive	Pro-competitive	Tax cap with employer mandate	Tax cap w/ small group reform
Cost Containment				
Cost-Sharing	Higher cost sharing encouraged thru tax policy.	Higher cost sharing encouraged thru tax policy.	Higher cost sharing encouraged thru tax policy.	"Safe harbor" for 30% overall cost sharing.
Managed Care	Managed care encouraged thru tax policy.	Managed care encouraged thru tax policy.	Managed care encouraged thru tax policy.	"Safe harbor" for "managed care" plans.
Limit Tax Subsidy for Employer Paid Health Benefits	Replaces exclusion with refundable tax credit for individuals & families.	Replaces exclusion with refundable tax credit for individuals & families.	Caps exclusion for all workers at lowest priced plan provided thru small employer purchasing group. For small businesses, income exclusion is available only if coverage is obtained thru small employer group.	25% tax penalty for employer if employer share of premium is greater than $160/$300 a month unless (i) 30% cost sharing or (ii) managed care.
Price Regulation	No	No	No new regulation	No new regulation
Supply Regulation	No	No	No	No
Other	No	No	Preempt state mandates for insurance purchased thru small employer group.	Preempt state mandates for small business; insurers must offer a basic coverage plan. Preempts state "anti-managed care" laws.
Access				
Scope of Coverage	Universal	Universal	Near universal	Expands, not universal
Benefits	Catastrophic coverage w/ high deductible	Basic w/ income related out-of-pocket cap	Basic	Basic
Medicaid Expansion / Buy-In	Retains Medicaid with expansion and buy-in.	Replaces Medicaid with private coverage thru tax credit.	Thru small employer purchasing group w/ sliding scale premiums.	No
Tax Credits and Subsidies	Tax credit varies as percent of actual premium cost.	Tax credit varies by income and health risk.	Special tax credit for small employer premiums in excess of 8% of payroll.	Increases premium deduction for self employed to 100%.
Individual Mandate	Yes	Yes	No	No
Employer Mandate	No	No	Yes, play or pay mandate	Employer must offer coverage, but not required to pay.
Universal Public Insurance	No	No	No	No
Who Pays				
Government / Financing	Repeal of income exclusion for health benefits & other funding.	Repeal of income exclusion for health benefits & other funding.	Cap on income exclusion for health benefits & other funding.	Financing not specified
Employers	Voluntary	Voluntary	80% of tax cap amount	
Individuals	Difference between premium and credit.	Difference between premium and credit.	Excess above employer contribution.	
Small Employer Market	Not specifically addressed.	Replaces private insurance cross subsidies with health-risk adjusted tax credit.	Small employer purchasing groups &"community" rating.	State must implement "market reforms" or Federal preemption
Quality	Not specifically addressed.	Not specifically addressed.	Health plans must gather outcomes data.	Requires outcomes data for hospitals.

"Basic" coverage generally includes hospital, physician, and diagnostic services. $---/$-- refers to individual/family coverage.

09/27/91

Summary of Comprehensive Health Reform Proposals Now Being Debated

	H.R. 1300 (Russo)	S. 1446 (Kerrey)	S. 1227 (Mitchell)	H.R. 3205 Rostenkowski
General Approach	Canadian-style	Canadian-style	Play or pay w/ rate setting	Play or pay w/ rate setting
Cost Containment				
Cost-Sharing	None allowed.	Maximum: $100 /$300 deductible; $5 co-pay first physician visit; coinsurance not to exceed 20%; $1000 /$2000 cap.	Maximum permitted: $250/$500 deductible; 20% coinsurance; $3000 cap.	Maximum permitted: $250/$500 deductible; 20 %coinsurance; $2500 /$3000 cap.
Managed Care	HMO option	HMO option	Weak incentives	Weak incentives
Limit Tax Subsidy for Employer Paid Health Benefits	Not Applicable	Not Applicable	No	No
Price Regulation	Total health care spending limited by National Budget. Global budgets for hospitals, physicians and other services.	Total health care spending limited by State and National Budgets. Global budgets for hospitals. Negotiated Fee Schedules.	Federal Health Expenditure Board to set national spending goals. Provider/Payer negotiations to set payment rates consistent with Board's spending goals.	National health care spending limits. Health Care Cost Containment Comm. to negotiate prices with health care providers. Medicare-like ceilings for provider payment rates.
Supply Regulation	Separate capital budgets	Separate state capital accounts	State level capital budget option	National capital budget.
Access				
Scope of Coverage	Universal	Universal	Near-Universal	Near-Universal
Benefits	B, P, M, LTC, Rx, D, V	B, P, M,LTC, Rx	B, P, M	B, P, M, LTC
Medicaid Expansion / Buy-In	Replaces Medicaid with universal program.	Replace Medicaid with universal Health USA program.	Replaces Medicaid with AmeriCare; sliding-scale premium.	Replaces Medicaid with Public plan; sliding scale premium.
Tax Credits and Subsidies	LTC premium subsidized for low-income senior citizens.		Subsidy for low-income workers to help pay employee premium share.	Premium, coinsurance, and deductible subsidy for low-income individuals
Individual Mandate	No	No	No	No
Employer Mandate	No	No	Yes	Yes
Universal Public Insurance	Yes - Federal Program	Yes - State/Federal Program	No	No
Who Pays				
Government / Financing	Financing from new federal income and corporate taxes. Continued State participation.	Federal grant to each State -- ranges between 82% and 92% of State expenditures. New taxes.	"Play or pay" tax and continued state effort -- other financing needed but not specified.	"Play or pay" tax, income surtax, individual premiums/cost-sharing, and continued State effort.
Employers	HI payroll tax rate increased to 6%. Corporate taxes increased to 38%.	Employer payroll tax of 4% of wages > $30K. Add' l tax equal to 50% of the amount employer paid for retiree health coverage. Corporate tax increased to 44%.	Play or pay payroll tax (delayed implementation for firms w/ < 25 workers). Credit of 25% of premiums for firms w/ < 60 workers.	Play or pay payroll tax. Phased-in corporate income surtax of 6% (1993) to 9% (1996).
Individuals	Marginal income taxes raised to 38%. OASDI taxable wage based increased to $125K. 85% of OASDI benefits taxable. LTC premium of $55/month for individuals 65 years and older.	Add'l 1% tax on wages and 2% on unearned income. Top marginal indiv. income tax rate of 33%. OASDI wage base to $125K. 85% of OASDI benefits taxable. Cigarettes, liquor.taxes.	Sliding-scale premiums for enrollment in public AmeriCare. Workers may be required to pay 20% of private premiums, w/ gov't subsidy for low-income workers.	Sliding-scale premiums for enrollment in public plan. HI tax base to $200K, rate raised to 1.65% (1996). Self-employment tax to 3.30% (1996). Income surtax of 9% (1996).
Small Employer Market	Not Applicable	Not Applicable	Market Reform	Market Reform
Quality	Continued PRO review	Quality of care committee	No new regulation	Continued PRO review

B=Basic health care (hospital, physician, diangostic); P=preventive services; M=mental health (inpatient /outpatient psychiatric); LTC=long term care; Rx=Prescription Drugs; D=Dental; V=Vision. $---/$-- refers to individual/family coverage.

Summary of Comprehensive Health Reform Proposals Now Being Debated

	UNY*Care	H.R. 2535 (Pepper Comm'n/Waxman)	H.R. 8 (Oakar)	Canada
General Approach	Play or pay with rate setting	Play or pay	Canadian-style	
Cost Containment				
Cost-Sharing	Unspecified, but out-of-pocket costs would be capped on sliding scale.	Maximum permitted: 20% coinsurance, $250/$500 deductible; $3000 cap.	Maximum permitted: 20% coinsurance, $200/$500 deduct; $1000/$2500 cap.	None allowed
Managed Care	Employer financing may encourage managed care	Limitation on State regulation, and favorable treatment	No incentives are provided.	Little utilization review. Few HMOs; no PPOs.
Limit Tax Subsidy for Employer Paid Health Benefits	No	No	No	n/a
Price Regulation	All-payer rate setting	Medicare-like payment. Possible State uniform payment rates.	All-payer rate setting	Gov't monopsony
Supply Regulation	Certificate of need regulation.	No	Capital budgets	Capital budgets Limits on manpower
Other	Lower billing costs thru single payer.	Malpractice reform. Practice guidelines.	Comm' n to assess technology and set coverage standards.	Strong regional management by provincial governments.
Access				
Scope of Coverage	Near universal	Near universal	Universal	Universal
Benefits	B	B, P, M	B,P,M	B, P, M - others variable
Medicaid Expansion / Buy-In	Yes, but few specifics are provided.	Federalized program with expansion and buy-in.	Replaces Medicaid with universal program: public/private hybrid.	n/a
Tax Credits and Subsides	For low-income families.	Premium, coinsurance and copayment subsidy for low-income individuals.	No	n/a
Individual Mandate	No	No	No	No
Employer Mandate	Play or pay mandate	Play or pay mandate with phase-in for small business	No	n/a
Universal Public Insurance	$25,000 stop loss would be provided by state	Hybrid - Public and Private Insurance	Hybrid - public finance with private insurance	yes
Who Pays				
Government / Financing	Redirects gov't charity care/bad debt pay. Other-unspecified	Public Health Plan financed through Employer "Pay" tax and additional surtaxes	Financing not specified	Fed. income tax and provincial payroll tax
Employers	Responsible for most	Employer "Pay" tax or 80% of premiums. Corp. surtax.		Provincial payroll tax
Individuals	At employer option: workers responsible for up to $250/ $500 a year. Sliding scale for others.	At employer option: workers responsible for up to 20% of premiums. Premiums to buy-in to Public Health Plan, Add'l. Surtax (amt unspecified)		
Small Employer Market	Market reform	Market reform	Community rating	n/a
Quality		Practice guidelines,Outcomes research, Peer Review	Commission to establish standards w/ enforcement	

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Preliminary Descriptive Analysis of Cost Containment Options

	1. Incentives for Cost Sharing	2. Incentives for Managed Care	3. Limit Tax Subsidy for Employer-Paid Benefits	4. Government Monopsony	5. All-Payer Rate Setting	6. Supply Controls
Where proposed?	Johnson (directly). Enthoven, Pauly, Heritage (indirectly).	Johnson (directly). Enthoven, AEI/Pauly , Heritage (indirectly).	Enthoven, AEI/Pauly, Heritage*	Canada, Russo, Kerrey	Mitchell (modified), Rostenkowski, UNY*Care	Canada, Russo, Kerrey, Mitchell (optional), Rostenkowski, UNY*Care,
Potential Advantages	Cost sharing has been shown to reduce health spending with little impact on health outcomes. Little overhead cost.	Provides framework and incentives for cost-effective care delivery. Selective contracting may strengthen price competition. May reduce unneeded care.	Strengthens competition encouraging increased cost sharing & managed care. Could improve equity if revenues used to fund expanded access.	Used with apparent success by other nations. Substantial administrative savings may be possible.	Similar to (4) but leaves private insurance somewhat intact. Retains some incentive for managed care.	Has had modest effect on health spending growth. Market forces alone may be insufficient to correct imbalance in physician supply.
Potential Disadvantages	Some consumer resistance likely. Little impact on service intensity. Little effect likely on price competition.	Some consumer resistance likely. Difficulty of defining managed care. Savings from provider price competition may be limited.	Impact on cost is indirect. Potential for inequitable impact (depending on detailed design).	Would disrupt U.S. health system. Major increase in taxes and role of government. Weak incentives for efficiency . Price competition eliminated.	Could limit access. Major increase in regulation & role of gov't . Could weaken incentives for managed care.	Could limit access and create shortages that US public may not accept. Potential adverse impact on quality & innovation.
Impact on Costs	Depends on degree of cost-sharing.	Substantial savings possible, but lag time needed to develop effective managed care plans & build enrollment.	Similar to (1) and (2), but indirect.	May not work in U.S. Admin. cost savings. Could have rapid cost control effect, after initial start-up.	Comparable to (4), except less potential for administrative savings.	More likely to limit spending for "high tech" care.
Impact on Unnecessary Care	Could reduce "needed" as well as "unneeded" care; little evidence.	Has potential for reducing unneeded care.	Similar to (1) and (2), but indirect.	Little direct effect.	Little direct effect.	Could reduce some unneeded care
Impact on Health Care System	Little impact.	Major change, but consistent with trends.	Could trigger shift to managed care & competition.	Expands regulation. Increased opport'y for political intervention. Could slow movement toward managed care.	Similar effects as (4), but less extensive.	Little disruption over short run. Major potential for disruption over long run.
Impact on Quality and Innovation	Concern about quality impact, but little evidence to support. Little innovation impact.	Concern about quality, but little evidence. Concern about limiting choice.	Similar to (1) and (2).	Little short run effect. Potential for underfunding could have adverse effect.	Same as (4).	Potential adverse effect.
Impact on Role of Government	Little impact.	Defining managed care may increase gov't role.	Little impact.	Major increase in gov't role.	Similar effect as (4), but less extensive.	Similar to (4).
Implementation and Other Issues	Could have adverse effect on equity if low-income protections not included.	Monitoring required to determine compliance with managed care standard.	Tax cap could have inequitable impact due to variation in premium costs.	Minimum of 2 yrs lead time needed.	Same as (4).	Would likely require hospital-level capital budgeting to have impact.

* Enthoven limits the income exclusion for employer paid health benefits with a dollar cap. AEI and Heritage totally replace the income exclusion with a new health insurance tax credit. Distinctive implications of the Heritage and AEI approach are discussed more fully in the analysis of access options.

Preliminary Descriptive Analysis of Access Options

	1. Medicaid Expansion With Buy-In	2. Individual Mandate & Tax Credit Based on Income & Health Risk	3. Individual Mandate & Tax Credit Based on % of Premium Cost	4. Employer Play or Pay Mandate	5. Universal Public Insurance
Where Proposed?	Mitchell, Rostenkowski, Pepper Comm'n, UNY*Care (w/ modifications)	AEI/Pauly	Heritage	Mitchell, Rostenkowski, Pepper Comm'n, UNY*Care, Enthoven	Canada, Russo, Kerrey
Potential Advantages	Builds on current program. Matching of Fed.& State funds.	Universal coverage. Blends individual rights and responsibilities. Targets subsidies based on need.	Similar to (2) but tax credits are not targeted based on need.	Retains private insurance system. Relatively low cost to gov't.	Perceived equity. Potential for cost control.
Potential Disadvantages	Expands gov't reach with associated problems. May be perceived as "second class care" for beneficiaries. Burdens States with more costs.	Potentially high gov't cost due to transfers to employers and low-risk workers. Disrupts risk pooling in private insurance that keeps premiums low for high risk individuals.	Only catastrophic coverage required -- may be inadequate for many (but tax credits available for broader coverage). Disrupts risk pooling as (2).	Passes cost to private sector. Will reduce employment and economic growth. Could depress wages for low-income workers.	Major increase in gov't role and cost. Political system in U.S. may fail to control costs. May limit diversity & innovation.
Impact on Access	Covers half the uninsured.	Universal basic coverage.	Universal catastrophic cost coverage.	Covers about half of the uninsured.	Provides universal coverage.
Approx. Annual Cost for Gov't	>$30 billion in Federal/state costs.	Difficult to estimate.	Difficult to estimate.	Could lowers Federal/state Medicaid & indigent care cost	$200-300 billion.
Transfers	$5-10 billion to providers. $7-10 billion to households. Compared with (2) & (3) less potential for transfers to employers.	$10-15 billion to providers. Substantial transfers to young, healthier workers, and to employers (if employers reduce premium contributions for low-wage workers to take advantage of the tax credit).	Similar to (2).	$5-10 billion to providers. $10-15 billion to households.	$10-15 billion to providers. $25-30 billion to households. $150 billion to employers.
Impact on Insurance & Delivery System	Substantially expands gov't reach.	Could reduce gov't role by replacing Medicare/Medicaid w/ credit & private insurance	Could reduce gov't role by replacing Medicare with voucher.	Builds on current private insurance system. Substantially expands gov't reach.	Eliminates most private insurance.
Implications for Cost Containment	No significant effect likely.	Could result in less employer involvement which could weaken pressure for cost containment.	Similar to (2), except sets tax credit based on percent of actual premium costs.	Concern that political system will be overly generous with employers' money. Retains employer incentive for cost containment.	Depends on politics.