Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. notes	Health Care Strategy Meeting (3 pages)	nd	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23754

FOLDER TITLE:
October 1994 HSA

gf121

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
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This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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M E M O R A N D U M

TO: Bob and Carol
FR: Chris Jennings
RE: Insurance Reform Background Information
DT: October 24, 1994
cc: Bill and Gene

Attached for your review is background information on the many issues surrounding insurance reform. The information has been prepared tapping into the expertise of the staff of the NEC/DPC working group and is now ready, pending your approval, for distribution among the principals.

The attached is provided in a 2-page outline format, a 4-page brief summary format, and a 12 page more detailed format. Different principals will like different formats, so all are available for distribution. **It is important to note that no recommendations or preferences are outlined in the documents, and I believe no one would conclude that they are presented in a manner that could be viewed to be controversial.**

The reforms we are considering can be categorized in three ways: (1) coverage protections for the currently insured, (2) access to insurance guarantees for all, and (3) market-based approaches to promote desirable competition among insurers. All three of these categories have been the focus of major pieces of legislation (Bentsen, Mitchell, Gephardt, Chafee, Dole, Rowland/Bilirakis, Cooper, and others) throughout the last two Congresses.

Although complex, the issues are not new. However, while most bills appear to have many of the same goals, the approaches and potential consequence vary widely.

The challenge of pursuing any insurance reform agenda is to ensure that it will be drafted and implemented correctly. If not, we risk not only unacceptably disrupting the current market and raising premiums to particularly influential constituencies, but undermining public confidence in our ability to move forward with future reforms. If we succeed in passing a strong set of reforms, we can make a real and positive change to our currently quite flawed insurance market.

Please review the attached. Pending your approval, it is my hope that we can distribute this background information sometime tomorrow. In that vein, I will draft up a cover memo from you two to the principals enclosing the attached.

INSURANCE AND MARKET REFORMS

Preliminary Review
October 25, 1994

OUTLINE OF POSSIBLE OBJECTIVES

OBJECTIVE 1: PORTABILITY: To improve the ability of the currently insured to maintain coverage.

POSSIBLE INITIATIVES:

1. Limit the use of pre-existing condition exclusions.
2. Require insurers to renew coverage regardless of health status.
3. Guarantee access to insurance for new employees in businesses that offer coverage.
4. Prohibit insurers (and self-insured employer plans) from imposing caps on benefits for specific diseases.

OBJECTIVE 2: ACCESS AND AFFORDABILITY: To guarantee access to coverage for everyone and to limit variations in premiums across individuals and businesses (which can make coverage unaffordable for high risks).

POSSIBLE INITIATIVES:

1. Guaranteed issue: Require insurers to make coverage accessible to everyone, regardless of health status.
2. Limit premium variations across individuals and small businesses.

Possible Options:

1. Limit Premium Increases: The extent to which insurers can vary premium increases due to health status could be limited.

2. Limit Premium Variations: The extent to which insurers could vary their experience rated premiums could be limited.

3. Permit Premium Variations only for age for each benefits package.

4. Pure Community Rating.

3. Integrate individual purchasers and small businesses into a single community risk pool.

OBJECTIVE 3: ENCOURAGE COMPETITION: To restructure the market to promote competition among insurers based on efficiency and service and to reduce opportunities for risk selection by insurers.

POSSIBLE INITIATIVES:

1. Promote establishment of purchasing cooperatives for individual purchasers and small businesses.

   Possible Options: The Federal government could:

   1. Provide administrative funding and technical assistance.

   2. Require the establishment (e.g., by states) of cooperatives.

   3. Enact uniform standards for cooperatives.

   4. Make FEHBP -- the health program for Federal employees -- available to other businesses and individuals.

2. Standardize benefit packages.

   Benefits could be standardized to a single package, or to several packages (with some more comprehensive than others). Standardization of a defined set of benefits makes it easier for applicants to compare premiums across insurers, which increases competition. It also limits the ability of insurance companies to avoid sick people through the design of their benefits packages.

INSURANCE AND MARKET REFORMS

Preliminary Review
October 25, 1994

SUMMARY

Three possible objectives of reforming the insurance market -- in order of increasing comprehensiveness -- are:

1. **PORTABILITY:** To improve the ability of the currently insured to maintain coverage.

2. **ACCESS AND AFFORDABILITY:** To guarantee access to coverage for everyone and limit variations in premiums across individuals and businesses.

3. **ENCOURAGE COMPETITION:** To restructure the market to promote competition among insurers based on efficiency and service and to reduce opportunities for risk selection by insurers.

While we can break these components into pieces for analysis, it is important to note that they are usually interactive.

POSSIBLE OBJECTIVES

OBJECTIVE 1: To improve the ability of the currently insured to maintain coverage.

POSSIBLE INITIATIVES:

1. LIMIT THE USE OF PRE-EXISTING CONDITION EXCLUSIONS.

These proposals generally prohibit insurers from imposing pre-existing condition exclusion periods for the currently uninsured.

Issues:

- Could raise premiums, especially for individuals purchasers.

- Not necessarily true portability: As long as insurers can still deny coverage altogether or experience rate their premiums, sick people still may not be able to switch from one plan to another.

2. **REQUIRE INSURERS TO RENEW COVERAGE REGARDLESS OF HEALTH STATUS.**

Issues:

- In the absence of rating reforms, insurers can just charge sick people who renew their policies unaffordably high premiums.

3. **GUARANTEE ACCESS TO INSURANCE FOR NEW EMPLOYEES IN BUSINESSES THAT OFFER COVERAGE.**

This initiative would require insurers to accept new employees of any employer group.

Issues:

- For very small groups, there is a concern that employers will hire their friends and relatives for the purpose of qualifying them for coverage.

- In the absence of rating reforms, insurers can still increase premiums if employers hire new workers who are high risks.

4. **PROHIBIT INSURERS (AND SELF-INSURED EMPLOYER PLANS) FROM IMPOSING CAPS ON BENEFITS FOR SPECIFIC DISEASES.**

Issues:

- Could raise premiums a small amount.

- ERISA currently preempts states from doing this for self-insured plans.

OBJECTIVE 2: To guarantee access to coverage for everyone and to limit variations in premiums across individuals and businesses (which can make coverage unaffordable for high risks).

POSSIBLE INITIATIVES:

1. **GUARANTEED ISSUE: Require insurers to make coverage accessible to everyone, regardless of health status.**

Issues:

- Insurance may not be affordable: Without rating reforms, insures could simply charge those who are sick unaffordably high premiums.

- Overall premiums are likely to rise. [Premiums are likely to be higher when subsidies are offered.]

2. LIMIT PREMIUM VARIATIONS ACROSS INDIVIDUALS AND SMALL BUSINESSES.

The majority of states have implemented at least minimal rating reforms, but generally only for small businesses -- not individuals.

Possible Options:

1. Limit Premium Increases: The extent to which insurers can vary premium increases due to health status could be limited.

2. Limit Premium Variations: The extent to which insurers could vary their experience rated premiums could be limited.

3. Permit Premium Variations only for age for each benefits package.

4. Pure Community Rating.

Issues:

- The more premiums are compressed, the greater the disruption to the market. Businesses with and individuals who are younger and healthier are likely to pay more the more premiums are restricted.

- To limit premium variations, it is necessary to define a risk pool (i.e., individuals and employers with 50 or fewer employees). In order for this to be effective, self-insurance for those who qualify for the risk pool would have to be prohibited.

  - There was -- and will likely continue to be -- pressure from associations of small employers to separate themselves from the larger community risk pool. This separation would reduce the effectiveness of pooling, potentially leaving the community pool with a sicker than average population and higher premiums.

- Rating reforms are more difficult to enforce without standardization of benefits.

- Rating reforms in conjunction with guaranteed access to coverage may require some mechanism, such as risk adjustment or reinsurance, to ensure that insurers are not penalized for attracting sicker people or rewarded for attracting healthy people.

3. **INTEGRATE INDIVIDUAL PURCHASERS AND SMALL BUSINESSES INTO A SINGLE COMMUNITY RISK POOL.**

Issues:

- Integration may be necessary to make comprehensive insurance reforms viable in the individual market. Otherwise, the risk pool may contain only sick individuals.

- Integration could increase premiums for small businesses and increase their desire to leave the community risk pool. This effect increases in the presence of generous subsidies.

OBJECTIVE 3: To restructure the market to promote competition among insurers based on efficiency and service and to reduce opportunities for risk selection by insurers.

POSSIBLE INITIATIVES:

1. **PROMOTE ESTABLISHMENT OF PURCHASING COOPERATIVES FOR INDIVIDUAL PURCHASERS AND SMALL BUSINESSES.**

Federal law is not a barrier to the establishment of purchasing cooperatives, but Federal initiatives could promote their establishment.

Possible Options: The Federal government could:

1. Provide administrative funding and technical assistance.
2. Require the establishment (e.g., by states) of cooperatives.
3. Enact uniform standards for cooperatives.
4. Make FEHBP -- the health program for Federal employees -- available to other businesses and individuals.

Issues:

- Purchasing cooperatives are not likely to be viable without comprehensive insurance market reforms, because healthy people will choose to buy insurance at lower costs outside the cooperatives, leaving only the sick inside the pool.

2. STANDARDIZE BENEFIT PACKAGES.

Benefits could be standardized to a single package, or to several packages (with some more comprehensive than others). Standardization of a defined set of benefits makes it easier for applicants to compare premiums across insurers, which increases competition. It also limits the ability of insurance companies to avoid sick people through the design of their benefits packages.

Issues:

- Establishing the composition of the package can generate significant controversy.
- Some people would be required to change their existing coverage (though they could still buy supplemental coverage).
- Some type of standardization may be necessary to act as a benchmark if substantial premium subsidies are to be offered to low income people.

INSURANCE AND MARKET REFORMS

Preliminary Review
October 25, 1994

Three possible objectives for reforming the insurance market -- in order of increasing comprehensiveness -- are:

1. PORTABILITY: To improve the ability of the currently insured to maintain coverage.

2. ACCESS AND AFFORDABILITY: To guarantee access to coverage for everyone and limit variations in premiums across individuals and businesses. [These reforms are essential to coverage expansions through private insurance.]

3. ENCOURAGE COMPETITION: To promote competition among insurers based on efficiency and service and to reduce opportunities for risk selection by insurers.

OBJECTIVE 1: To improve the ability of the currently insured to maintain coverage.

POSSIBLE INITIATIVES

▸ PROHIBIT PRE-EXISTING CONDITION EXCLUSIONS FOR THE CURRENTLY INSURED.

Most insurance reform proposals prohibit insurers from imposing pre-existing condition exclusions on people with coverage who change insurers (e.g., when they change jobs).

Issues:

- Most states have limited pre-existing condition exclusions in the small business market, but only some have done so for individual purchasers. States are limited in their ability to limit exclusions for larger businesses because most of them self-insure, and ERISA preempts state regulation of self-insured arrangements.

- Limiting the use of pre-existing condition exclusions could raise premiums somewhat in a voluntary insurance market. The effect on

premiums would be bigger with respect to individual purchasers (e.g., the self-employed) than employer groups, because employer groups and pool risks across a mix of both healthy and sick employees.

However, as long as insurers are permitted to deny coverage or charge higher premiums based on health status, limiting the use of pre-existing condition exclusions would likely increase premiums for those who are sick and would benefit from the limited exclusions, but leave premiums largely unchanged for those who are healthy.

- Some assert that prohibiting pre-existing condition exclusions for the currently insured would guarantee portability of coverage. However, portability of coverage is not assured without guaranteed access to coverage and rating reforms because, without them, people could be denied coverage or charged high premiums when trying to change insurers.

▸ REQUIRE INSURERS TO RENEW COVERAGE REGARDLESS OF HEALTH STATUS.

Issues:

- Some rating reforms (e.g., limiting discriminatory rate increases) are necessary to make guaranteed renewal meaningful. Otherwise, insurers can effectively cancel coverage for people who become sick by raising their premiums to unaffordable levels.

- The effect on overall premiums of guaranteed renewal is likely to be modest.

- The vast majority of states have assured renewability for small businesses, but only several have done so for individual purchasers (e.g., the self-employed). States have generally implemented guaranteed renewal for small businesses in conjunction with rating reforms.

▸ GUARANTEE ACCESS TO INSURANCE FOR NEW EMPLOYEES IN BUSINESSES THAT OFFER COVERAGE.

In some states, insurers can decide to reject specific employees in a business because of their health status. This initiative would require insurers to accept new employees of any employer group that they insure.

Issues:

- For very small groups, there is some danger that employers will hire their friends or relatives (particularly those who are sick) for the purpose of qualifying them for coverage.

- This initiative would help solve "job lock" for the vast majority of employees, since they could change jobs without fear of losing coverage because of poor health status. However, some "job lock" would remain, because not all employers contribute towards coverage (and some employers offer less generous benefits than others).

- Without rating reforms like community rating, premiums would likely rise for employers who hire someone who ordinarily would have been denied coverage by an insurer because of poor health status.

- This initiative is a more limited form of a guarantee that everyone has access to insurance. It would guarantee access for new employees of businesses that already have insurance. But, it would not guarantee that a small business or individual purchaser could get insurance to begin with.

▸ PROHIBIT INSURERS (AND SELF-INSURED EMPLOYER PLANS) FROM IMPOSING CAPS ON BENEFITS FOR SPECIFIC DISEASES.

This initiative would prohibit plans from placing a cap on benefits for a specific disease, particularly after a person has become ill.

Issues:

- While many states have limited the ability of insurers to impose disease-specific caps, ERISA preempts states from doing so for self-insured plans.

- Prohibiting the use of disease-specific caps (e.g., for cancer or AIDS) would raise premiums (or costs for self-insured plans) a small amount. In the absence of rating reforms like community rating, premiums would likely rise primarily for those employers with employees who have one of the relevant illnesses.

OBJECTIVE 2: To guarantee access to coverage for everyone and to limit variations in premiums across individuals and businesses (which can make coverage unaffordable for those who are sick).

POSSIBLE INITIATIVES

▸ REQUIRE INSURERS TO MAKE COVERAGE ACCESSIBLE TO EVERYONE, REGARDLESS OF HEALTH STATUS.

Issues:

- The vast majority of states have assured access for small businesses (e.g., 3 to 25 employees). Few states have done so for individual purchasers (e.g., the self-employed), for very small businesses, or for businesses with more than 25 employees.

- Rating reforms are necessary to make guaranteed acceptance and renewal by insurers meaningful. Otherwise, insurers could simply charge those who are sick unaffordably high premiums.

- Comprehensive insurance reforms -- including guaranteed access and rating reforms like community rating -- are necessary to create a program that provides subsidies for the purchase of private health insurance.

- Unless insurers are allowed to impose some pre-existing condition exclusions (generally 6 months) on the previously uninsured, individuals who were not previously insured may tend to wait until they get sick to purchase insurance.

- Guaranteed access to insurance would raise overall premiums somewhat as sicker people enter the insurance market (particularly if significant subsidies are offered, allowing greater numbers of the uninsured to buy coverage).

    - According to an analysis by Lewin-VHI for the Catholic Health Association, comprehensive insurance reforms without any subsidies to make coverage more obtainable would raise premiums by about $4 per person per month on average (assuming community rating with premium adjustments for age).

Insurance reforms along with significant subsidies would raise premiums by about $10 per person per month on average. And with universal coverage -- which would bring healthy as well as sick people into the system -- premiums would rise by about $3 per person per month.

- Experience with COBRA -- which allows employees who leave their jobs to continue buying insurance for a limited period of time at about the same rate as the employer pays -- also offers evidence that premiums would likely rise. Generally, people who opt to continue coverage through COBRA (at full cost to themselves) are much sicker than average.

- While premiums would likely rise, out of pocket health spending and uncompensated care would likely fall.

▸ LIMIT PREMIUM VARIATIONS ACROSS INDIVIDUALS AND SMALL BUSINESSES.

There are a number of options for limiting premium variation (listed in order of increasing limitations):

1. Limit the extent to which insurers can vary premium *increases* due to health status. For example, an insurer could be required to give the same percentage premium increase to all small business upon renewal of coverage.

   This option would not immediately increase or decrease premiums for the currently insured, but would tend to narrow variations in premiums over time. Insurers would, over time, likely give newly insuring businesses similar premiums, because they could no longer give healthy groups low premiums to begin with and then increase their premiums significantly over time if someone in the group gets sick.

2. Permit limited premium variations for specified rating characteristics. For example, insurers could be permitted to charge sicker employer groups up to one and a half times what they charge healthier groups, and to charge businesses in certain "high risk" industries up to one and a half times what they charger businesses in "lower risk" industries. The bill sponsored by Secretary Bentsen in the Senate contained provisions similar to these and to the option described above.

3. Eliminate experience rating, permitting premium variations in a geographic area only for benefit differences, age, and family status (i.e., "age/demographic rating"). Variations for age could be limited (e.g., an insurer could charge older individuals no more than twice what it charges younger individuals, rather than four or five times as is common today).

4. Eliminate experience and age rating, permitting premium variations in a geographic area only for benefit differences and family status (i.e., "pure community rating," as in New York).

Issues:

- The more that premiums are compressed (i.e., the greater the restrictions on how much insurers can vary premiums from one group to another), the greater the disruption to the market:
  - Businesses with healthy workers would pay more than they do today and businesses with sicker workers would pay less. In general, more businesses would likely see premium increases than decreases, although the increases would, on average, be smaller than the decreases.
  - Individuals and businesses with workers who are younger and healthier would be less likely to maintain their insurance (particularly if age rating is significantly limited or prohibited). The pool of insured people would consequently become older and sicker, which would raise average premiums.
- An analysis conducted by the American Academy of Actuaries looked at the effect of different rating reforms.
  - According to the analysis, moving to pure community rating would require little or no change for 39% of individuals and small employers with fewer than 25 employees. One-fifth of individual purchasers and small employers would see premium increases of more than 20%, and 12% would see premium decreases of more than 20%.
  - Permitting premium variations for age would lessen the impact of premium increases, according to the analysis. 63% of individuals would see little or no change, 9% would see increases of more than 20%, and 6% would see premium decreases of more than 20%.

- The analysis makes a number of simplifying assumptions (it does not, for example, account for any administrative cost savings or for the cost of covering sicker people by expanding access).

  Moreover, the study does not look at impacts over time. For example, without reform, a small business with a low premium today could see its premium rise significantly if an employee became ill.

- Permitting limited experience rating (e.g., permitting an insurer to charge a sick employer group one and a half times what it charges a healthy group) would tend to mitigate this disruption.

◆ To limit premium variations, it is necessary to define a risk pool. For example, it is necessary to define the size of business to which the reforms apply.

- In most of last session's Congressional reform bills, the largest businesses to which community rating applied generally ranged from 100 to 1,000 employees.

- Many businesses -- especially larger employers that are part of the pool -- believe that they would be better off negotiating separately with insurers instead of being part of one large community risk pool with other businesses.

- There was -- and will likely continue to be -- pressure from associations of small employers to separate themselves from the larger community risk pool. This separation would reduce the effectiveness of pooling, potentially leaving the community pool with a sicker than average population and higher premiums.

- Businesses larger than the threshold for community rating may want the option to purchase community-rated coverage, particularly in geographic areas where they have a small number of employees. If they are permitted to do so, premiums for small employees would likely rise, because sicker large businesses would be more likely to purchase community-rated coverage than healthier large businesses. Employer-specific risk adjustments designed to prevent this behavior are difficult to implement.

- Comprehensive federal insurance reforms raise the issue of whether, and to what extent, to permit states to enact reforms that are more comprehensive.

  - In the last Congressional session, some suggested (e.g., in the Senate Mainstream proposal) that federal reforms should preempt further state reforms. Large insurers generally advocate national uniformity and preemption of further state reforms.

  - Allowing states to enact more comprehensive reforms also raises technical issues. It is sometimes difficult to determine whether a reform is more comprehensive or less comprehensive.

  - A particularly difficult area of federal preemption concerns self-insured plans offered by associations of small employers. States currently have the authority to restrict or prohibit self-insured association plans (and some have done so), but there would be pressure in the context of federal reforms to grandfather-in these plans (some of which are now operating illegally).

- Rating reforms are more difficult to enforce without standardization of benefits.

  - Permitting insurers to vary benefits significantly gives them greater opportunities to use benefit differences to segment healthy people from sicker people, and to charge the benefit packages chosen by the sicker people higher premiums.

  - For example, a benefit plan with prescription drug coverage will attract sicker people (and have higher premiums) than a benefit plan without drug coverage. Similarly, healthy people would tend to prefer a catastrophic package if they were offered a choice of that or a more comprehensive package.

  - Providing for multiple, standardized packages makes reforms easier than with multiple, un-standardized packages. With standardized packages, it is easier to prevent insurers from varying premiums across the packages for risk selection.

- Rating reforms in conjunction with guaranteed access to coverage may require some mechanism to ensure that insurers are not penalized for attracting sicker people or rewarded for attracting healthy people.

- One such mechanism is "risk adjustment" -- where funds are transferred from plans that attract healthy people to plans that attract sicker people -- but there is little actual experience with risk adjustment.

- "Reinsurance" -- where the cost of certain high-risk cases is spread across all insurers -- is an alternative approach that has been used more extensively.

◆ To make rating reforms effective, self-insurance would have to be prohibited among the businesses to which the reforms apply (e.g., businesses with fewer than 100 employees). Otherwise, healthier businesses would tend to self-insure, leaving higher premiums for the sicker businesses that do not.

However, it is generally believed that smaller firms have increasingly been choosing to self-insure, and there will likely be pressure to allow them to do so.

If it is necessary or desirable to allow smaller firms to self-insure, an alternative to rating reforms like community rating would be to permit businesses to self-insure, but only if they buy mandatory stop loss coverage (which limits the employer's financial exposure in exchange for a small premium). This would limit variations across employers to some extent, but would require new regulation of stop loss coverage.

◆ The majority of states have implemented at least minimal rating reforms.

- States have generally permitted experience rating, but limited the amount by which premiums can vary from one business to another.

- Most states have implemented reforms only for small businesses (e.g., those with up to 25 employees). They have generally excluded from reforms individual purchasers and the smallest of businesses (e.g., those with one or two employees).

▸ INTEGRATE INDIVIDUAL PURCHASERS AND SMALL BUSINESSES INTO A SINGLE COMMUNITY RISK POOL.

An insurer would charge an individual unaffiliated with an employer (e.g., a self-employed person) the same premium that it would charge to a small business.

Issues:

- Integration may be necessary to make comprehensive insurance reforms viable in the individual market.

  In a voluntary market, insurance reforms inevitably lead to some adverse selection (i.e., higher premiums as a result of sicker people tending to buy insurance more often than healthier people). In the employer market, adverse selection is mitigated by the fact that most employer groups have a mixture of healthy and sick individuals.

  In the individual market, however, adverse selection could be severe (leading to very high premiums). The effect on premiums for individuals could be smaller if it were spread more broadly, such as across small and medium sized employers, as long as the groups could not self-select themselves out of the market.

- This integration would increase premiums for small businesses, and increase their desire to leave the community risk pool (e.g., through plans serving associations of small employers).

  The effect on small business premiums depends heavily on the extent to which coverage of individuals is expanded through broad-based subsidies. Without significant subsidies, few individuals are likely to purchase coverage even with insurance reforms, so the overall effect on premiums would likely be smaller.

OBJECTIVE 3: To promote competition among insurers based on efficiency and service and to reduce opportunities for risk selection by insurers.

POSSIBLE INITIATIVES

▸ PROMOTE ESTABLISHMENT OF PURCHASING COOPERATIVES FOR INDIVIDUAL PURCHASERS AND SMALL BUSINESSES.

Federal law is not a barrier to the establishment of purchasing cooperatives, but federal initiatives could promote their establishment.

The Federal government could:

1. Provide administrative funding and technical assistance.

2. Effectively require the establishment of purchasing cooperatives (e.g., by providing incentives for states to do so, and/or disincentives for them not to do so).

3. Enact uniform standards for cooperatives.

4. Make FEHBP -- the health program for federal employees -- available to other businesses or individuals.

Issues:

- Purchasing cooperatives for small businesses or individuals (including the use of FEHBP) are not likely to be viable without comprehensive insurance reforms (e.g., guaranteed access and rating reforms). Otherwise, cooperatives will attract sicker individuals while insurers outside of cooperatives cover healthier people.

  In California, for example, the Health Insurance Plan of California (HIPC) operates on a generally level playing field with the rest of the small business insurance market.

- Cooperatives can be mandatory (i.e., where insurance can only be purchased through the cooperative) or voluntary (i.e., where insurance can be purchased inside or outside the cooperative). In general, voluntary cooperatives have attracted broader support.

▸ **STANDARDIZE BENEFIT PACKAGES.**

Benefits could be standardized to a single package, or to several packages (with some more comprehensive than others). Insurers could be required to offer a standard package, but permitted to offer other packages as well.

Issues:

- Standardizing benefits requires the establishment of the package(s) (either through legislation or regulation), with significant controversy over what to include in the package.

- Standard benefit packages make it easier for applicants to compare premiums across insurers, which increases competition.

- Standard packages help to prevent insurers from avoiding sick individuals through the design of their coverage. For example, not offering coverage of prescription drugs helps to dissuade people who are sick from joining a particular plan.

- If insurers can offer only the standard benefit package(s), some people would be required to change their existing coverage (though they could still buy supplemental coverage). The greater the number of standardized packages, the fewer the number of people who would have to change coverage (and the more complicated the system).

- Options to standardize the "level" of coverage by permitting insurers to design benefit packages that meet a specified "actuarial value" do not achieve the advantages of standardization. They do not provide the ability to compare packages, nor do they prevent insurers from designing packages to attract the healthy and avoid the sick.

- Some type of standardization may be necessary to act as a benchmark if substantial premium subsidies are provided to lower income people. That is, subsidies have to be tied to some established level of benefits, which insurers are required to offer.

Next Steps in Health Reform

I believe that consensus can be reached on three components for health legislation.

I. **Expanding Coverage** - invest in cost-effective measures to improve health outcomes.

1. Focus on younger age groups
2. There is more to expanding access than giving insurance
3. Make lifestyle changes a part of the program

II. **Insurance Reform** - increase portability of coverage; promote cost savings.

1. Encourage small group pooling
2. Ensure portability
   - Pre-existing conditions/guaranteed issue/guaranteed renewability
3. But, impose restrictions on individual and insurer behavior
   - Hard to join new policies if voluntarily uninsured
   - Risk adjustment / reinsurance of high risk cases

III. **Health Costs** - work to lower level of costs and have lower long-term cost growth.

1. Make individuals more cost conscious when they receive care
   - Tax cap
   - Subsidy for out-of-pocket payments if catastrophic policy
2. Make people more cost conscious when they choose insurance and increase insurance choices
   - Promote group purchase, particularly for small firms.
   - Tax cap
3. Malpractice reforms
   - Caps on damages, or no fault at enterprise level
4. Redo public sector to lower costs without painful costs
   - Increased use of managed care, potentially through voucher in Medicare
   - Have more bidding for services run publicly
   - Fold into FEHBP

A Potential Balance Sheet

Spending	**Source of Revenue**
Kids Program	Taxes on alcohol/cigarettes
Increase take-up rates	Tax Cap
Violence inititive	Savings in public sector from direct cuts or increased use of managed care

I. Coverage Expansions

Three issues are relevant in coverage expansions.

1. **Younger is better.**

Increasing evidence suggests that adverse conditions early in life (before age 3) may affect health throughout life, as well as school preparedness and other short-term indicators. There are three potential ways to provide more health care for children:

- Guarantee universal coverage of children, with a buy-in for higher income families.
  - To avoid dropping of dependent coverage, want to require that if dependent coverage is offered at work, must take it there.
- Provide care through schools for school-age children.
- Provide care directly in poor areas.

2. **There is more to expanding access than eliminating insurance barriers.**

Giving the poor insurance coverage is a start -- but only a start -- to improving access to health care. In addition to guaranteed coverage, two other strategies are worthwhile:

- **Increase take-up rates** - Low take-up rates appear to be a big problem. In many recent expansions, people received public insurance only at the time of acute needs, rather than when they could have received preventive care. Care this late does little good.
  - Want to spread more information about qualification, potentially through schools.
- **Promote one point of entry to system.** - In almost every universal system, the rich get more health care than the poor. This is probably because the rich are better at finding doctors, searching around for treatments, etc. A remedy for this is to have a clear point of entry for poor folks when we expand coverage.

3. **Make lifestyle changes a part of the program.**

If asked to rank what things the government could do that would most improve the health of Americans, I would list the following:

- Reduce violence.
- Promote healthy behavior while pregnant - no smoking, drinking, or illegal drug use
- Reduce smoking, drinking, and illegal drugs among young adults.

Some initiatives along these lines could easily be included in a health program.

Insurance Reform

1. Goals

There are two goals of insurance reform:

(i) Portability/access - allow people to transition jobs easier; reduce cancellations because a person becomes sick; reduce premium changes in response to getting sick.

(ii) Cost containment - reform market so people have ability and incentives to lower costs (discussed in next section)

2. The problem

Most of the portability problems ("job lock"; "self-employment lock"; "small business lock") are because people are afraid that if they change jobs, they will not be covered immediately (**pre-existing conditions**), or they will be refused coverage (**lack of guaranteed issue**). They also feel that if they work for a small firm, they will not be allowed to renew coverage (**lack of guaranteed renewability**), or their premiums may increase dramatically (**experience rating**).

Want to require: - no pre-existing condition restrictions
- guaranteed issue/renewability, with rate bands

Want to encourage: - small groups to pool together in purchasing pools

3. Difficulties in solving these problems

1. Demand side: If people can qualify for coverage easily when they are sick, they will have incentives to wait until they are sick before signing up for care

Solutions:

- Designing insurance reforms:
  - Allow age-rating of insurance premiums.
  - Allow pre-existing conditions if person moves from not having insurance to having insurance. No pre-existing conditions if move from job with insurance to another job with insurance.
- (Potentially) assess people an additional amount if they show up for insurance without having purchased in several years.

2. Supply side: Insurers will have incentives to attract the healthy and discourage the sick if they cannot charge the healthy a very low price or the sick a very high price.

Solutions:
- Risk adjustment, particularly within purchasing pools.
- Require mandatory reinsurance for very high cost cases (e.g., > $25,000 per year).
  - Just like a state high-risk pool.

3. Large firm problem: Many of these proposed reforms, if done at a state level, require that states be able to impose requirements on large, self-insured firms. Currently, states cannot do that because of ERISA exemptions.
- Need to open ERISA issue. Very complicated political problem.
- Related issue is MEWAs.

4. Policy Design

Consideration of these problems suggests a solution of the form:

Basic Policy	Qualifications
• No pre-existing condition exclusions	• Allow exclusion for people moving from uninsured to insured
• Guaranteed issue/renewability; rate bands	• Allow age adjustment • Relatively loose bands (outside of purchasing groups) • Risk adjustment • Require reinsurance for very high cost cases
• Encourage purchasing groups	

Cost Containment

1. There are two basic problems regarding health costs

(i) The level of costs is higher than it should be. This is largely because of administrative expenses (**approx. 5 percent**), and more importantly, provision of unnecessary care (**approx. 10 percent**). Net unnecessary expense is **approx. 15 percent**.

(ii) Cost growth is rapid. This is largely because of cost increasing technological change. Need either incentives to have cost-decreasing technological change or to impose limits on use of new technologies.

2. Worthwhile Reforms

(i) Demand-side: Make individuals more cost-conscious when they go to the doctor, through higher out-of-pocket payments (e.g., catastrophic policy with free preventive care).

- Eliminate or cap favorable tax treatment for employer-provided insurance.
- Encourage high cost-sharing policies, through:
  - Subsidies to out-of-pocket payments if have high deductibles
  - Medical savings accounts if choose high deductibles.

(ii) Demand-side: Allow individuals more choice over health insurance plans and give financial incentives to choose less expensive plans (managed competition).

- Encourage group formation among small firms. Potential solutions (ranging from least to most intrusive).
  - Promote formation of HIPCs at state level.
  - Allow small firms/individuals access to reformed FEHBP pool.
  - Require firms that offer insurance to offer multiple policies.
  - Eliminate tax deductibility for insurance purchased by small firms outside of HIPCs.
- Eliminate or cap favorable tax treatment for employer-provided insurance.
- Require all firms to offer choice of policies
- Require equal contribution rule

(iii) Malpractice Reforms: Ranges from caps on damages to no fault at the enterprise level. Don't expect big savings here.

(iv) Public Sector Programs: Need savings in public sector. Either get from deep cuts, or from restructuring programs.

- Increase use of managed care
  - Make this the guarantee for Medicaid
  - Encourage use for Medicare, or guarantee this amount and let people supplement (like a voucher program)
- Have competitive bidding for public services
  - E.g., bidding for DRG rates, RBRVS amounts.
- May want to open up FEHBP to Medicare/Medicaid recipients as way to encourage choice.

Suggestion: To avoid overly harsh cuts in Medicare/Medicaid alone if an entitlement cap is necessary, form a Federal health budget, including Medicare, Medicaid, VA, DOD, Public Health, and Tax Expenditure from employer-sponsored insurance. Makes cuts occur in all of these areas proportionately.

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3. What's not included

Limit doctors incomes/hospital revenues. This appears to be more interventionist than people are willing to accept. May also be bad policy.

- Best idea: wait and see what happens with steps (i) and (ii).

4. Potential for Cost Savings

Upper bound: Waste on the order of 15% can be squeezed out in the next decade.
Lower bound: Savings of 5 percent in the next decade.

Then, range of savings is:

	Range of Private Sector Savings	
Estimate	Amount	
Lower Bound	About .5 percent per year	5% total
Upper Bound	About 1.5 percent per year	15% total

Stacey - pl file under medical malpractice

HEALTH CARE LIABILITY REFORM

Title I. Patient Protection

Mandatory Patient Safety Programs

Mandatory Risk Management For All Hospitals and Physician Offices

Physician Licensing Fees Earmarked For Patient Safety Programs

75% Federal Excise Tax on Punitive Damages Awards; Establish Federal Trust Fund; AHCPR to Administer Grants to States for Improvement in Licensing and Monitoring for Patient Safety

Title II. Health Care Liability Reform

Mandatory, Non-Binding Alternative Dispute Resolution (SFC)[1]

Certificate of Merit (CB) (SLHRC)[2]

Reasonable Limits on Attorneys' Fees (SFC) (SLHRC)[3]

Periodic Payment of Future Awards (CB) (SLHRC)

Mandatory Offset of Collateral Source Benefits (CB) (SLHRC)

Elimination of Joint and Several Liability for Non-Economic and Punitive Damages Only (SFC)

Uniform Statute of Limitations for Adults and Minors

Title III. Preemption

Federal Law Will Serve as a Floor; States May Implement More Stringent Reforms (CB) (SFC) (SLHRC)

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[1] "SFC" refers to the bill passed by the Senate Finance Committee, S. 2351.

[2] "CB" refers to the Clinton Bill, S. 1757, H.R. 3600.

[3] "SLHRC" refers to the bill passed by the Senate Labor and Human Resources Committee, S. 2296.

File - Insurance Reform 94 DRAFT

INSURANCE AND MARKET REFORMS

Preliminary Review
October 25, 1994

SUMMARY

Three possible objectives of reforming the insurance market -- in order of increasing comprehensiveness -- are:

1. **PORTABILITY:** To improve the ability of the currently insured to maintain coverage.

2. **ACCESS AND AFFORDABILITY:** To guarantee access to coverage for everyone and limit variations in premiums across individuals and businesses.

3. **ENCOURAGE COMPETITION:** To restructure the market to promote competition among insurers based on efficiency and service and to reduce opportunities for risk selection by insurers.

While we can break these components into pieces for analysis, it is important to note that they are usually interactive.

POSSIBLE OBJECTIVES

OBJECTIVE 1: To improve the ability of the currently insured to maintain coverage.

POSSIBLE INITIATIVES:

1. LIMIT THE USE OF PRE-EXISTING CONDITION EXCLUSIONS.

These proposals generally prohibit insurers from imposing pre-existing condition exclusion periods for the currently uninsured.

Issues:

- Could raise premiums, especially for individuals purchasers.

- Not necessarily true portability: As long as insurers can still deny coverage altogether or experience rate their premiums, sick people still may not be able to switch from one plan to another.

2. **REQUIRE INSURERS TO RENEW COVERAGE REGARDLESS OF HEALTH STATUS.**

Issues:

- In the absence of rating reforms, insurers can just charge sick people who renew their policies unaffordably high premiums.

3. **GUARANTEE ACCESS TO INSURANCE FOR NEW EMPLOYEES IN BUSINESSES THAT OFFER COVERAGE.**

This initiative would require insurers to accept new employees of any employer group.

Issues:

- For very small groups, there is a concern that employers will hire their friends and relatives for the purpose of qualifying them for coverage.
- In the absence of rating reforms, insurers can still increase premiums if employers hire new workers who are high risks.

4. **PROHIBIT INSURERS (AND SELF-INSURED EMPLOYER PLANS) FROM IMPOSING CAPS ON BENEFITS FOR SPECIFIC DISEASES.**

Issues:

- Could raise premiums a small amount.
- ERISA currently preempts states from doing this for self-insured plans.

OBJECTIVE 2: To guarantee access to coverage for everyone and to limit variations in premiums across individuals and businesses (which can make coverage unaffordable for high risks).

POSSIBLE INITIATIVES:

1. **GUARANTEED ISSUE: Require insurers to make coverage accessible to everyone, regardless of health status.**

Issues:

- Insurance may not be affordable: Without rating reforms, insures could simply charge those who are sick unaffordably high premiums.

- Overall premiums are likely to rise. [Premiums are likely to be higher when subsidies are offered.]

2. LIMIT PREMIUM VARIATIONS ACROSS INDIVIDUALS AND SMALL BUSINESSES.

The majority of states have implemented at least minimal rating reforms, but generally only for small businesses -- not individuals.

Possible Options:

1. Limit Premium Increases: The extent to which insurers can vary premium increases due to health status could be limited.

2. Limit Premium Variations: The extent to which insurers could vary their experience rated premiums could be limited.

3. Permit Premium Variations only for age for each benefits package.

4. Pure Community Rating.

Issues:

- The more premiums are compressed, the greater the disruption to the market. Businesses with and individuals who are younger and healthier are likely to pay more the more premiums are restricted.

- To limit premium variations, it is necessary to define a risk pool (i.e., individuals and employers with 50 or fewer employees). In order for this to be effective, self-insurance for those who qualify for the risk pool would have to be prohibited.

  - There was -- and will likely continue to be -- pressure from associations of small employers to separate themselves from the larger community risk pool. This separation would reduce the effectiveness of pooling, potentially leaving the community pool with a sicker than average population and higher premiums.

- Rating reforms are more difficult to enforce without standardization of benefits.

- Rating reforms in conjunction with guaranteed access to coverage may require some mechanism, such as risk adjustment or reinsurance, to ensure that insurers are not penalized for attracting sicker people or rewarded for attracting healthy people.

3. **INTEGRATE INDIVIDUAL PURCHASERS AND SMALL BUSINESSES INTO A SINGLE COMMUNITY RISK POOL.**

Issues:

- Integration may be necessary to make comprehensive insurance reforms viable in the individual market. Otherwise, the risk pool may contain only sick individuals.

- Integration could increase premiums for small businesses and increase their desire to leave the community risk pool. This effect increases in the presence of generous subsidies.

OBJECTIVE 3: To restructure the market to promote competition among insurers based on efficiency and service and to reduce opportunities for risk selection by insurers.

POSSIBLE INITIATIVES:

1. **PROMOTE ESTABLISHMENT OF PURCHASING COOPERATIVES FOR INDIVIDUAL PURCHASERS AND SMALL BUSINESSES.**

Federal law is not a barrier to the establishment of purchasing cooperatives, but Federal initiatives could promote their establishment.

Possible Options: The Federal government could:

1. Provide administrative funding and technical assistance.

2. Require the establishment (e.g., by states) of cooperatives.

3. Enact uniform standards for cooperatives.

4. Make FEHBP -- the health program for Federal employees -- available to other businesses and individuals.

Issues:

- Purchasing cooperatives are not likely to be viable without comprehensive insurance market reforms, because healthy people will choose to buy insurance at lower costs outside the cooperatives, leaving only the sick inside the pool.

2. STANDARDIZE BENEFIT PACKAGES.

Benefits could be standardized to a single package, or to several packages (with some more comprehensive than others). Standardization of a defined set of benefits makes it easier for applicants to compare premiums across insurers, which increases competition. It also limits the ability of insurance companies to avoid sick people through the design of their benefits packages.

Issues:

- Establishing the composition of the package can generate significant controversy.
- Some people would be required to change their existing coverage (though they could still buy supplemental coverage).
- Some type of standardization may be necessary to act as a benchmark if substantial premium subsidies are to be offered to low income people.

ATTACHMENT 1

The big health care debate in Washington in the fall of 1993 focused on whether the President's health plan used "fantasy numbers" when projecting the potential for cuts in the growth of private health premiums and of Medicare. These slowdowns in growth were essential to financing the President's plan and to the Administration's assertion that premium caps were only a backup mechanism required for CBO scoring.

The President, the First Lady and the health care team all believed that competitive forces already underway would slow health cost growth short term and that Administration projections were conservative. However, these projections were criticized in The Wall Street Journal and by many others inside and outside the Administration, most notably Senator Moynihan (see attached articles.)

The following data shows that indeed the Administration's projections were conservative. Even if one assumes that the various surveys understate system wide premium growth, the President's proposal had more than enough money to fund universal coverage and reduce the deficit by large amounts beyond those projected.

Exhibit 1 shows that private sector premium growth rates for 1994 and 1995 were estimated at 16.2 percent cumulative in the Health Security Act, and in fact, have gone up only in a range of 1.0 percent to 7.1 percent cumulative in various surveys.

Exhibit 2 shows that Medicare savings already put into the CBO baseline and proposed in the President's 1997 budget result in a 7.1 percent annual increase in Medicare spending versus 7.8 percent projected in the Health Security Act (8.7 percent if the drug benefit and long term care initiatives are included.) Though cuts of the magnitude proposed were criticized as ruinous two years ago, almost everyone now agrees that steeper cuts are possible (even without universal coverage to cushion the blow for health care institutions.)

Longer term, the health care cost problem remains unsolved. Few health experts believe that the short term savings reflected in the figures above are sustainable without major system reform. Proposals such as the ones the Administration made -- a standard benefits package, one uniform claims form, community rating, a better outcomes information and quality system, universal coverage, cost conscious consumer choice, etc. -- are necessary to ensure the kind of sustainable productivity improvements which will slow growth without hurting the quality of care longer term.

Exhibit 1

Private Health Insurance Premium Increases, 1994-95*

	Administration Forecast for HSA	Foster-Higgins	Hay-Huggins	KPMG Peat Marwick
1994	7.8%	-1.1%	2.9%	4.8%
1995	7.8%	2.1%	1.2%	2.2%
Cumulative (compounded)	16.2%	1.0%	4.1%	7.1%

Sources: HCFA, Foster-Higgins, Hay-Huggins, KPMG Peat Marwick.

* The Administration's forecast in the HSA for the period prior to the beginning of the premium caps was for baseline growth in health insurance premiums per privately insured person under 65 years of age in the United States. This forecast was derived from aggregate data for the nation as a whole. The private firms' data are from their own surveys of firms. They are the weighted answers to the question about premium costs per employee. While the private firms claim that their weighted survey questions produce nationally representative estimates, they consider their weights to be proprietary and therefore do not reveal them. Most researchers consider the surveys more representative of large firms (where most workers work) than of small firms. The Administration data and forecast implicitly include small firms' experiences as well.

Exhibit 2

Medicare Cost Increases

	Average Annual Growth Projected in the 1993 CBO Baseline	Projected Average Annual Growth Rate Proposed (outlays, net of offsetting receipts)
Health Security Act Savings Only	10.8%	7.8%
Health Security Act All Impacts (drug benefit & long term care)	10.8%	8.7%
FY 1997 Budget (All Impacts)	10.8%	7.1%

Source: OMB

April 15, 1996

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Dear David and Haynes:

I have just had the opportunity to read your book. Let me congratulate you. The book is thoughtful and will enhance public understanding of the health debate of 1993-94, the health care crisis the country still faces and the problems with our political system.

Your assessments of the failure of reform are by and large balanced, noting the difficulty of the task we took on, the additional burdens placed by the ambitious timetable, various mistakes we made, the power and ferocity of the opposing interest and political groups and their effective new strategies, the discord within the Democratic party, the complacency of many supportive interest groups and the crass political motivations of many of the Republican actors.

Your descriptions of the problems which remain, the failure of the Republican Medicare and Medicaid proposals and your use of real life situations in California and Minnesota to show the stakes for "outside the beltway" America are inspired and compelling.

Your characterizations of the White House decisionmaking process, the health care taskforce and of me and my career are in many ways not accurate and I don't agree with some of your conclusions. Nevertheless, I think you have done a very good job in telling a very complicated story in a compelling fashion and drawing useful conclusions.

I am moved to write this letter because there is one issue which you miss. It is as fundamental an issue as any in defining the health reform effort, our motivation in undertaking it the way we did, the disagreements which racked our Administration and the health policy world, the ultimate defeat of reform and the real tragedy of the opportunity which the nation lost.

When you first came to see me, you said that your book was not about the substance of health reform but rather about the politics of it, the way the system in Washington works. Just as you can't divorce policy from politics, you can't divorce politics from policy either.

There was one fundamental policy disagreement which prevented sincere advocates of health reform from finding common ground. Because you do not focus on this issue, you judge some of the President's decisions harshly, when in fact he was displaying a greater wisdom than many of those you praise.

THE DILEMMA

During the first months of 1993, we confronted a policy "catch 22" which drove the failure of health reform as sure as any of the other factors you mention in your book.

Managed competition advocates and many of their supporters in the private sector believed that managed care and increased competition were already bringing down private sector health care costs and that a restructured marketplace could bring long term cost relief. They also believed that the Medicare and Medicaid programs were very wasteful.

The President, based on his many discussions with health practitioners during the campaign agreed with this view. I also agreed, based on my 20 years of analyzing the power of competition across many industries and my two years of study of the health industry.

The Washington Democratic health care establishment, including people I respect greatly like Bob Reischauer, Judy Feder, Henry Aaron, the "blueberry donut" group, the health staff of the House Ways and Means Committee and the experts at HCFA believed that costs could only be slowed gradually and that only price controls could be guaranteed to constrain cost. This group included the scorekeepers at CBO and HCFA.

The moderates and private sector forces felt that price controls would inhibit market development, would not allow integrated care companies to raise money and would eventually lead to complete government control of the health system.

The Washington Democratic establishment felt that managed competition was untested and would not work anywhere near as well as proponents said without harming the health system. In April of 1993, CBO published some studies making clear that they would not score competition savings without controls.

Reflecting the Washington bias, the approach that the health transition team wanted to take assumed that near term cost containment opportunities were limited, which required raising significant taxes or increasing the deficit to fund universal coverage. This would have pushed health costs up over 20 percent of GDP, squeezing middle class wages, feeding an already bloated health care system, removing the incentives for cost cutting which were then

beginning to take effect and allowing Medicare and Medicaid to continue to chew up too much budget.

The President could not accept this because he believed (correctly) that cost growth could and should be slowed.

Nor would this approach have yielded any better political results. The President had received numerous complaints from moderate Democrats and private sector health supporters who objected to the transition approach. Large tax increases or increased deficits to finance coverage would just not have been feasible.

We worked with private sector groups to pull together analyses and examples of savings to try to convince the Washington group including CBO that significant short term savings were coming in the marketplace. We didn't succeed.

We went to the private sector managed competition groups and explored back-up cost containment mechanisms they might accept -- voluntary freezes, triggered controls, etc. We didn't succeed with them either. They said these were too heavy handed and urged confronting CBO and the Washington Democratic health establishment, to try to force them to score competition-based savings.

Secretary Bentsen and Director Panetta were clear that CBO scoring had to govern. We would be dead on arrival if CBO tore our numbers apart.

ADMINISTRATION CHOICES

We looked at slowing the phase-in, but that didn't help. Because HCFA and CBO projected health costs to increase at three times the rate of inflation, delaying phase-in meant increasing the costs of universal coverage dramatically. We then looked at cutting benefits, but that also didn't solve the dilemma because benefit cuts mainly meant increasing copays and deductibles which cost the government more money in low-income subsidies. Lowering benefits would have also alienated many core supporters.

Instead, we based our reforms on the managed competition model, but also included premium caps as a back-up, designing them explicitly to meet the HCFA and CBO criteria for successful cost containment. We then proposed setting these caps and taking Medicare and Medicaid cuts at rates that represented a consensus among a large number of private sector experts working in the field.

We knew this would not avoid controversy, but we hoped we could weather it because the premium caps were taken at Senator Danforth's suggestion from a moderate bill sponsored by Senators Kassebaum, Danforth and Burns and Congressmen McCurdy and

Glickman. The Medicare and Medicaid cuts would be balanced by new benefits for drugs and long-term care which we hoped would make them more acceptable for liberals.

The Administration's economic team was generally supportive of the structure we chose -- managed competition backed up by premium caps and mandatory alliances for CBO scoring purposes and the employer mandate. Only HHS would have preferred a Stark-like Medicare price control system. The debate in the Administration which unified Cabinet members against the position taken by the President, the First Lady and me was over how much cost savings could be projected in the private sector over the next few years and how much savings could be achieved in Medicare and Medicaid.

We ultimately didn't succeed with this compromise and the result was not good for me personally. The managed competition advocates at Jackson Hole, in the private sector, and among moderate Democrats were angry. They had been pleased by my appointment because they knew I was competition oriented. Now they felt I had betrayed those principles by proposing premium caps and the associated regulatory alliances.

For many liberals, the adoption of a competition model with private insurance companies still in control and significant Medicare and Medicaid cuts confirmed their worst fears about me. They preferred a single payer system or a government run system of Medicare price controls instead of premium caps and alliances.

Many in the Administration, relying on respected Washington health economists, felt that the projections of private sector cost growth seemed unrealistic and therefore worried that the caps were too tight. They were even more concerned about our proposed Medicare and Medicaid cuts which they feared might be so high that they would hurt these programs.

Many thought that I was force-fitting -- calculating how much we needed to finance all the benefits and then setting unrealistic Medicare cuts and premium caps to produce the needed savings. This resulted in the "rosy scenarios," "fantasy numbers," and "stupid assumptions" charges made by many as recounted in your book. As history has demonstrated, I did not do that.

The President and the First Lady made their decisions for good reasons. They did not as you suggest, rely on one person when making such momentous decisions. And certainly, they would not rely on any one person just because he had been in the "snows of New Hampshire" with them.

They consulted with many eminent health experts outside our team, the majority of whom thought these savings to be realistic or even conservative. These included C. Everett Koop, Jack Wennberg, officials from the Mayo Clinic and Health Cooperative of Puget Sound, officials from the Pennsylvania Cost Containment Council, and Uve Reinhardt. On our team, Paul Starr, Rick Kronick and other key members of the health group also agreed.

In addition, the President had far more first hand health care experience than many of his economic advisors and his HHS Secretary, from talking to hundreds of people around the country about health care during the campaign and having coped with a state Medicaid program. The First Lady had worked full time for months on the issue including visits and intense discussions with hospital officials, doctors, health experts and consumers of health care.

They believed, correctly as it turned out, that these were reasonable projections and plans and they well understood the political risks and difficulties of these proposals. Nor were the warnings about attacks on our program as too bureaucratic or too big anything new. These warnings echoed those in my original work plan of January 1993, which David has written about. We knew our approach would be difficult, but we also knew that any other approach would be at least as difficult.

Ultimately, the dilemma was never solved. Elite opinion branded our cost estimates as unrealistic. The moderates would not accept any bill with cost controls or premium caps, even triggered ones. Even Senators Danforth and Kassebaum backed off their original proposal which they had urged us to use.

On the other hand, moderate attempts to put together bills without scoreable cost containment were doomed from the beginning. The Cooper bill was scored as $300 billion short to achieve 91 percent coverage even with a tax cap (which by our count could gain only 20-25 votes in the Senate). Had the first Chafee bill been scored, it would have had even worse problems.

The rump group proposals, the Senate Finance proposal and the eventual mainstream compromises being worked on over the summer never had a chance. Without scoreable cost containment, their bills created a whole series of taxes on companies and consumers with good health insurance in order to pay for coverage. This is why they had so little support.

Had they faced public scrutiny, they never would have lasted. They proposed spending large amounts of money to achieve relatively little additional coverage. They would have rightly been accused of making the insurance that most people had much more expensive in order to pay for the low income uninsured and not even guaranteeing that people could keep their coverage. There were a number of attempts by Senators Bradley, Durenberger and others to design other scoreable means of cost containment which all failed.

Congressman Cooper, Senators Durenberger and Chafee and Christy Ferguson thought you could get a scoreable bill which would find political acceptance without an employer mandate and back-up cost containment. We told them for a year that it wouldn't work. You couldn't get the coverage without scoreable cost containment unless you proposed a whole series of unacceptable taxes. They hit a policy brick wall when they tried. It was on August 19 after they met with CBO that their effort really collapsed.

THE LOST OPPORTUNITY

The real tragedy of health reform is that the President was right (see attachment 1). Within six months of the collapse of health reform, CBO revised its baseline projections for Medicare and Medicaid growth downward by over $100 billion over seven years and recent forecasts have subtracted even more. Everyone now agrees that an additional $180 billion in savings is possible even beyond this and many feel even more can be achieved. Our bill would have cushioned the effect of these cuts by protecting hospitals and doctors who serve the indigent from bearing too much of the negative effects of these cuts which is a problem today.

Private sector premium rates have grown much slower than even our projections and have not done irreparable harm to the system. Indeed, the provisions in our bill for consumer choice and consumer protection would have protected the public from the harsh effects of managed care which are sometimes felt today as cost growth slows.

We could have financed health reform as we proposed and had far bigger deficit reduction numbers than we projected.

Those who argued that the Medicare growth rates we were proposing would ruin the program were simply wrong. Those who argued that the premium caps would have to kick in because cost growth would not slow enough and that they would be too stringent were also wrong. This was a case of the Washington community, including manly people I respect enormously, simply being behind in their understanding of what was happening in the world of health care.

We did not believe then and don't believe now that costs will stay constrained without major changes in the system, but the short term savings we were banking on were already occurring and the initial cuts in Medicare and Medicaid were possible. History has proven us right.

I can't help feeling that what you have done in the book is to look at all of the distinguished Washington figures on one side of the argument and me and a group of non-Washington people largely unknown to you on the other and decided that the Washingtonians must have been right.

Because I was arguing against the conventional wisdom of well respected people, the book paints me as a zealot. Then you ask the question of why the President listened to me instead of them and you can only conclude that Hillary didn't understand numbers and the President was being loyal to an old friend. The reality is more straightforward. The Washington "group think" on the issue was wrong and the President and First Lady made their decisions not out of ignorance or loyalty but out of a greater knowledge, a wider consultation and a better understanding.

Your book is very insightful on the political process, but it lacks accountability for who was right or wrong on the substance. And without this, it is not possible to gain a full understanding of what happened politically. We made many mistakes as you show, but we understood the policy possibilities better than most. The quest for a more moderate, less bureaucratic, more incremental, less stringent, lower cost, less complex alternative to the president's proposal never led anywhere, because at the end of the day, the fundamental policy dilemma still existed.

What Bill Clinton understood better than anyone else was that there was a golden opportunity for universal health care in this country even in a period of budget restraint, because there was so much fat in the public and private health systems that reform could be financed primarily from savings. He was right. But the unwillingness of the Washington Democratic health establishment to acknowledge that significant short term cost savings were possible and the unwillingness of the competition advocates to allow back-up cost containment policies which could be scored contributed significantly to closing the window of opportunity.

There are other issues about the book which perhaps we can discuss over lunch sometime, but I thought that this is one you might want to ponder as you begin your book tour.

Again, congratulations on the publication of your book.

Regards,

Ira C. Magaziner
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ICM:dpr

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BODY:

For almost a year, I have been answering questions about health care reform issues in this column. In the process, I learned a great deal -- about what concerns people had, what issues were confusing and about the details of a wide range of reform proposals.

Nonetheless, along the way I was struck by what people didn't ask as the debate proceeded. Today, the Health section gave me the prerogative of making up my own questions to fill in some of these gaps.

Q. Why did it take President Clinton more than 1,300 pages to spell out his reform plan?

A. As critics and proponents alike pointed out, this was a very ambitious plan that touched on nearly every aspect of the U.S. health care system. But even if you took out those parts that dealt with issues such as medical education or malpractice reform, for example, it would still have been a very complex bill.

There are essentially two reasons this approach and the others like it are so complicated. First, the proposal opted to keep the system we now have where health insurance is most often provided through the workplace. But since we live in a world where many families have two or more earners and some workers have more than one job, the plan needed a raft of rules about which employers would pay for which employees. Many pages of the proposal were devoted to these rules -- trying to make sense out of a system that is inherently messy. It also meant that new rules for covering those who did not work had to be created to fill in the gaps. Part of the complexity arose because our current system is so jury-rigged.

The second factor that increased complexity was the decision to allow many insurance companies to participate in the plan and to offer all Americans a choice among a variety of plans. But people cite the current fragmented system, with its many insurers, as a cause of our problems. For example, insurance companies have found that one of the best ways to hold down their costs is to exclude sick people from their plans. So the plan needed to have rules and regulations prohibiting discrimination against sick people and prohibiting more expensive premiums for some people. To monitor these insurers and to guarantee

that individuals had a choice of plans, the Clinton administration created an elaborate alliance system, but this also complicated the proposal.

Yet, despite the complexity of the proposal, I was impressed by how many of these details were needed to answer the questions posed by readers. It actually was possible to find answers to many of the details that people cared about in that proposal. The only proposals that were simple to describe were either the single-payer approach, which would throw out the current system and replace it with simple requirements that everyone pay taxes and get coverage under a government plan, or proposals that did not achieve universal coverage and hence did not try to sort out who should pay for what.

Q. What is the story about choice? Is it restricted or not in all these health care plans?

A. An important theme of the health care debate was how much choice would be allowed. And while opponents and proponents of various proposals made claims about choice, they often failed to clearly define what they meant. Some of the confusion arose over whether choice referred to insurance plans or choice of doctors and other health care providers. The latter is clearly a bigger concern for most people. But restricting the number of insurance plans available could also limit access to doctors and hospitals if those plans limited their coverage to only certain doctors that they considered qualified.

All of the major reform proposals went out of their way to assure choice of both plans and doctors by requiring two things. The first was that there be at least one plan that allowed individuals to choose doctors who were not necessarily part of an insurance network but who charged for individual services. The second was that most of the plans that did offer price advantages by relying on doctors who were part of their own network or were contracting with the plan also allow patients to go outside the network to choose other doctors if they wished. Even the most ardent supporters of managed care, such as Rep. Jim Cooper (D-Tenn.), allowed such flexibility.

Thus, these proposals would actually broaden choice for many people. Already many Americans have no choice of health care plan: Their employer chooses for them, and when their plan is one with many controls -- such as a health maintenance organization (HMO) or other highly managed plan -- they are already restricted in terms of what doctors or other providers they may see.

Another possible issue for which choice has become the buzzword is the ability to seek desired treatment and have it paid for by insurance, regardless of whether an insurance plan or a physician or anyone else considers it unnecessary. If this is what people want to protect, then they are quite correct in assuming that reform will place limits on choice -- either by government regulation or by limits established by plans that must compete for business by offering lower prices. Again, this is an area where people's flexibility will likely be restricted in the future even if no reform legislation passes. If health care spending continues to alarm those who pay for care -- that is, employers and the government -- more efforts to make sure that care is efficiently delivered will occur and more controls will be established.

Q. Why can't we just get rid of the bad parts of the system and keep what we like?

A. It is relatively easy to imagine ways to expand coverage through incremental changes, such as subsidies for low-income people, if Americans are willing to raise taxes to pay for such expansions. But incremental changes are much less likely to be effective at controlling the costs of health care. And since many of the proposals would have relied on reducing the costs of health care to make expanded coverage more affordable, comprehensive reform makes sense for expanding coverage as well.

One of the problems with trying to limit what gets changed under reform is that parts of the system that people find appealing and want to protect may actually be the reason why others are excluded from insurance or find it so costly. For example, healthy people who want to keep the lower premiums they now pay are essentially in conflict with those who have health problems and want better, less expensive coverage than they can now get. These two positions are on the opposite sides of the same issue and no reform proposal -- not even incremental ones -- can satisfy both.

Finally, insurance reforms as part of an incremental approach will be limited in what they can accomplish. The practice of excluding people with pre-existing conditions can be eliminated for those of us who already have insurance but not totally eliminated for the uninsured. Sen. Bob Dole's (R-Kan.) bill would still allow a one-year pre-existing exclusion for those who are newly insured, for example. The guarantee that you can keep insurance if you change jobs is limited by whether your new employer offers it, and even that is limited to the insurance that the employer offers. Your plan may change substantially even though you are guaranteed "portability." Thus, these reforms are likely to deliver less than many Americans think may be possible with incremental change.

Q. Now that there will be no health care reform, can we protect what we now have?

A. Many of the questions addressed in this column came from people who were well covered and feared losing something after reform. But remarkably few people ever asked whether the coverage they now have would likely stay the same over time, even though most of us have seen major changes in our insurance policies in the past few years and will likely see many more. This certainly applies to the issue of choice but also to whether employers will continue to pay for expensive plans without asking their employees to contribute more themselves. Employer-subsidized coverage peaked in the mid-1980s and has been declining since then.

Like many other observers of our system, I suspect that the system will not resolve its many problems on its own and instead we will experience a gradual deterioration in insurance coverage and choice. If that is the case, my hope

is that next time there will be a more honest and reasoned debate on these critical issues.

GRAPHIC: ILLUSTRATION, JEM SULLIVAN FOR TWP

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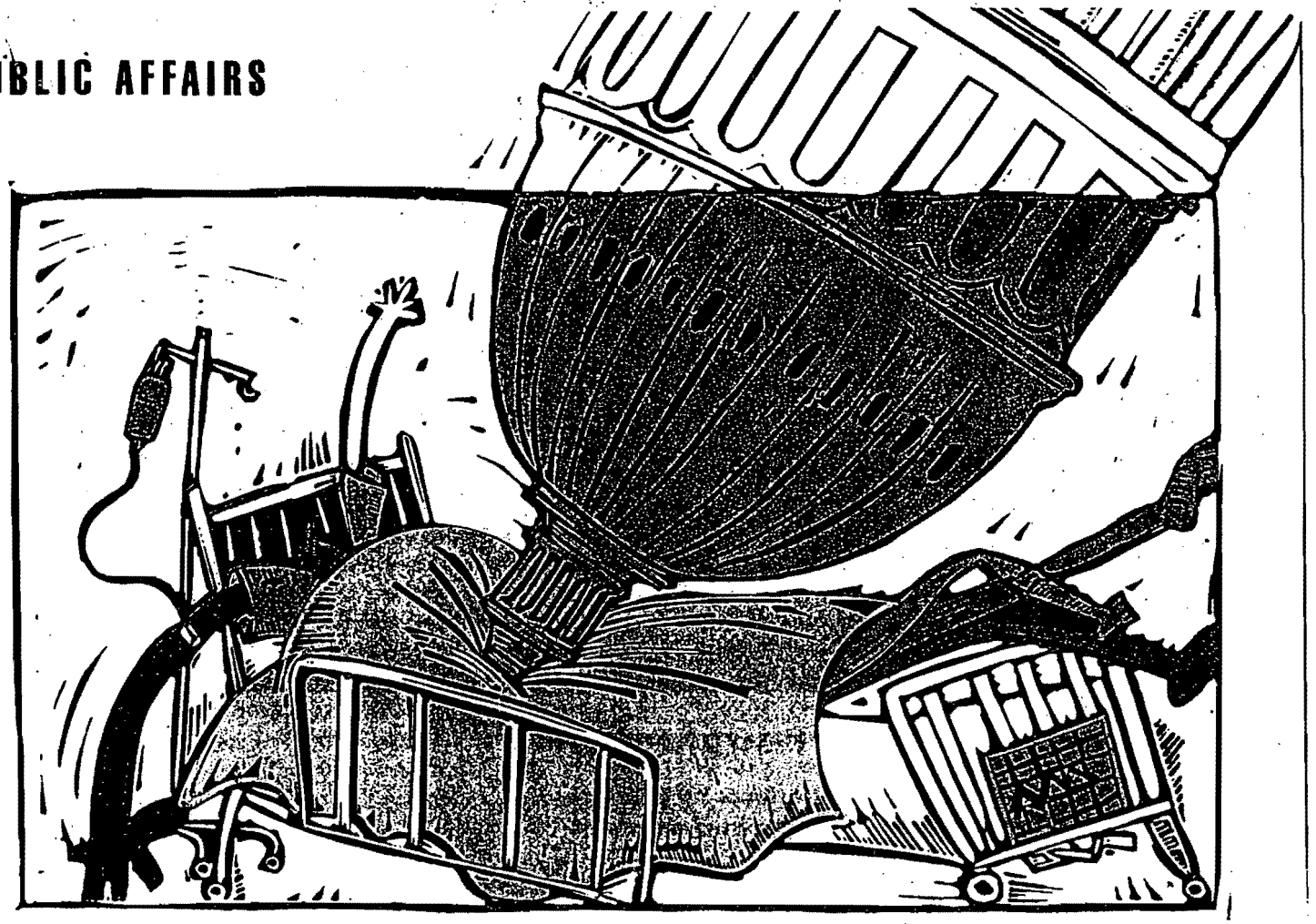


A Triumph of Misinformation

Most of what everyone "knows" about the demise of health-care reform is probably wrong—and, more important, so are the vague impressions people have of what was really in the Clinton plan

by James Fallows

By the time the Clinton health-care-reform plan was abandoned, in September, everyone knew how terrible it was. It had been hatched in secret by an egghead team that knew a lot about policy details but had no grasp of political reality. The Administration had wasted time and missed deadline after deadline for presenting the plan to Congress, causing the plan to miss its best opportunity for passage—during the President's brief honeymoon period, in 1993. The scheme was fatally overcomplicated. The proposed legislation, 1,342 pages long, was hard for congressmen to read and impossible for anyone except the plan's creators, Hillary Rodham Clinton and Ira C. Magaziner, to understand.

The Clinton plan would have imposed sweeping changes on one seventh of the national economy, with consequences far greater than Congress could possibly consider before casting a rushed vote. It represented a regulation-minded, top-down, centralized approach at a time when the world was moving toward decentralization and flexibility—and when the supposed health crisis was solving itself anyway. The more people learned about this plan, the less they liked it, and it finally died a natural and well-deserved death.

Or so goes the conventional wisdom, as relayed in countless newspaper and magazine postmortems of the health-care struggle. The critiques were usually accompanied by veiled jabs at Hillary Clinton—what will she do with her time now that health care's gone?—and outright ridicule of Magaziner, who was portrayed as the smartest person with the dumbest plan since Robert McNamara and the Vietnam War.

But suppose that what everyone knows is wrong. This happens all the time in politics. Barely a year ago, for example, everyone in Washington knew that Congress was absolutely certain to pass a health-care program by now. The leaders of the Administration's health-care-reform effort, Hillary Clinton and Magaziner, believe that everyone is wrong again now. I heard them elaborate this view in September and October, during a series of

Illustrations by Randall Enos

tion of both parties. . . . Clinton has been playing the health-care issue with an eye to keeping everyone at the table, at least at the outset.

In late September of 1993, when Hillary Clinton appeared before five congressional committees in three days to explain the rationale behind the bill, not a single legislator complained about "closed" or "secretive" deliberations: not Robert Dole, not Robert Packwood, not John Danforth—Republican senators who all later came out against the bill. Senator John Breaux, of Louisiana, a conservative Democrat who supported a competing reform plan, praised Hillary Clinton for the "truly remarkable" consultations the task force had carried out.

So when did the task force become "secretive"? Complaints inevitably arose when Magaziner and his assistants stopped soliciting outside advice and started announcing decisions. Those who disagreed felt that they hadn't been listened to. "Some people say they were excluded because in this case we didn't agree with them," Hillary Clinton told me. "But I think that a fair assessment is that we listened to everybody—and then made recommendations based on what we thought made the most sense."

The larger problem was with the one group that truly was excluded from the deliberations—the Washington press and, by extension, the public in whose interest it is supposed to act. During the brusque early weeks of the Clinton Administration, when George Stephanopoulos was walling reporters out of the White House press office and the Administration thought it could use talk shows to take its message directly to the public, over the heads of the daily press, Magaziner was told by the White House communications office that he and his associates should not talk to reporters about what ideas they were considering for the new bill. Instead they were supposed to refer all queries to the communications office. This didn't stop leaks, of course, but it gave Magaziner a lasting reputation among reporters as a man who liked to operate in the dark. Hillary Clinton is known within the Administration for a combative attitude toward the press. But she now says that the news blackout on emerging details of the health bill was a major mistake.

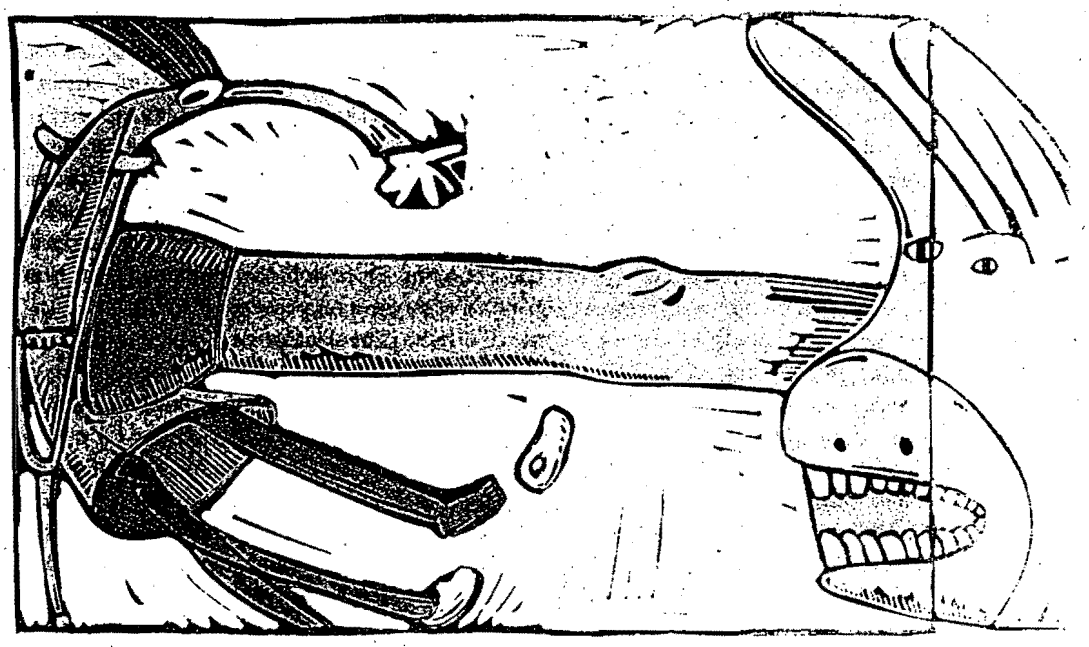
"Even though we had a process unlike any other that has drafted a bill," she told me, "—more open, more inclusive—we got labeled as being secretive because of . . . our failure to understand that we should be more available to the press along the way. That was something we didn't do well. . . . We were not aware of how significant it is to [shape] the inside story in Washington, in order to make the case . . . for whatever your policy is."

Secrecy toward reporters was stupid. But reporters are now acting as if it were something worse: closed-mindedness about ideas.

SECOND count: *The plan was politically naive.* Everyone now knows that the health-care reformers drew up their master plan without taking the slightest interest in what most Americans thought or felt. In reality, though, the plan suffered because the Administration was too attentive to shifting political moods.

Even before Inauguration Day, Magaziner was churning out memos about the right way to pitch the plan to editorialists and interest groups, about the likely Republican arguments and how to rebut them, about the connection between a health-care bill and a re-election campaign in 1996. Week in and week out his memos to Bill and Hillary Clinton contained head counts of likely Senate and House votes—who was leaning, who could be pressured and pushed. In his conversations with me Magaziner seemed to spend half his time sizing up the legislators he had had to deal with: Senator X was in thrall to Bob Dole because of personal problems, Congressman Y had to start out opposing the bill because of donations from Interest Group Z.

Two fundamental decisions about the plan had much less to do with policy than with judgments of political reality. One involved handling the single-payer challenge. A Canadian-style single-payer system has two big virtues. It is simple to administer, since doctors, hospitals, and patients no longer have to worry about dozens of insurance companies with scores of different payment plans. The single-payer approach also guarantees that everyone in the country has medical coverage. But Clinton was dead set against a single-payer plan, arguing that it would require sweeping new taxes and would, in effect, abolish the entire medical-insurance industry. This left the political problem of how to deal with the hundred or so members of the House who supported some kind of single-payer plan.



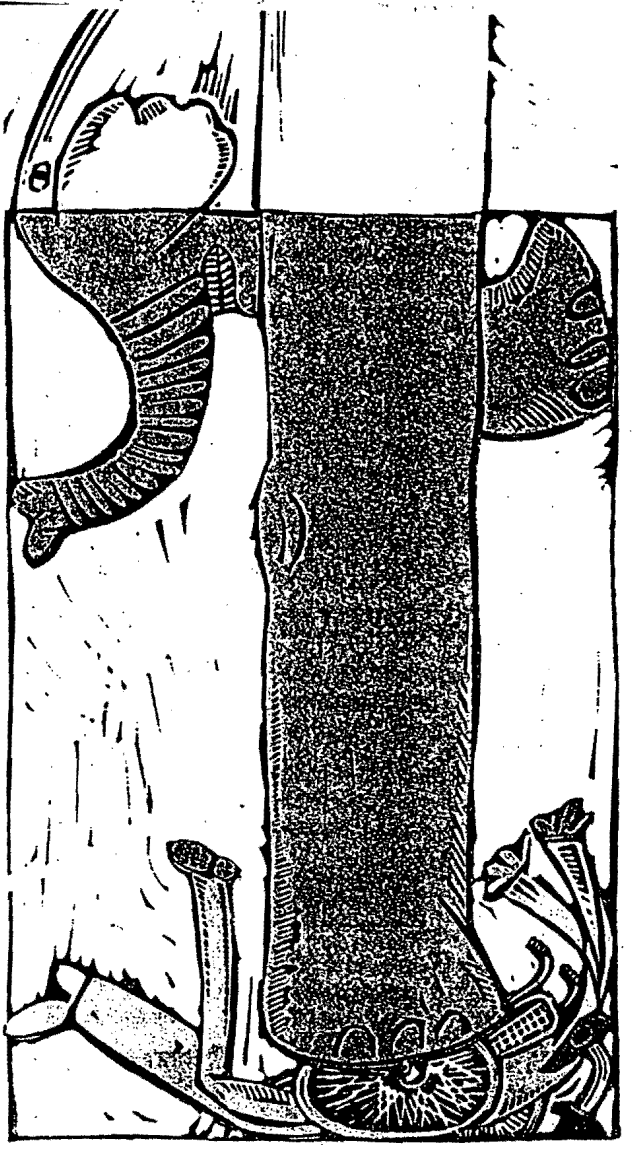
Congressional politics has quietly moved into the "supermajority" system that Lani Guinier was widely denounced for seeming to recommend. In theory it takes fifty-one votes to get a bill through the Senate. In reality it takes sixty votes to end a filibuster, so Bill Clinton knew that the Senate's forty-plus Republicans could stop nearly any legislation they chose.

They could not stop budget bills. These come to the floor under rules that limit debate, and with only a fifty-one-vote majority required for passage. So if the health-care plan could be made part of the budget bill, the Administration could get it acted on quickly, with enough of its own party's votes to see it through.

The Senate's majority leader, George Mitchell, endorsed this strategy, but its de facto parliamentarian, Robert Byrd, objected, scuttling the plan. The Administration then decided that it would introduce the health-care plan as soon as the budget bill passed. But passage was the rub. The budget bill, with its big deficit-reduction package, was seen by everyone in Washington as a major early test of the Administration's strength. (The struggle over the bill is the subject of Bob Woodward's book *The Agenda*.)

The budget fight dragged on much longer than Bill Clinton had hoped or planned. As it became obvious that the final budget vote would be very close (on August 6 it finally passed the Senate 51–50, with Vice President Al Gore casting the deciding vote), the Administration wanted to avoid any extraneous controversy that might affect it. Clinton had been scheduled to make the final decisions about the health-care plan in late May. Because of fears that leaks about his choices would complicate the budget vote, the decisions were put off—a delay that had ripple effects lasting the rest of the year. Without Clinton's decisions, the task force could not prepare detailed legislation; without legislation, it could not start negotiations with congressmen and their staffs. Without final choices on what would be in the package, it could not prepare budget estimates; without those estimates, the Treasury and the Congressional Budget Office could not vet the plan.

By the fall the budget fight was over—but then NAFTA became the issue of the moment. Clinton had been scheduled to spend most of the month of October traveling and speaking about the health-care



money. Employers would also have been free to offer additional coverage.) The health-care task force argued that the alliances had to be mandatory in order to create the community-rating effect. Otherwise, young, healthy people would stay out of the system, and the pernicious cycle of adverse selection would begin. An exception was made for employees of very large companies, who would still have been able to buy through their own firms' open-enrollment plans. The reasoning was that a General Motors or an AT&T had a work force large and diverse enough to constitute a community-rating pool all by itself. Everyone would have been forced into a pool one way or another.

Some health-care-reform plans have no mandatory component. Several versions of managed competition, for instance, would set up alliances like those in the Clinton bill but not require anyone to buy from them. It is virtually impossible, though, to achieve universal coverage without some element of compulsion. (Medicare offers universal coverage for those over sixty-five, but everyone who works is compelled to pay a Medicare tax.) Moreover, Magaziner argued, for most people the mandatory system would in practice mean more choice and freedom than they now enjoy.

When he ran a small business in Rhode Island, Magaziner said, he covered all health-insurance costs for his employees but could give them only two plans to choose from. Handling the bidding and paperwork for a broad range of plans would have been impossible. "If there had been an alliance, I could have paid my dues to the alliance and let people choose among all the plans." The alliances in the Clinton bill would have been required to offer customers a choice among all plans that met basic certification requirements. In big cities a dozen or more plans might be available. The minimum offering would be three kinds of coverage, including at least one fee-for-service plan that would permit a family to stay with the independent doctor it had been using.

After the plan was withdrawn, Uwe Reinhardt, an economist at Princeton University, told *The New York Times*, "No one understood this, but the average American patient would have had more choice under the Clinton plan than they now will. If you work for a particular company, your choice of HMOs is whatever that company offers you." Some critics argued that the Clinton plan would destroy the market for coverage beyond the plan's basic benefits, and that as a result people would find it difficult to buy as much coverage as they might like. But that is different from the widespread belief that extra coverage would be against the law—and for most people the range of choice would probably be broader under Clinton's plan.

Far from concocting a system that would look and feel radically different from what Americans were accustomed to, the task force believed that it was changing the surface of health care as little as possible while altering its underlying economic structure. The alliance system, despite its strange name, was meant to look familiar to people who already had coverage. The employer-mandate system of finance, in which companies would bear most of the health-insurance costs, reflected the fact that 90 percent of the people who now have insurance (excluding those on Medicare) get it through their employer. The employer mandate is a de facto tax but a well-established one, and a familiar concept in health-policy circles. Many Republicans, including Robert Packwood and Richard Nixon (!), have over the years endorsed employer-mandate plans.

Indeed, none of the individual elements of the Clinton plan was a shocking new entrant into the health-care debate. The plan's system for controlling expenditures, through premium caps that limited how fast the cost of basic coverage could rise, departed from Paul Starr's recommendations. But it closely resembled a plan offered by a group of congressional moderates that included the Republican senators John Danforth and Nancy Kassebaum.

To say that the resulting package of proposals was "too complex" is like saying that an airplane's blueprint is too complicated. The Medicare system is complex. So is every competing health-care-reform plan. Most of the 1,342 pages of Clinton's Health Security Act (which I have read) are either pure legal boilerplate or amendments to existing law. Conventional wisdom now holds that the sheer bulk of the bill guaranteed its failure. The NAFTA bill was just as long, and so was the crime bill that passed last summer. If the health bill had been shorter and had not passed, everyone would know that any proposal so sketchy and incomplete never had a chance.

employer mandates, very little content except a long-term goal of universal coverage. Led by Bob Dole and Newt Gingrich, Republicans by September were opposing any plan. "Every time we moved toward them, they would move away," Hillary Clinton says.

"We always knew that in the end people's trust of the President and First Lady would be crucial," Ira Magaziner says. "The debate was going to be complicated, and that trust factor was very important." Whitewater eroded the trust factor. The President looked beatable, and he lost.

Economic factors counted too. Doctors had fought bitterly against Medicare in the early 1960s, but for the most part they sat this battle out. If they weren't controlled by the government, they would be controlled by insurance companies, which in some ways were worse. But other interest groups had more to lose. Health-insurance agents would be put out of business. Health-insurance companies could have their premiums capped. For-profit hospitals thought they would lose money. Manufacturers of medical equipment thought that market growth might slow. Large businesses that did not already offer health care for workers knew the employer mandate would cost them money. (These were mainly corporations like PepsiCo and General Mills, which own restaurant chains whose part-time workers are uninsured.)

During the 1992 campaign the Clinton war room excelled at answering negative charges immediately, before damaging impressions could set in. But even flatly untrue attacks on the health plan went unanswered—direct-mail campaigns saying that everyone would have to go to a government clinic, daily doses of misinformation from Rush Limbaugh, TV advertisements fanning McCaughey-style fears of jail terms for people who wanted to stick with their family doctor. Last March *The Wall Street Journal* found that a panel of citizens preferred the provisions of the Clinton plan to the main alternatives—when each plan was described by its contents alone. But when pollsters explained that the preferred group of provisions was in fact "the Clinton plan," most members of the panel changed their minds and opposed it. They knew, after all, that Clinton's plan could never work. ❦

Receive Health Care
Alice Rivlin File

Orig: CHR
cc: Bonnie
Chris Jennings
Jennifer Klein

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

THE DIRECTOR

October 14, 1994

MEMORANDUM FOR BOB RUBIN
CAROL RASCO

FROM: Alice M. Rivlin

SUBJECT: Health Care Reform Strategy

As we begin to think about options on health care, it is important to establish a framework for evaluating the choices to be considered. This memo suggests a possible framework for beginning discussions of how to proceed with a health policy initiative for next year. Much of the necessary analytic work was produced over the past year to support the congressional process, and is already available to us. Assuming we are no longer looking at a plan which leads directly to universal coverage, the challenge is to rethink our approach to design the most effective reform measure to help the most people, and cause the least disruption. To a considerable extent, the challenge is to pose systematically the questions that Administration and congressional decision makers will need to consider.

Criteria for a New Health Care Reform Proposal

There are several clear criteria -- both positive and negative -- for any health care package that we develop.

The health care proposal must:

(1) **Take clearly necessary first steps to universal coverage** -- In the absence of universal coverage, a carefully targeted initiative should take incremental steps towards expanding coverage for populations most likely to lack adequate insurance, particularly the welfare to work target population. Expanded coverage should help a significant number of people as soon as possible.

(2) **Make progress towards cost containment** -- The plan should contain believable incentives to reduce the rate of growth of health care costs for the nation as a whole.

(3) **Be fully and credibly financed** -- A health care bill must be fully financed with credible sources of funds to cover any new expenditure commitments. The bill must be at least deficit neutral, and in the outyears, health care reform must contribute in a credible way to deficit reduction. The balance between funding sources should be carefully weighed so that program savings, particularly in Medicare and Medicaid, are believable.

(4) **Enhance health security through incremental insurance reform** -- Even if we do not reach universal coverage, the plan should still make the most progress possible to maintain coverage when people change or lose jobs or suffer a medical catastrophe.

The health care proposal must not:

(1) **Be complex** -- A health care proposal should be easy to explain to Congress, the press and the public.

(2) **Be overly bureaucratic** -- A health care initiative must build to the maximum extent possible on existing institutions, keeping to a minimum any new bureaucracy. If any new entities must be established, incentives for new institutions should be favored over mandates that new institutions be created.

(3) **Contain any mandates.**

(4) **Contain price controls.**

<u>Fundamental Components of Health Care Reform</u>

The building blocks which in one form or another are likely to be included in any health care reform bill are familiar at this point. While most were addressed in a similar manner in the end of session compromise efforts, in light of our shift to developing an incremental approach, there are significant issues that we may choose to reexamine.

(1) **Insurance reform** -- In order to substantially expand access to health insurance, some degree of insurance reform would be necessary. An early decision will be the extent to which any community rating is feasible. If so, policy options must be considered which would have the least disruptive impact on the market.

In the context of a bill designed to achieve universal coverage, broad community rating was essential, because it made affordable coverage, and a mandate -- even if as a back-up -- feasible. If the objective of insurance reform is more narrowly defined, it might be preferable to take more modest steps to close coverage gaps when people change jobs and to have a high risk pool for people who would otherwise not be insurable. Any insurance reform will have winners and losers, but a more modest approach would have less dramatic redistributive consequences.

In order for a more competitive health care system to evolve, consumers will have to be presented with more standard options for comparison. We will need to consider whether there should be a single standard package or a range of options. We will also need to reconsider whether standard benefits should be defined in law or administratively based on actuarial values.

(2) **Risk pooling** -- In order for individuals and small businesses to have access to affordable health insurance, some level of risk pooling is necessary.

If risk pooling is voluntary, how can we ensure that all health individuals and low risk small businesses leave the pool, leaving only high risk people in the pool? What rules can be developed to prevent adverse selection and how would such a risk pool be administered without creating a new bureaucracy.

(3) **Financing** -- We will need to review all of the financing alternatives that were considered last year -- including the tobacco tax and the various forms of tax caps that were on the table. Since realistic funding and deficit reduction are essential for even a scaled back plan to be successful, estimates of feasible financing may well define the scope of what can be achieved overall.

(4) **Cost containment** -- In the absence of universal coverage, and with premium caps and price controls off the table, we will need to develop an alternate credible plan for cost containment. I am inclined to review different tax cap scenarios, much as Senator Bradley did.

(5) **Expanded coverage** -- We need to consider various options for expanding coverage -- including low-income families, children, etc. The availability of funding may well dictate a more modest subsidy scheme, or a phased in approach. We should review additional options which would be less expensive, but still make real progress towards expanded coverage.

Additional building blocks likely to be included in any plan include information and quality and access in underserved areas. I would suggest that we establish a second tier of issues to discuss as we proceed in this process.

Next Steps

I propose that we spend some time over the next several weeks exploring these and other questions. In order for the staff to have time to prepare option memos for our review, we should meet early next week to define the scope of our policy review and set a timetable. After we have the opportunity to review these options within each area, and possible packages, it may make sense to block out some time, perhaps on a weekend, to make decisions on our recommendations.

Rx Drug Lily

DRAFT

DRUG BENEFIT FOR QMB'S/SLMB'S

Issue

What alternatives exist for the Federal government to provide low-income Medicare beneficiaries with a drug benefit?

The cost of drugs for low-income beneficiaries often precludes their obtaining medically necessary drugs. The Medicare benefit package does not now cover prescription drugs. Medicare beneficiaries also eligible for full Medicaid receive drug coverage through Medicaid. Some low-income Medicare beneficiaries receive Medicaid coverage of some or all Medicare cost-sharing but not the full package of Medicaid services.

Background

QMBs and SLMBs are Medicare beneficiaries with income below poverty or below 100 or 120 percent of poverty (starting 1/1/95), respectively, and assets below 200 percent of the SSI limits. States' medical assistance programs pay Medicare premiums for all QMBs and SLMBs. For QMBs, States also pay Medicare deductibles and coinsurance. In addition, for certain QMBs and SLMBs, the so-called dual-eligibles, who are typically receiving SSI or in an institution, States also provide Medicaid regular benefits, which include prescription drugs. Substantial numbers of people could qualify for QMB/SLMB benefits but have not enrolled. If they did, they would probably qualify for Medicare cost-sharing benefits, but not Medicaid drug coverage. (See chart on next page.) Providing a drug benefit to QMBs/SLMBs would improve coverage of the 1.3 million people who now get only the Medicare cost-sharing benefit. It might also encourage increased program participation among the 2.2 million who qualify for the QMB/SLMB benefit but have not enrolled.

August 1994, data from the Medicare Current Beneficiary Survey [to be updated to include VA and State programs] indicate that when a beneficiary and spouse have income less than 100 percent of poverty ($9,840 for a family of two in 1994), 48.5 percent have prescription drug coverage under private health insurance (PHI) or Medicaid (17% have PHI and 33% Medicaid). Of those with incomes between 101 and 120 percent of poverty 34.6 percent have coverage (23 % PHI and 12.1% Medicaid). Between 121 and 150 percent of poverty, 36.5 percent have drug coverage (33.2% PHI and 3.9% Medicaid). When the income levels are between 151 and 200 percent of the poverty level, 44.1 percent are covered for drugs with only 1.5 having Medicaid benefits and 42.8 having private insurance coverage. (See attached chart.) Consequently, the higher the income level used to determine a Federally funded drug benefit, the more a cost shift will occur from private health insurance coverage to the Federal government.

MEDICAID COVERAGE *

MEDICARE COST-SHARING AND

PRESCRIPTION DRUGS

Coverage	People	
Part B "Buy-In's"	4.0 mil.	100%
- Medicare cost-sharing only (no Rx)	1.3 mil.	33%
- Medicare cost-sharing, plus full Medicaid (incl. Rx) - dual-eligibles	2.7 mil.	67%
Probably meet QMB/SLMB criteria but no enrollment	2.2 mil.	

* Numbers to be updated by Actuary.

MEDICARE CURRENT BENEFICIARY SURVEY 16:47 FRIDAY, AUGUST 26, 1994

ROUND 4 RESULTS
DRUG COVERAGE IN AT LEAST 1 PRIVATE INSURANCE PLAN
BY INCOME OF SP AND SPOUSE

	R4 CROSS-SECTIONAL FINAL WGT						
		P.H.I. RX COVERAGE OR MEDICAID		HAS PRIVATE RX DRUG COVERAGE		MEDICAID IN ROUND 4	
		NO	YES	NO	YES	NO	YES
	%	%	%	%	%	%	%
CLASSES	100.0	51.6	48.4	63.5	36.5	87.5	12.5
INCOME AS % OF POVERTY							
Unknown	14.5	50.9	49.1	76.1	23.9	74.1	25.9
<=100%	21.7	51.5	48.5	83.0	17.0	67.0	33.0
101-120%	6.9	65.4	34.6	77.0	23.0	87.9	12.1
121-150%	10.2	63.5	36.5	66.8	33.2	96.1	3.9
151-200%	12.9	55.9	44.1	57.2	42.8	98.5	1.5
201-300%	15.6	47.3	52.7	47.5	52.5	99.7	0.3
301% +	18.2	40.7	59.3	41.2	58.8	99.5	0.5

SOURCE: Medicare Current Beneficiary Survey

DRAFT

Options

Option 1: Create a prescription drug benefit operated through the Medicaid program at 100% FFP for QMBs/SLMBs.

By incorporating the program as part of the existing Medicaid drug rebate program, this would provide a State-defined benefit for the 2 million who are not dual-eligibles covered by the existing Medicaid program, but who have incomes below 120% of poverty. This category of people would only be entitled to a drug benefit, not the entire Medicaid package.

This benefit could be administered under contract through a private contractor, or by the State through the existing Medicaid program.

Pros:

- Would be an add-on to an existing benefit and well-established Medicaid program.
- The outpatient drugs provided under the expanded coverage would qualify for rebates.

Cons:

- Administratively difficult -- Funding the benefit at 100% FFP would be difficult to administer because it would not be for the entire prescription drug program, but for drugs paid only for a specific set of eligibles.
- Since States now must return to the Federal government a share of their rebates based on the State FMAP, a decision would have to be made as to whether and how States would compensate HCFA for what share of what rebates for the drugs paid for under this benefit. There could be pressure to handle this benefit more like the PHS drug discount program in order to simplify it, and this in turn could lead to pressure to change the entire Medicaid drug program.
- Costs would increase not only due to the new drug benefit but also due to Medicare cost-sharing associated with new enrollees who have not previously participated.

Option 2: Create a prescription drug benefit under Medicare at 100% Federal cost for low-income individuals.

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This option would create a uniform benefit administered as part of the Medicare program that would be limited to certain low-income individuals. This benefit would not be available to the current Medicaid dual-eligibles, but would be available to Medicare beneficiaries with incomes up to 120% of poverty.

Pros:

- Uniform administration makes sense if the eligibility and the benefits are standardized nationwide.
- Medicare is a more administratively appropriate program for a benefit at 100% Federal cost.
- Implementing a program for a small number of Medicare beneficiaries could provide a pilot for a more comprehensive Medicare drug benefit.

Cons:

- This would establish a means-tested benefit under Medicare.
- While this would be a benefit for a relatively small number of beneficiaries, there would be pressure to make it available for all Part B beneficiaries.
- Implementing a drug program for a small number of Medicare beneficiaries would increase Federal staffing needs as well as administrative and systems costs.
- Implementing even a limited benefit at 100% Federal cost would make it difficult to propose a premium-based benefit expansion to more beneficiaries.

Option 3: Federalize and make uniform all aspects of the QMB and SLMB provisions -- financing, eligibility, reimbursement based on the Medicare rate structure, and Federal administration, and create a drug benefit as part of the Federal program.

This option would create a benefit that included both an expansion of drug benefits to higher income Medicare beneficiaries, as well as Federalizing the QMB benefit. The Federalized QMB benefit would provide considerable financial and programmatic relief to States.

Pros:

- Creates a drug benefit for the elderly near poor

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without doing it for all of Part B.

- Relieves the States of the payments for the QMBs and SLMBs.
- May result in increased participation in the QMB/SLMB programs.
- Uniformity and equity across States in the drug benefit and subsidies for the Medicare cost sharing for this population.

Cons:

- Federalization of all QMBs/SLMBs, rather than just those not otherwise eligible for Medicaid, could lead to excessive new costs.
- Cost shift from the States to the Federal entitlement program without any comparable benefit provided to other Medicaid or Medicare eligibles.

Option 4: Federalize the QMB/SLMB program and create a drug benefit for a portion of the population based on a specified income level.

This option would be similar to Option 3, but the income cut off for the drug benefit would be set higher than the 120% level required under the QMB/SLMB benefit.

In addition to the pros and cons in option three:

Additional Pro:

- Creates a drug benefit for even more of the poor elderly.

Additonal Cons:

- Would provide drug coverage to some elderly who may already have drug coverage, or who are able to pay out-of-pocket.
- The costs would be even higher than under the previous option, and the cost shift may occur not only from the States, but also from private insurance and individuals.