Congress of the United States
Washington, DC 20515

August 4, 1993

Dear Colleague,

Before leaving town for the August work period, we want to bring you up to date on the CDF's market-based health care reform initiative.

As you know, we made history last year by introducing the "Managed Competition Act", H.R. 5936. Prior to the CDF Health Care Reform Task Force's involvement in the debate, managed competition was virtually unknown in Washington. Now it forms the basis of the Administration's upcoming health care proposal.

Many of you have asked us when the bill will be reintroduced. Until now, we have held off on reintroduction with the hope that we could work with the Administration to develop a managed competition plan which we could support. We have been meeting regularly with the First Lady and her senior health care advisor Ira Magaziner urging them to stick with pure managed competition and reject the heavy-handed government regulation that is being pushed by those who favor a Canadian-style health care system.

While the President has yet to make some final decisions, it seems virtually certain that his proposal will include a mandate on employers to purchase health coverage for their employees and a "global" limit on private sector health care spending enforced by price controls on health plans. His plan is also likely to lack key elements of managed competition, such as an effective limit on employer tax deductibility to encourage cost containment.

The advocates of a Canadian single-payer approach already have 85 cosponsors in the House and appear to have momentum on their side. Despite their highly-public freak with the President, they are being catered to by the White House. We need to make a stronger statement about the support among Democrats for market-based reform. And we need to do that so it is clear we are trying to help the President develop a plan that actually has support enough to pass.

We are interested in hearing your thoughts about the best way to proceed. We still hold out hope that we can support the President's plan, but we are redrafting the bill for introduction when Congress reconvenes in August. Our intention is to send your offices a draft of the new bill the week of August 30th and to seek additional cosponsors that following month when members will be back in Washington.

Sincerely,

Jim Cooper Michael A. Andrews Charlie Stenholm

Press Conference Statement
by
Rep. Jim Cooper (D-TN)
October 6, 1993

[Before beginning, I would like to thank the extraordinarily talented staff for their able assistance, particularly Anand Raman, Atul Gawande, Caroline Chambers, Dave Kendall, and Colleen Kepner. None of us would be here without their remarkable work.]

My name is Jim Cooper. I am a Democratic congressman from Tennessee. Today we formally introduce the Managed Competition Act of 1993. It is the only comprehensive, bipartisan health reform plan in the 103rd Congress.

Standing with me are some of the 46 original cosponsors of the bill, 27 Democrats and 19 Republicans. A companion bill is expected to be introduced in the Senate in the next few days under the sponsorship of Senators Breaux and Durenberger.

All of us want health care reform to pass in this Congress and to be signed into law by the President. We applaud President and Mrs. Clinton's leadership in this vital domestic policy issue. We particularly applaud the First Lady's courage, vision, and outreach. No one could have worked harder, more compassionately, or more intelligently than she has to try to solve our health care problems. As the former Surgeon General, Dr. C. Everett Koop, has said, the Clintons have already shown more leadership in health care than all of their living predecessors combined.

These are tough issues; that's why most Presidents avoid them. But we share the White House's view, and the American people's view, that much of our health care system is broken and must be fixed... now.

When the President addressed the Joint Session of Congress two weeks ago, he said that there was room for honest disagreement on the best way to reform our health care system. While we support a great deal of what we know of the Administration's plan, we do have some serious concerns that must be addressed.

Areas of Agreement

We agree with the Administration that all Americans should be able to get health insurance and keep it no matter how sick they have been, where they work, or if they switch jobs. No American

will live in fear of a pre-existing condition or bad experience rating again. The price of coverage must also be affordable. We should help all of the poor and near-poor buy coverage, and enable everyone to obtain it at the lowest possible group rates, as if they worked for a Fortune 500 company. We also think the self-employed should be able to deduct 100% of the cost of health coverage.

We agree with the Administration that more Americans should be able to choose their favorite doctor instead of having to put up with their boss' choice. Nine million federal employees have expanded their choices and held down costs for thirty years using an annual menu shopping system that even the Heritage Foundation says is one of the best government programs in history. It's high time we shared that with all Americans, simplifying the menu by adding a standard benefits package. The price and quality of health care should be disclosed in advance so that all Americans can finally shop for health care the way they shop for everything else.

We agree with the Administration that preventive care, primary care, rural and inner-city care must be emphasized. Outcomes reporting, practice guidelines, gatekeepers and case managers should be utilized to help us get more value for our health care dollars. Like the Administration, we want the people to choose their favorite delivery system for health care, whether it is an HMO, PPO, IPA, POS, or regular fee-for-service medicine. Uniform claims forms and electronic processing will help us cut through the health care red tape. Malpractice reform is also necessary to help reduce the cost of defensive medicine.

We agree with the Administration that today's health care system has one of the worst incentive structures possible. It makes more money off of us the sicker we are and the more tests that are run. The system should have an incentive to keep us healthy and to do the right number of tests.

Not Managed Competition

Despite all of this bipartisan support for so much of the President's plan, we still think it falls short of real managed competition. Likewise, the various Republican plans fall short. Why does this matter? Because we feel that managed competition will work better back home and may be the only way to break the partisan gridlock in Washington.

We think that fledgling versions of managed competition are already working in California, Minnesota, Florida, and Washington State. One hundred fifty American cities already have employer purchasing coalitions. The Federal Employee Health Benefits System is a nationwide managed competition model.

The Administration started with managed competition and went to the left. The Republicans took managed competition and went to the right. Our bill is squarely in the middle, and is the only one with significant bipartisan support. It is the first health reform approach since Harry Truman to get major Democratic and Republican support. The New York Times, Fortune, and U.S. News & World Report have already predicted that the final legislative compromise will be very close to our bill.

We have no pride of authorship. Although several of us had introduced the first managed competition bill in history, H.R. 5936, in the last Congress, and although both President Bush and then-Governor Clinton endorsed managed competition in the last election, we chose not to introduce our bill in this Congress. Others introduced their health reform bills, but we did not. We hoped that the Administration would adopt enough of our ideas so that we would not have to introduce.

The father of managed competition, the Jackson Hole Group, and the leading exponents of it, the Conservative Democratic Forum (CDF) and the Democratic Leadership Council (DLC), have all concluded that the public should be able to see a real managed competition bill so that they can decide which plan is the best medicine. This issue will be, and should be, decided around the kitchen tables of America.

As my colleague Fred Grandy will mention, we object to employer mandates, global budgets, price controls, restrictive/regulatory purchasing cooperatives, excessive state flexibility and the continuation of unlimited corporate tax deductibility for health benefits. We want to hold down health care costs and to expand access using market forces, not big government.

We have grave concerns about a plan that allows any state to adopt a single-payer health system, but allows no state the chance to have real managed competition reform.

Continue the Dialogue

Our reluctant introduction of this bill is not an end to our dialogue with the White House and others on health reform. We fully realize our bill is not perfect, and are anxious to improve it. There are already parts of it that I and others would like to change. But it is a true bipartisan plan, and that is the best way to begin a debate on reshaping one-seventh of the U.S. economy. We need the collective wisdom of both political parties to help us find the right solutions.

Our purpose is entirely constructive. We emphasize what we are for. We have a bill that people can see and criticize before President Clinton or Senator Chafee have even introduced theirs.

As the former Speaker of the House, Sam Rayburn, once said, "Any mule, or elephant for that matter, can kick a barn down. It takes a carpenter to build one." I can guarantee you that every one of our original cosponsors is in the carpentry business.

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Agenda:

ANALYSIS OF THE COVERAGE AND INSURANCE MARKET REFORM ASPECTS OF HR 3222 (COOPER-GRANDY)

HEALTH ALLIANCES AND INSURANCE REFORM

DESCRIPTION OF THE PLAN

ESTABLISHMENT OF PURCHASING COOPERATIVES FOR SMALL BUSINESSES AND INDIVIDUAL PURCHASERS. In general, states would be expected to establish HPPCs as non-profit organizations with elected boards. Each region would have only one HPPC.

All employers with 100 or fewer employees ("small employers") would be required to offer coverage to employees through the HPPC (but would not be required to contribute towards the coverage) to receive any tax deduction for payments made for health benefits. Former Medicaid recipients (because Medicaid is repealed), the unemployed, and the self-employed who choose to purchase coverage would also be required to do so through the HPPC (in order to receive a tax deduction and subsidies). A state could raise the 100 employee threshold, but only to the point where no more than 50% of the employees in the state were required to participate in the HPPC.

HPPCs contract with "accountable health plans" to offer a choice of plans to HPPC participants (but there is no requirement that a choice of plans, in fact, be available). HPPCs collect premiums from employers and families and, in turn, pay health plans. HPPCs may **not** set or enforce payment rates for providers or premium rates for health plans. Nor may a HPPC, in general, exclude a health plan certified by the Health Care Standards Commission from participating in the HPPC. HPPCs are required to use risk adjustment to compensate plans that have riskier than average populations.

COVERAGE FOR EMPLOYEES OF LARGE EMPLOYERS. Employers with more than 100 employees ("large employers") would be required to offer coverage to employees through an accountable health plan (but not required to pay for it). Large employers would **not** have the option of joining the HPPC, but they could join with other large employers to form a separate purchasing group. To receive the tax deduction or subsidies, employees of large employers would be required to obtain coverage through the AHP chosen by their employer.

Health plans would be permitted to charge experience-rated premiums to large employers. Large employers would be permitted to operate self-insured plans, but no federal guaranty fund would be established.

CERTIFICATION OF AHPS. All health plans are certified by the Health Care Standards Commission (including self-insured plans operated by large employers).

A health plan would be required to guarantee access to coverage for anyone participating in a HPPC. For large employer

plans, an AHP would be required to accept all eligible employees within the large employer group.

Within a HPPC, health plans could vary premiums by age (the premium for an older individual could be up to twice the premium for a younger person) but not by health status. For large employer plans, AHPs could charge experience-rated premiums for the employer group, but the premiums charged to families within the group could only vary by age and geographic area.

The bill limits preexisting condition exclusion periods applied by AHPs to no more than six months. The exclusion period must be reduced or waived for enrollees who are continuously insured.

For insured health plans (as distinct from self-insured plans offered by large employers), states would continue to regulate financial solvency. However, in certifying insured health plans, the Health Care Standards Commission is required to ensure that the state in which the health plan is operating has adequate solvency protections. For self-insured employer health plans, the Health Care Standards Commission may require that the plan post a bond (or other assurance) to protect enrollees from insolvency.

Providers that participate in health plan networks cannot balance-bill patients. However, for providers outside of networks -- in a PPO, point of service plan, or fee for service plan -- there are no limits on balance billing.

POLICY ISSUES

LIMITS ON INSURANCE REFORMS. Insurance reforms are limited to employees of small businesses, the self-employed, and the unemployed. If an employer has 101 employees and one of them gets sick, there is no limit on how much an insurance company can raise the company's premium.

CHOICE OF HEALTH PLANS FOR FAMILIES. Alliances and purchasing cooperatives permit families, rather than employers, to choose their health plan. Under the HR 3222 no one working for an employer with more than 100 employees is guaranteed choice. An employer could offer only an HMO to its employees, with no opportunity to see a doctor outside of the HMO.

Less choice also means less continuity of coverage. Under HR 3222 changing jobs would likely mean having to change health plans (and possibly doctors) as well. This is particularly true since HR 3222 provides no guarantee that a fee-for-service plan is available to people working for small or large employers.

BALANCE BILLING. Without protections from balance-billing in non-network health plans, competitive pressures on AHPs and

providers may result in a shifting of costs to enrollees. Balance billing also distorts competition since consumers will not know the true out-of-pocket costs associated with each health plan.

SPREADING THE COST OF SERVING MEDICAID RECIPIENTS AND THE UNEMPLOYED. Restricting enrollment through purchasing cooperatives to small employers with 100 or fewer employees purchasers means that the cost of serving Medicaid recipients and the unemployed is loaded exclusively on small businesses and their workers. And since Medicaid recipients are included in the community rate within a HPPCs, premiums for small businesses providing coverage will rise significantly. In a voluntary market, this means that some small employers will drop coverage.

Roughly 200 million people would obtain coverage through regional alliances under the HSA, while about half that many would be eligible to receive coverage through HPPCs under the HR 3222. Under the HSA, about one-third of the participants in regional alliances would be under 200% of poverty, while about half of the eligible people in HPPCs would be under 200% of poverty under HR 3222.

THRESHOLD FOR SELF-FUNDING. Permitting employers with as few as 101 employees to self-insure threatens the health security of their employees (since these firms are not large enough to adequately assume risk). Without a federal guaranty fund for self-insured plans, providers serving self-funded plans could at substantial risk.

RESOURCES TO MONITOR LARGER FIRMS. Monitoring large employer plans under HR 3222 will be difficult and require substantial resources. The ability of the federal government to monitor firms outside of alliances/HPPCs deteriorates significantly as the number of such firms grows. Under the HSA, no more than a couple of thousand of firms would be eligible to form corporate alliances. Under the HR 3222, 50,000 to 100,000 firms would operate outside of HPPCs.

POTENTIAL FOR ADVERSE SELECTION. Since small employers and individuals are not technically required to purchase coverage through the HPPC and insurance reform rules do not apply outside of the HPPC, the HPPC pool could suffer adverse selection. Small employers, the self-employed, and individuals unaffiliated with an employer only receive the benefits of tax deductibility of health coverage if they purchase through the HPPC. In addition, families with income below 200% of poverty only receive subsidies if they purchase coverage through the HPPC.

Whether these financial incentives would be sufficient to make insurance obtained through the HPPC more attractive than coverage outside the HPPC depends on a number of factors:

- For young, healthy individuals it may be possible to

obtain less expensive coverage outside of the HPPC. This is because rating based on health status is not permitted in the HPPC, and variations in premiums for age are limited to a ratio of two to one.

(Unlimited age rating would likely result in a ratio of four or five to one from the premium for oldest individual to the youngest individual. Constraining this ratio at two to one means that premiums for younger individuals will rise and premiums for older individuals will fall.)

- If cost shifting inside the HPPC is severe (as a result of folding Medicaid recipients into the community rates and shifting the cost of low income subsides to small employers and non-low-income families), premiums outside the HPPC could be substantially lower.

- Tax deductibility may not create much of a financial incentive for some moderate income families with relatively low tax rates.

TAX CAP

DESCRIPTION OF THE PLAN

Under HR 3222, an employer would be subject to a 34 percent excise tax on any "excess health plan expenses" paid or incurred by the employer. Health plan expenses are considered "excess" if they exceed the lowest-cost accountable plan in the individual's health plan purchasing cooperative (HPPC). In addition, health insurance must be attributable to coverage under an accountable plan. The excise tax would also apply to employer contributions for cafeteria plans. The excise tax is non-deductible. Employees would continue to exclude all employer-provided health insurance benefits from taxable income.

The net effect of the HR 3222 tax cap is to subject a portion of employees' compensation -- the employer contributions for health insurance -- to a 34 percent excise tax. (The tax is collected from their employers.)

Taxpayers would be able to deduct premiums for coverage under an accountable health plan "above the line" -- without regard to the 7.5 percent-of-AGI floor on medical expense deductions. Deductible expenses could not exceed the cost of the lowest-price accountable plan in the HPPC. Moreover, the amount of the allowable deduction would be reduced by payments, if any, made by employers or a government entity for coverage of the individual under any health plan.

The deduction for health insurance expenditures by self-employed persons would be increased from 25 percent to 100 percent. However, qualifying expenditures would be limited to amounts paid for the lowest-cost accountable plan in the individual's region.

These provisions are generally effective for expenses incurred after December 31, 1994. A transition rule is provided for collectively bargained plans.

POLICY ISSUES

ALTERS CURRENT EMPLOYER-BASED SYSTEM. HR 3222 is based on the premise that the employers' role in providing health care for their employees should be reduced. If they offer anything better than the cheapest plan around, they have to pay a 34 percent tax to the Federal government.

Ultimately, the HR 3222 cap, combined with the proposed above-the-line deduction, can weaken the foundations of the current employer-based system for providing health insurance benefits. Under the current system, most employers pay for a significant portion of workers' health insurance benefits. In

large part, the extensive employer-based health insurance system in the current system reflects the fact that workers can only obtain preferential tax treatment for health insurance expenditures through their employer. The approach in HR 3222 penalizes workers whose employers provide health insurance benefits in excess of the standard benefit plan. Moreover, it provides employers with a rationale to opt out of providing health insurance benefits for their workers, by allowing individuals to deduct such costs from their own taxable income.

EXCISE TAX WILL AFFECT ALL EMPLOYERS EQUALLY. HR 3222's tax cap proposal is often described as a denial of the employer's deduction for the excess benefits. However, the excise tax in HR 3222 is generally more severe than a loss of deduction -- the 34 percent tax would apply regardless of whether the employer had any taxable income for the year and would also apply to non-profit organizations.

EFFECTS OF BASING TAX CAP BASED ON THE LOWEST COST PLAN IN A HPPC. HR 3222 bases the tax cap on the lowest cost plan "which enrolls at least such proportion of eligible individuals in the HPPC area as the [Health Care Standards] Commission shall specify." There are several implications of this policy for the stability of the system:

- Which health plan is designated as the lowest cost plan could change from year to year, leading to instability and confusion for employers and employees.

- Without any limits on premium increases, the premium charged by the lowest cost plan could change dramatically from year to year.

- If the Health Care Standards Commission specifies a low proportion of enrollment that a health plan must have to be designated as the lowest cost plan, that plan could be a small plan without the capacity to enroll all those employers and families who want to stay within the tax cap.

  If the Health Care Standards Commission specified a large proportion of enrollment that a health plan must have to be designated as the lowest cost plan, it is possible that in some areas there will be no cost plan, and presumably therefore no tax cap.

- A health plan designated as the lowest cost plan might not serve the entire HPPC. Therefore, a family living in a part of the HPPC that the plan does not serve will not be able to avoid a paying a tax penalty for enrolling in a health plan.

INCIDENCE OF COST OF EXCISE TAX. Employers will pass on the costs of the excise tax to their employees. Many employers will

be forced to scale back health insurance benefits for their workers. To the extent that employers substitute cash wages for health insurance benefits, workers will pay income and employment taxes on the additional wages. Other workers may be able to retain their current health insurance benefits, but their wages or other benefits will be reduced to pay for the 34 percent employer tax.

KEY QUESTIONS ON DETAILS. HR 3222 is short on details. HR 3222 has not identified which benefits must be offered by accountable health plans. Under HR 3222, the Health Care Standards Commission selects the standard benefit package after the enactment of the bill. This is a critical omission. Because the effects of a tax cap depend on the scope of benefits included in the standard package, Congress is being asked to OK a tax increase without knowing its effects on taxpayers.

BURDEN ON EMPLOYERS AND IRS. HR 3222 may look less bureaucratic because the Health Care Standards Commission is not required to determine and enforce premium caps for each Health Alliance. But HR 3222 relies on a complicated tax cap in order to contain costs. Under the HR 3222 the tax cap applicable to each worker's health insurance costs would vary depending on the worker's residence, age, and family status. If each state had only two health alliances and the cost of the standard benefit plan was allowed to vary for five distinct age groups, the IRS would be required to enforce as many as 1,000 distinct tax caps. Businesses would find it difficult to comply with such a confusing array of tax caps. With existing resources, the IRS would find it difficult to monitor compliance.

COST CONTAINMENT. Applying the tax cap to the lowest-cost plan in a region will penalize many consumers. Consumers will suffer if the lowest-cost plan is inexpensive simply because it skimps on some service many consumers value (such as short waits in the reception area or doctors who spend a little extra time with their patients).

TAX TREATMENT FOR THE SELF-EMPLOYED. Under the HR 3222, self-employed workers will only be able to deduct expenditures toward the lowest-cost plan, rather than the full costs of the standard benefits package in any health plan.

POTENTIAL FOR UNIVERSAL COVERAGE. HR 3222 provides a tax deduction as a way of encouraging uninsured persons to purchase health insurance. But even with the tax deduction -- and subsidies for low income families -- many will remain without coverage. If the uninsured do not respond to this incentive, those of us with insurance will continue to pay higher premiums to cover the costs of caring for the uninsured.

COST CONTAINMENT

DESCRIPTION OF THE PLAN

HR 3222 relies on insurance reform of the small group and individual market and on a tax cap to reduce health care costs.

HPPCs would offer a choice of AHPs to families employed by a small business or purchasing coverage directly. The AHPs would offer a standard benefit package (although the contents are not specified), and HPPCs are required to monitor disenrollment and provide information to consumers on health outcomes and quality. A risk adjustment system is required to protect AHPs that enroll a higher than average risk group of enrollees.

The bill uses the tax code and subsidies to encourage individual purchasers (e.g., the unemployed, self-employed people) and families working for small employers to purchase coverage through HPPCs. Small employers would receive a business deduction for a health plan payment only for contributions made to AHPs through HPPCs. Individual purchasers would be eligible for tax deductions or subsidies for health plan payments only if they purchase coverage from an AHP through a HPPC.

Large employers would be required to offer coverage through AHPs certified by the Health Care Standards Commission to receive a business deduction for health plan payments. Families working for large employers would be eligible for tax deductions and subsidies only if they purchase from the AHP selected by their employer.

The tax deduction available to all employers for providing health benefits to their employees would be limited to the cost of the "lowest-cost" plan in each HPPC area. Contributions in excess of the lowest-cost plans, however, would not be considered as income to the employee.

POLICY ISSUES

ENCOURAGING COMPETITION. The market structure created by HR 3222 does not necessarily reward efficiency and service. Large employers can limit the number and type of plans offered to their employees. Reduced family choice will attenuate the rewards to health plans that offer a quality product at a good price.

INTEGRATION OF MEDICAID RECIPIENTS INTO HPPCS. The relatively small HPPCs (only individual purchasers and families working for small employers) will result in higher premiums inside the HPPCs. Because the community pool is relatively small (only employers with 100 or fewer employees) and includes Medicaid recipients and the unemployed, AHPs contracting with HPPCs may be required to charge much higher community rates than

health plans not contracting with HPPCs. AHPs that can avoid contracting with HPPCs may be able to prosper even if they are not efficient.

BALANCE BILLING. The proposal does not prohibit balance-billing by non-network plans, which will result in cost-shifting to enrollees and will distort competition across health plans. Without protections from balance-billing in non-network health plans, competitive pressures on AHPs and providers may result in cost-shifting to enrollees. Balance billing also distorts competition since consumers will not know the true out-of-pocket costs associated with each health plan.

STABILITY OF MARKET UNDER REFORM. The insurance market structure proposed by the Copper bill is likely to be unstable. HR 3222 requires health plans to absorb part of the premium cost for low income people choosing AHPs above the lowest-cost plan. This will increase the premiums charged to small employers and families for those plans. Higher premiums may cause some small employers and individuals to stop purchasing coverage, making the pool of insured even smaller.

It may be possible for some families and employers to find coverage outside of the AHP system that is less expensive than that offered by AHPs (even with the tax benefits and subsidies restricted to AHPs). If AHP premiums in HPPCs are high (i.e., due to adverse selection, inclusion of Medicaid recipients at community rates and, potentially, inadequate subsidies), some or many may find it advantageous to forgo tax benefits and subsidies and purchase outside of the HPPCs. This would eliminate the positive effects of choice of health plan and focus competition back toward risk selection.

In addition, tying the tax cap to the lowest-cost plan may cause instability in some local markets. If the lowest-cost plan changes from year to year, employers will be uncertain as to which plans they can contract with (or the level of contributions they can make) without incurring a large tax penalty. Employers may need to amend their contribution levels (or switch plans) from year to year as the lowest-cost plan changes. This could be a particular burden for employers operating in more than one HPPC area.

CONTINUATION OF UNCOMPENSATED CARE. The lack of universal coverage means that the problems that result from uncompensated care will continue. Without universal coverage, uncompensated care will continue to be a problem for health care providers, who will shift the costs of treating the uninsured to other payers. This cost-shifting will distort competition because provider prices will be a function of both their relative efficiency and their share of the uncompensated care burden. This will penalize providers who treat disproportionate numbers of uninsured people.

RISK OF COST INCREASES. Without a cap on private sector

premiums, employers, families and taxpayers bear the risks of cost increases. HR 3222 has no backup to competition that assures that the growth of health care costs will be abated.

COVERAGE

DESCRIPTION OF THE PLAN

HR 3222 reforms the small group and individual insurance market to assure that individuals and families will be accepted by AHPs offering coverage in their area. The bill also provides subsidies for lower income families.

Unlike other proposals, the bill has no requirements for employers to offer or pay for coverage or for families to purchase coverage.

The exact benefits covered and cost-sharing requirements are not specified in the bill. The Health Care Standards Commission, an executive branch agency, would recommend a uniform set of benefits and cost-sharing to Congress. This benefit package would be required of all AHPs (both inside and outside the HPPC). The recommendations of the Commission are adopted unless Congress disapproves them.

POLICY ISSUES

POTENTIAL TO ACHIEVE UNIVERSAL COVERAGE. The absence of any mandate means that universal coverage is much less likely to be attained. The most definitive studies of health insurance purchasing behavior would suggest that average premium reductions on the order of 30% would be necessary to create universal coverage voluntarily. This seems highly unlikely under any scenario.

POTENTIAL FOR ADVERSE SELECTION. Without universal coverage, the problem of adverse selection will continue and could be exacerbated by community rating. Adverse selection is the greater tendency of less healthy or higher risk people to seek insurance for their health care needs. When adverse selection occurs, the pool of insured people over time becomes disproportionately higher risk and higher cost, which increases the price of insurance beyond the average price of covering all of the people in the community. Higher premiums may result in some people dropping coverage, especially those that are healthy and have less demand for insurance.

The bill tries to mitigate one selection problem by permitting premiums to be adjusted for age. On average, older people use more health care services than younger people, and therefore are more expensive to insure. The bill, however, limits age adjustments to 100%, whereas the current marketplace uses age adjustments in excess of 300% to 400%. In a voluntary insurance market, an age adjustment of 100% may not be sufficient to protect against increased premiums caused by a disproportionate tendency of older people to seek insurance.

The potential that some families and employers may find less expensive coverage outside of the AHP system (even with the tax benefits and subsidies restricted to AHPs) could lead to significant selection against the AHPs offering through the HPPCs.

UNCOMPENSATED CARE. Without universal coverage, uncompensated care will continue to be a problem. Under the proposal, large numbers of people may remain uninsured. This will preserve the cost-shift to private payers that exists today. Coupled with the end of Medicaid disproportionate share payments (under the abolished acute care Medicaid program), this could also create difficulties for some local hospitals treating large numbers of the poor.

LOW-INCOME SUBSIDIES

DESCRIPTION OF THE PLAN

HR 3222 provides subsidies on behalf low-income individuals and families, but no subsidies for businesses contributing towards health coverage.

There are two components of premium assistance on behalf of the low income families:

- Establishment of a maximum premium that health plans can charge with respect to a low income family.
- A subsidy payment by the federal government to the plan enrolling the low income family.

The total amount received by a health plan for a low income family under HR 3222 -- both subsidies and premiums paid by the family -- will not add up to the premium a health plan normally charges to someone who is not subsidized. The difference is left as a responsibility to the plan. This amount would presumably be recouped through cost shifting to small employers and families in the HPPC.

Separate premium adjustments are made for those under 100% of poverty and for those between 100% and 200% of poverty. Those over 200% of poverty are responsible for the full premium.

For families with income below 100% of poverty:

- The family can enroll in the lowest cost plan in the HPPC with no required premium payment.
- If federal subsidies are fully funded -- based on caps set out in the bill -- the health plan gets paid by the federal government its full premium.
- If the family chooses to enroll in a health plan more expensive than the lowest cost plan, the family is only responsible for 10% of the difference between the cost of the lowest cost plan and the cost of the chosen plan.

  If federal subsidies are fully funded, the higher cost plan gets paid the premium for the lowest cost plan and must absorb (or shift) 90% of the amount of its premium that is above the lowest cost plan.
- If there is a deficit in the federal funding for subsidies, then the federal government pays plans only a percentage of the premium for the lowest cost plan and the health plans have to absorb (or shift) the

difference.

Subsidies are calculated in a similar manner for families with income between 100% and 200% of poverty on a sliding scale basis.

In addition, a fixed amount of federal out-of-pocket subsidy dollars will be provided. These dollars will be paid out to plans on an average basis (i.e., on behalf of each low income family, a plan will receive a fixed amount of federal out-of-pocket dollars, adjusted for the family type).

Federal assistance is also provided for low-income Medicare beneficiaries: Those below 120% of poverty receive full subsidization for Part A and Part B premiums and those under 100% of poverty are not required to pay their co-insurance and deductibles.

The total dollar amount available for federal subsidies is equal to federal Medicaid dollars that would have been payable to states for the year, plus the net change in revenues resulting from provisions in the bill, particularly the tax cap provisions. This total applies to the financing of all of the following provisions in the bill: phased-out long-term care assistance to states; Medicare low-income assistance; cost-sharing assistance; low-income premium subsidies; and grants and other expenditures. Estimation errors on the total federal dollars available are corrected in full in the next year.

POLICY ISSUES

COST-SHIFT TO INDIVIDUAL AND SMALL BUSINESS PURCHASERS. HR 3222 explicitly forces a cost-shift of potentially substantial proportions from the low income enrollees in the HPPCs to the non low income individuals and their small employers who purchase insurance through the HPPCs. The greater the enrollment of the low income population, the greater the burden upon the non low income populations/small employers enrolled in the HPPCs.

Even if the federal subsidies are fully funded, cost shifting to small employers is likely because some low-income families will choose to enroll in plans other than lowest cost plan (especially since they only have to pay 10% of the difference in cost between the lowest cost plan and a higher cost plan). If federal subsidies are not fully funded, then the cost shifting is exacerbated.

Due to this cost-shifting inherent in the funding of low income subsidies, small employers who currently provide coverage for their workers might find it preferable to drop coverage. Small employers might drop coverage entirely, or forego the tax preference that comes with purchasing through a HPPC. If this happens to a large extent, individual purchasers could be priced

out of the insurance market completely.

The smaller the HPPCs become as a result of the incentives for purchasers to opt out of them, the greater the cost shifting burden becomes for those who remain. Depending upon the severity of the migration of private payers out of the HPPCs, it may become difficult to convince insurers to provide coverage through the HPPCs at all.

BIDDING BY HEALTH PLANS. The funding of low-income subsidies complicates bidding by health plans. The actual premium dollars received by a health plan will depend on a variety of factors:

- How many low income families are in the HPPC, and which health plans they choose.
- The premium for the lowest cost plan (which determines the base amount in subsidies paid by the federal government).
- Whether or not subsidies are fully funded, and therefore what percentage of the lowest cost premium the federal government will pay.

A health plan has no way of knowing this when it is submitting a premium bid, and therefore is at substantial risk for collecting insufficient premiums to cover costs. Health plans may very well react by setting premiums high in order to compensate for this risk (which would, in turn, exacerbate any under-funding of subsidies).

MEDICAID

DESCRIPTION OF THE PLAN

HR 3222 eliminates the Medicaid program, effective January 1, 1995.

The people formerly served by Medicaid (AFDC recipients, the disabled, pregnant women, low-income children, and the medically-needy) would be included in the community rated HPPC pool. They would be provided subsidies for premiums and cost sharing through the low income subsidy program.

Disproportionate share (DSH) payments to hospitals (currently over $15 billion) would be replaced by a $50 million per year transition fund for "safety net" hospitals.

A new federally funded program for wrap-around services for all families below 100% of poverty (including Medicare eligible people) would be established. The Health Care Standards Commission would establish the exact scope of services.

A new federally funded program for Medicare beneficiaries below 120% of poverty for payment of part B premiums would be established. In addition, a new federally funded entitlement program for Medicare beneficiaries below 100% of poverty would cover Medicare deductibles and coinsurance.

States would be financially responsible for providing all long term care services (both institutional and home and community based). Federal matching payments for long term care would be phased out over five years.

POLICY ISSUES

INCLUSION OF MEDICAID RECIPIENTS AT COMMUNITY RATE. Including the Medicaid population in HPPCs at a community rate could increase premiums for small employers and their employees substantially (a rough estimate is as much as 45%). If the federal funds available for subsidies do not meet the total need for subsidies, then a further increase in the community rate will result.

The financing mechanism in HR 3222 relies on transferring the currently "experience rated" payments for the SSI and medically needy disabled populations into a "community rated" payment in HPPCs. This transfer, however, shifts the higher costs for the disabled from Medicaid to HPPC participants.

EFFECTS OF ELIMINATING DSH. Eliminating DSH without achieving universal coverage will create hardships for both providers and patients. This is especially true if increased

competitive pressure decreases the ability of providers to cost shift to the insured.

THE NEW REPUBLIC

FEBRUARY 7, 1994

Why the Cooper plan won't wash.

COOPER POOPER

By Harris Wofford

After a season of new health care proposals, political posturing and broad-brush propaganda by private interest groups, Congress is about to get down to work on crafting a comprehensive health care plan. The final result should be a private-sector system that has lower inflation than our present one, has less bureaucracy and offers greater individual choice among doctors and health plans.

That happy prediction is based on something like Winston Churchill's wartime faith in the American people. In 1941, when Britain's survival hung by a thin transatlantic lifeline, Churchill said he was confident that the Americans "in the end will do the right thing ... after they have tried every other alternative."

Doing the right thing in health care means achieving two basic goals: guaranteeing coverage for every American and checking the escalation of costs. The challenge is for members of Congress to reach across ideological lines and work with the president to overcome the resistance to reform that thwarted Harry Truman and Richard Nixon alike. Political fantasy? No. Pennsylvania's 1991 special election showed that health care is too important to ignore. It's a problem not only of the poor and uninsured, but of the middle class, which is

concerned about the cost and security of its coverage.

So now there are plenty of "reform" plans on the table, most importantly the president's Health Security Act, of which I am a co-sponsor. THE NEW REPUBLIC, in a recent editorial ("For the Cooper Plan," December 6, 1993) is right that no measure will pass without the support of proponents of Representative Jim Cooper's plan (and backers of Senator John Chafee's Republican proposal and Representative Jim McDermott's "single-payer" plan). And it's right to discard proposals like Senator Phil Gramm's as "hardly worth taking seriously" because they do so little to achieve universal coverage or limit rising costs. But to ask Congress to accept only the half-steps proposed by Jim Cooper is to risk losing a historic opportunity.

As thoughtful as he is, Cooper's bill does not do what needs to be done. He promises "universal access," but that's not saying much. As my colleague Tom Daschle puts it, we all have "universal access" to Rolls Royce dealerships. That doesn't put us behind the wheel. In fact, according to the Congressional Budget Office, Cooper's plan would leave 22 million people without coverage. Yet a recent NBC/*Wall Street Journal* poll shows that 78 percent of Americans see guaranteed coverage as the sine qua non of health reform.

Changing certain insurance industry practices will improve the availability of coverage: portability of coverage from job to job, a prohibition against denying coverage on the basis of pre-existing conditions. These are part of the Cooper plan—and the president's—but they don't guarantee universal coverage. Health plans must also be required to "community-rate." That is, they must charge all enrollees in a certain area the same amount. Without this step, they will still discriminate against people: not by excluding them but by charging them exorbitant premiums.

While Cooper's plan reflects a healthy skepticism about government's ability to solve every problem, it shows how a little reform can be a dangerous thing. He calls his plan "Clinton-lite." It has the distinction of being both less filling and more expensive. For the Cooper plan is "lite" on reaching comprehensive coverage, but it's heavy on family pocketbooks—as well as the national budget. Unlike the president's plan, the Cooper bill would increase the deficit by some $70 billion over five years, according to CBO/Joint Tax Committee estimates. That doesn't sound very "New Democrat" to me. Nor does the plan's reliance on the IRS: it would create a new layer of government paperwork for every employer by having the agency enforce the cap on tax deductibility.

The Cooper plan would do nothing to reverse the present trend toward limiting people's choice of their own doctors and pressing them into low-cost HMOs. Indeed, by making employers pay taxes on any health premiums higher than those of the lowest-cost plans, it would speed up the process of restricting choice.

Like the president, Cooper proposes reducing the rate of growth in Medicare and Medicaid. But he does so without controlling spending on the private sector side. As a result health care providers will shift costs, as they do today, by charging their privately insured patients more. Unlike the Health Security Act, the Cooper bill includes no protection for early retirees, who are increasingly seeing their coverage cut off by former employers. It doesn't begin to face the challenge of long-term care. And it doesn't cover prescription drugs for the elderly.

Crafting health care reform isn't a multiple-choice question with one right answer; it's an essay in which many primary sources contribute to the final product. Cooper himself lists fifteen similarities between his proposal and the president's, as well as eight key differences. He calls the plans "first cousins" and suggests a "family reunion" in any final legislation.

The most fundamental agreement is that competition should be promoted by regional purchasing groups through which individuals and businesses would buy coverage. Cooper calls them "Health Plan Purchasing Cooperatives"; the president calls them "Health Alliances." But this rose by either name is the agency for the "managed competition" Cooper has championed. Cooper should declare victory (and Congress should adopt many of his provisions to assure that the groups are consumer-run cooperatives, not new government agencies). The common ground also includes a standard claims form, electronic billing and consumer "Report Cards" on the competing plans. And there is agreement that Medicaid should be replaced, so the poor can have the same choices as everyone else.

So what is holding us back? Rhetoric aside, the fight is over this: Should employers continue to pay health care premiums and should the present employer-employee contribution system be extended to all employers and their workers who are uninsured? Or should the only "mandate" be put on individuals and families, with the help of some new government subsidies?

Supporters of the Cooper and Chafee plans aren't willing to insist that all employers contribute. That may appear like political practicality. But it runs into a harsh reality: any plan that does not provide for a shared employer-employee responsibility would put great financial pressure on companies to dump coverage and shift billions in cost onto working families. The fact is most insured Americans now receive coverage through employers. The Cooper plan could mean that a family earning $30,000 per year would have to spend what *The New York Times* labeled a "merciless" $5,000 per year for basic coverage.

Restraint may be a virtue. Far more virtuous, however, would be to fulfill Truman's promise of universal, private health insurance. Jim Cooper's proposal fails that test. So having considered the alternatives, we should in the end, as Churchill suggested, "do the right thing."

HARRIS WOFFORD is a Democratic senator from Pennsylvania.

Congress of the United States
House of Representatives
Washington, DC 20515

February 14, 1994

The Honorable Jim Cooper
125 Cannon House Office Building
Washington, D.C. 20515

Dear Jim:

We are writing to express our deep concern that your health care reform plan shortchanges women's health.

This is an historic moment. Health care reform presents us with an unprecedented opportunity to correct long-standing inequities in women's health care. In order to meet this challenge, Congress must pass a reform plan with a specifically defined comprehensive benefits package that includes coverage of women's health. Such a package is vital to improving women's health care and must be central to any reform effort.

Unfortunately, the Cooper plan defers the responsibility of developing and defining a comprehensive benefits package to a national commission, thus placing fundamental decisions in the hands of unaccountable and unelected officials. As women who have suffered from our health care system's historic failure to adequately fund, cover, and teach women's health, we have little confidence that a national commission will provide for an equitable system. It is the clear responsibility of the Congress to define a comprehensive health benefits package that recognizes women's needs.

Any comprehensive health care reform package that treats women fairly must explicitly include the full range of reproductive health care services, including abortion, as a basic benefit. Coverage of prenatal care and maternity care, family planning services, and abortion are all part of basic women's health care. In addition, comprehensive health care reform must ensure that a basic benefits package covers mammograms, pap smears, and pelvic exams at appropriate intervals that allow women and their doctors flexibility. Women and their families must know that they will have access to these critical services, or health care reform will not have met its stated objective.

We look forward to working with you to enact a health care package that provides equitable care for all Americans. However, we will not support a reform package that fails to offer explicit coverage of women's health care. We cannot allow health care reform, which offers such promise, to take women backwards.

Sincerely,

Louise M. Slaughter

Nita M. Lowey

Pat Schroeder

Lucille Roybal-Allard

Lynn C. Woolsey

Jolene Unsoeld

Elizabeth Furse

Mary T. Mink

Leslie Byrne

Barbara B. Kennelly

Nancy Pelosi

Lynn Schenk

Cynthia McKinney

Patricia Saiki

Carrie P. Meek

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Constance A. Morella

Lynn N. Rivers

Ileana Ros-Lehtinen

Lynn N. Rivers

Eva M. Clayton

Lonnie Thurman

Eva M. Clayton

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Chris — FYI — you're now on the mailing list

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To: Tennesseans Following Health Care Reform

From: Congressman Jim Cooper

Date: Friday, August 13, 1993

WASHINGTON TURNS TO HEALTH CARE REFORM

Now that his budget plan has been enacted, the President and Congress will turn their attention to health care reform. September 21 is the current target date for release of the Administration's plan -- probably before a joint session of Congress -- but the general framework may be laid out as early as next Monday in President Clinton's address to the National Governors' Association.

Conservative and moderate Democrats continue to have grave reservations about what we have heard of the proposal. I have been leading meetings of like-minded Members of Congress with representatives of the White House to communicate these concerns. As many of you know, until now I have withheld reintroducing my managed competition bill, preferring to work with the White House to develop a plan which could receive bipartisan support.

SINGLE-PAYOR ADVOCATES GAIN STEAM

However, Congressional advocates of a Canadian-style, government-run system have not been so cooperative. They have attacked the Administration's plan at every opportunity, introduced their own bill and garnered 86 cosponsors, despite the Congressional Budget Office's estimate that their proposal would require raising about $600 billion a year in new taxes.

As a result, the White House now appears to be more worried about losing the support of the single-payor advocates than they are about losing moderate Democrats. This is short-sighted. One thing that the battle over the deficit-reduction plan taught us is that health care reform must be bipartisan in order to pass. Pure, market-based managed competition, as I have proposed, is the only plan with true bipartisan support in Congress.

EMPLOYER MANDATE RECEIVES MORE SCRUTINY

In another important signal, last week forty-one Republican senators sent a letter to the President opposing a mandate on employers to purchase health coverage for their employees. This means that even without any Democrats (of which there are many who would agree), Republicans could sustain a filibuster in the Senate over any bill containing such a provision.

The Healthcare Leadership Council recently commissioned the respected consulting firm Lewin-VHI to study the impacts of an employer mandate under the best available version of the Clinton plan. Their state-by-state analysis concludes that the Clinton mandate would increase aggregate health care costs for Tennessee employers by 88%. Employers nationwide would pay on average 53% more.

WHITE HOUSE PLAN LIKELY TO ALIENATE MODERATES

Unfortunately, it now seems virtually certain that the President's plan will include not only an employer mandate, but also a global budget on private sector health care spending enforced by price controls on health plans. In addition, the White House Task Force has transformed managed competition's purchasing cooperatives into government Health Alliances with the power to regulate and exclude health plans. The proposal is also likely to lack key elements of managed competition, such as an effective limit on tax deductibility to encourage cost containment.

In order for moderates to show the breadth of support for real, market-based reform in Congress, we need to have a rallying point. Therefore, I will have my bill ready to reintroduce when Congress returns to Washington next month. My colleagues and I in the Conservative Democratic Forum have been working closely with the Congressional Mainstream Forum and the Democratic Leadership Council to build support for this approach.

I was recently asked by the Congressional newspaper Roll Call to describe the important ways in which the original managed competition differs from the hybrids. I have no pride of authorship in my proposal; it's not perfect. But I do feel that in order for health care reform to work, it must be internally consistent. Unfortunately, many of the adaptations of managed competition, in my view, make it unworkable. I have attached the article for your information.

P.S. For those of you who have been forwarding these letters to the White House, you no longer need to waste your stamp. The White House is now on the mailing list.

Managed Competition That's Real

You Can't Tinker With the Idea for Political Expediency, Writes Its Chief Advocate, Rep. Jim Cooper. He Explains What's Acceptable, What's Not.

By Rep. Jim Cooper

A year ago, few people had ever heard of managed competition in health care reform. Today, the term is used by so many it has nearly lost its meaning.

As President Clinton is poised to introduce a health care plan that is likely to include managed competition as its basis, many people have forgotten that certain elements are essential in order for managed competition to work.

Managed competition was conceived over the course of several years by the Jackson Hole Group, a collection of academics and industry leaders who have met regularly for the past two decades in Jackson Hole, Wyo. In the last Congress, my colleagues in the Conservative Democratic Forum and I introduced a pure managed competition bill using the Jackson Hole model. The Democratic Leadership Council and the Progressive Policy Institute also embraced this approach in their book **Mandate for Change**.

Managed competition has proven to be politically attractive because it represents a compromise between complete government takeover and laissez faire in health care. But the balance that managed competition strikes between regulation and competition is not arbitrary. One cannot simply adjust it for political expediency without ruining the mechanism that makes it work.

Managed competition requires just enough government intervention to establish ground rules for health plans competing in the system, to enhance the power of consumer choice in the market, and to guarantee access to coverage for all Americans.

What are the key elements of managed competition, and where does it draw the line between government responsibilities and the role of the market? Here is a guide:

The balance that managed competition strikes between regulation and competition is not arbitrary. Adjustments could ruin the mechanism that makes it work.

• **Insurance Market Reforms.** There is competition in today's market, but it is destructive competition among insurance companies trying to avoid sick customers.

The new Accountable Health Plans (AHPs) will be required to offer coverage to everyone. They will not be able to deny coverage or charge more for a preexisting medical condition. Coverage will be portable.

Insurers have also competed negatively by crafting hundreds of different benefits packages. Under managed competition, there must be a single, standardized benefits package that all health plans offer so consumers can make "apple to apple" comparisons. Any package offering more than basic care still would be fully and freely available as long as it did not duplicate basic coverage.

Some have suggested different benefits packages for different types of health plans (e.g., HMOs, PPOs, and fee-for-service). But this plays into the hands of the insurance industry and will subvert effective competition.

As price competition intensifies, health plans and their providers must be held accountable for the quality of the care they deliver. Consumers should have comparative quality information on all health plans. This information should not be limited to process measures (e.g., immunization or mammography rates); it must also include analysis of clinical and functional outcomes. Providers must be constantly challenged to improve their care of patients.

Because AHPs will be held accountable for price and quality, they must have the ability to establish networks and to exclude inefficient or poor-quality providers. AHPs also must be free to reimburse their providers any way they choose.

• **Purchasing Cooperatives.** Pooling the buying power of individuals and small businesses will give them market advantages only the largest employers enjoy today: a large risk pool, choice of multiple health plans, lower administrative costs, market power, and group rates.

But in order for managed competition to be effective, health plan purchasing cooperatives (HPPCs) must have exclusive service areas. Competing HPPCs would eliminate most of the administrative savings, create greater opportunity for segmentation of health risks, and make the system less user-friendly for the consumer.

Most calls for competing HPPCs arise from concern over certain proposals, not supported by the Conservative Democratic Forum, which would give HPPCs excessive discretionary authority.

To slow increases in spending, buyers must bear the cost of choosing wasteful health plans.

Managed competition HPPCs, however, are neutral farmers' markets, not regulators. They must offer all qualifying health plans in the area, allowing consumer choice to determine which health plans succeed and which fail. HPPCs should not have the power to limit enrollment in plans, regulate premiums, or set provider fees.

Finally, HPPCs must not bear risk or have a financial stake in any health plan. Managed competition HPPCs are designed to enhance consumer choice, not limit it.

Since large employers already have the benefits of group purchasing, they don't need much government help. Through direct contracting with AHPs or through self-insuring, large-employer purchasing will provide an important counterbalance to the HPPC in the marketplace. Of course, large-employer plans must meet the same access and quality standards as any other AHP.

• **Tax Reform and Employer Contributions.** In order for managed competition to slow increases in health care spending, buyers must bear the cost of choosing wasteful or excessive health plans. Subsidizing the cost of expensive health care plans, as em-

Rep. Cooper: Health Reform With a Real Track Record

ployers and federal tax policy do today, is anticompetitive. It actually discourages health plans from reducing their prices.

An employer must not be allowed to vary its contribution to employees' health benefits according to the health plan an employee has chosen. An employer must be required to "define" a specific dollar amount for its contribution so that employees don't receive a greater contribution if they pick a higher-priced plan. An employer could still define its contribution to be the price of the most expensive plan, but employees must be able to choose a less expensive plan and receive a rebate for the difference.

Federal tax policy shields employers from the full cost of choosing relatively expensive health plans because it allows

Government-imposed limits on what health plans may charge are fundamentally incompatible with managed competition.

employers unlimited deductibility of the cost of health benefits provided to employees.

But limiting employer deductibility to spending on the standardized benefits package, as some have proposed, is not sufficient because it does not influence the purchaser's decision among health plans offering those benefits. Deductibility must be limited to the price of the most cost-effective plan meeting federal quality standards.

• **Artificial Price Constraints.** Government-imposed limits on what health plans or providers may charge are fundamentally incompatible with managed competition.

If, after several years, fully implemented managed competition fails to constrain sufficiently health care cost increases, then government regulation may be necessary. But trying to combine managed competition with global budgets or price regulation from the outset will prevent managed competition from working.

The failure of price controls to contain spending in health care and other segments of the economy are legion. History has shown us time and again that we lack the necessary data to set them fairly and the tools to enforce them.

Instead, we must change the underlying incentives in the system before we can make real headway on cost containment. Managed competition tries to do that by

Managed competition isn't perfect. But its performance — in states like California, Minnesota, and Wisconsin — is better than its alternatives.

giving health plans and providers the financial incentive to provide only high-quality, cost-effective care.

Price regulation will destroy those incentives. It will send a mixed message to providers about where they should focus their efforts. Being profitable in a competitive environment and being profitable in a regulatory environment require very different skills.

Providers need to know that they are going to be challenged every day by a market demanding more cost-effective treatments and technologies, not challenged to think up new ways to increase their reimbursement rates.

No one is arguing that managed competition is perfect. But its track record — in states like California, Minnesota, Wisconsin and in 150 cities with employer-purchasing coalitions — is better than its alternatives.

Managed competition has worked because it does not ignore the behavioral responses of the private sector to government interventions. In fact, it relies on those responses to reform the system in a way government could never do alone.

Rep. Jim Cooper (D-Tenn) is a member of the Energy and Commerce subcommittee on health and the environment.

Chris,

Andrea (HHS - 690-7538) called to let you know that she gave the msg. to the Secy. but she failed to acknowledge Sen. Leahy.

Thanks,
Diane

Do NOT FAX

"THE MANAGED COMPETITION ACT OF 1993": SOME CONCERNS

There are many components of this approach we completely agree with. Like Congressman Cooper, we believe community rating returns insurance to a community responsibility, not an exercise in profit making and risk avoidance. Like Congressman Cooper, we believe that an increased emphasis on competition will promote efficiency, reduce waste, and lower costs. And finally, like Congressman Cooper, we believe increased cost-consciousness is an important aspect of health care reform, and a necessary ingredient for cost control.

But we cannot support the Cooper bill because it does not provide health security for all Americans. We believe all Americans need and deserve health care security; this plan just doesn't provide that. We believe that comprehensive benefits should be spelled out and guaranteed; this plan doesn't provide that. We believe choice of doctor is a right; this plan considers choice a taxable luxury. We believe HMOs are one alternative; this plan believes HMOs are for everyone.

The Cooper plan must get a failing grade as it does not meet five of the six principles the President has set forth for comprehensive health reform.

1. *It does <u>not</u> provide the security of a comprehensive package of benefits that can never be taken away.*
2. *It does <u>not</u> provide increased choices for consumers.*
3. *It does <u>not</u> provide a simpler system.*
4. *It does <u>not</u> guarantee savings -- it continues the cost shift and raises the deficit.*
5. *And it asks responsibility from <u>no one</u>. In fact it gives no one any reason to be responsible.*

COOPER: *"[The plan does not] compel employers to pay the health plan premiums of their employees."*

Translation: In fact, the Cooper plan doesn't require anyone -- not employers, not individuals, not the government -- to take responsibility for health care. Therefore, it doesn't provide health care coverage for everyone and guarantees no one security.

There are only a few ways to guarantee coverage for all Americans. One is to raise a broad-based tax, and have the government finance and deliver health care. The second is to require employers to contribute to coverage for all of their workers. The third is to require all individuals to purchase insurance for themselves. Whether it's the government, employers, individuals, or some combination... for everyone to have coverage, someone has to pay.

The Cooper plan assumes that between better incentives and government help for the poor, more Americans will be covered. But individuals can still decide that health care isn't their responsibility-- it's yours and mine. They can still go without coverage, show up at the emergency room, and shift the cost to those with coverage. Employers can continue to drop workers who are costly, or not cover any of their workforce. In fact, this plan encourages employers with low wage workers to drop the coverage they now provide-- and let the government pick up their care. The result? After Cooper-style health reform, **22 million Americans will still be uncovered.** [Congressional Budget Office, July 1993]

In fact, the Cooper plan provides incentives for employers to drop coverage for many workers leading CBO to warn of 6 million newly uninsured Americans.

By providing government vouchers for low-income workers who now have coverage through the workplace, this plan could encourage some employers to drop their workers coverage, knowing the workers would be picked up by the government program. According to the Congressional Budget Office, "Enactment of the law is likely to cause a few employers to drop their health insurance plan and allow the government to assume the cost of covering their low income workers." [CBO, "*Estimates of Health Care Proposals from the 102nd Congress*," p. 52, 7/93]

COOPER: *"If an individual loses his job, he can remain in the HPPC and pay premiums himself."*

Translation: For millions, when you lose your job, you lose your coverage.

- If you lose your job, this plan does not guarantee you any protection at all.
- If you're locked into a job because you don't want to lose benefits, you're still trapped.

COOPER:: *"A national commission will establish a uniform set of effective health benefits."*

Translation: This plan does not even specify -- much less guarantee -- a comprehensive set of benefits, nor does it protect American families from exorbitant out-of-pocket costs.

The Cooper proposal shifts the responsibility for defining the benefits package to a National Board -- to be determined after the legislation has passed and become law. How can the public be asked to support a bill when they don't know what health care they'll receive? The millions of Americans who want and need health care reform have made clear that health care reform must mean comprehensive benefits.

This approach does not answer a single important question about benefits:

Which services will covered, and which will be denied?
Are preventive services fully covered? which ones?
How much is a family liable for in a given year?
Is mental health care covered?
What about lifetime limits?

No American consumer would pay up front for a new car, only to have the dealership decide later on the type of engine in the car, on the features that were included, or what kind of warrantee the car came with. There are certain things the American people have a right to know up front: guaranteed, spelled out benefits are one of them.

COOPER: *". . . to discourage inflationary "Rolls Royce" health policies, which don't control costs, the bill caps tax deductibility at the cost of the lowest price AHP plan . . . "*

Translation: You could be penalized if you pick your own doctor and pay a "choice tax" to belong to certain plans or see certain doctors.

This proposal doesn't just target the "Roll Royce", it targets the family station wagon. Millions of Americans will pay new taxes for the same benefits. By trying to reward consumers for choosing tightly managed, cost-efficient plans like HMOs, the proposal punishes individuals and their employers for any other choices. If you want to continue to get health care the way you do now -- or to see the same doctor you've always seen outside of an HMO -- you get taxed.

If you choose not to go into an HMO or HMO-type organization, you and your employer both pay new taxes on your health care premiums. HMOs are a fine alternative for many Americans, but they are not for everyone. Free choice of doctor is an American tradition, and is the only type of health care delivery in many areas of the country. The "one-size-fits-all" approach doesn't work for health care, and HMOs are not the best fit for many people who don't want to see such major change in their health care.

Under this plan:

- Those who currently have restricted choices will find their choice is still limited or more limited.
- Those who currently have a free choice of doctor will lose that choice, or pay a tax to maintain it.

COOPER: *"Employers will be allowed to deduct the cost of the most efficient health plans but not the cost of excess benefits or wasteful spending."*

Translation: **The Cooper plan encourages employers to reduce benefits by levying tax penalties on employers that give their workers comprehensive coverage.**

Does Congressman Cooper consider prescription drugs "excessive benefits"? Does he consider investments in mental health and long-term care "wasteful spending"?

Today employers can deduct the cost of any and all health benefits as a business expense. The Cooper proposal would set a "tax cap" at the lowest cost plan in the area -- a plan with benefits that are less generous than what most people have today.

So even though this plan says that "*individuals would choose*", employers would have every incentive to force their workers into only one plan -- the cheapest plan. This trend exists today...workers are increasingly locked into one plan by their employer, forcing them to give up relationships with doctors they trust.

COOPER: *"This is financed by . . . reducing the increase in provider fees under Medicare. . . "*

Translation: **The Cooper plan worsens today's cost shifting, raising private sector costs and endangers access for Medicare beneficiaries.**

Most experts agree that there is room to slow the growth of spending in Medicare. But responsible lawmakers and senior advocates believe that there are two important conditions: first, if seniors are asked to pay more, they should get more. And second, if costs are controlled on the public side, they must be controlled on the private side.

This plan fails to meet both those conditions. It slows growth in Medicare spending, both by reducing rates to providers and by dramatically increasing Part B premiums for upper-income Medicare recipients. And yet it dedicates none of that money to new benefits or increased protections for seniors ... not one thin dime.

Secondly, it slows Medicare spending without controlling spending on the private side. The result? Private sector health care will continue to be threatened by ever-rising costs, as the budgeted public programs shift costs to the unbudgeted private sector. Second, as the gap between Medicare rates and private sector rates continues to widen, more doctors will choose not to see Medicare recipients, and more Medicare patients will find they have less and less choice of doctor as a result.

BUT

The Cooper plan gives seniors nothing in return.

For three out of four senior citizens, prescription drugs are the single highest out-of-pocket expense. Million of other seniors, even those with comfortable incomes, live with the lurking fear that a serious illness could wipe out their savings by forcing them to enter a nursing home.

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Today, the federal government contributes at least 50 cents of every dollar states spend on Medicaid long-term care; in some cases, up to 75 cents. The Cooper plan says that states should bear those costs completely on their own, a proposition that would bankrupt many states.

Original Cosponsors
of the
Managed Competition Act of 1993

Democrats

1. Cooper, TN
2. Andrews, TX
3. Stenholm, TX
4. Payne, VA
5. Peterson, FL
6. Barcia, MI
7. Browder, AL
8. Carr, MI
9. Clement, TN
10. Dooley, CA
11. Edwards, TX
12. Gordon, TN
13. Hayes, LA
14. Hughes, NJ
15. Hutto, FL
16. Laughlin, TX
17. Lloyd, TN
18. Long, IN
19. McCurdy, OK
20. McHale, PA
21. Montgomery, MS
22. Moran, VA
23. Neal, NC
24. Orton, UT
25. Parker, MS
26. Tanner, TN
27. Tauzin, LA

Republicans

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3. Johnson, CT
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9. Fowler, FL
10. Gilchrest, MD
11. Goss, FL
12. Horn, CA
13. Houghton, NY
14. Machtley, RI
15. Miller, FL
16. Nussle, IA
17. Petri, WI
18. Quillen, TN
19. Snowe, ME

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FROM THE HEALTH CARE DELIVERY ROOM

Talking Points on Congressman Cooper's "Managed Competition Act of 1993"

We cannot support the Cooper bill because it does not provide health security for all Americans.

There are many components of this approach we completely agree with.

Like Congressman Cooper, we believe community rating returns insurance to a community responsibility, not an exercise in profit making and risk avoidance.

Like Congressman Cooper, we believe that an increased emphasis on competition will promote efficiency, reduce waste, and lower costs.

And finally, like Congressman Cooper, we believe increased cost-consciousness is an important aspect of health care reform, and a necessary ingredient for cost control.

But we believe all Americans need and deserve health care security; this plan just doesn't provide that.

We look forward to continuing the dialogue with Congressman Cooper and towards providing health security for all Americans.

End of Talking Points
10/6/93
11:30a

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QUESTIONS TO ASK REPRESENTATIVE COOPER

1. Does the Cooper plan guarantee coverage to all Americans?

2. Doesn't the Cooper Plan penalize employers that now provide their employees with comprehensive benefits?

3. Doesn't the Cooper Plan give employers incentives to drop their employees' health coverage or drastically reduce their employees' health benefits?

4. What security does the Cooper plan offer the American people
   - when they are <u>not</u> guaranteed health coverage
   - they are <u>not</u> guaranteed a comprehensive package of benefits, *and*
   - there is <u>no</u> lifetime limit on what they can spend?

5. Doesn't the Cooper plan have a "choice tax" -- where Americans are taxed for choosing their own doctors unless their doctor is in the lowest cost plan?

6. When you read between the lines, isn't this just a National HMO plan? Don't employers have every incentive to just force their employees into the cheapest cost plan?

7. Couldn't this be called the "IRS full employment bill" because it is such an administrative nightmare requiring the IRS to monitor the lowest cost plan in every region in the country?

8. Isn't it true that if you're one of the tens of millions of workers whose employer doesn't cover you today, this plan does nothing to encourage them to cover you tomorrow?

9. Isn't this the case that the CBO/Joint Tax Committee assessment of this same plan last year show it running a deficit of $70 billion in its first 5 years?

10. Isn't it true that if you lose your job today, this plan does nothing to keep you from losing your entire life savings and everything you've ever worked for?

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"THE MANAGED COMPETITION ACT OF 1993": SOME CONCERNS

There are many components of this approach we completely agree with. Like Congressman Cooper, we believe community rating returns insurance to a community responsibility, not an exercise in profit making and risk avoidance. Like Congressman Cooper, we believe that an increased emphasis on competition will promote efficiency, reduce waste, and lower costs. And finally, like Congressman Cooper, we believe increased cost-consciousness is an important aspect of health care reform, and a necessary ingredient for cost control.

But we cannot support the Cooper bill because it does not provide health security for all Americans. We believe all Americans need and deserve health care security; this plan just doesn't provide that. We believe that comprehensive benefits should be spelled out and guaranteed; this plan doesn't provide that. We believe choice of doctor is a right; this plan considers choice a taxable luxury. We believe HMOs are one alternative; this plan believes HMOs are for everyone.

The Cooper plan must get a failing grade as it does not meet five of the six principles the President has set forth for comprehensive health reform.

1. *It does <u>not</u> provide the security of a comprehensive package of benefits that can never be taken away.*
2. *It does <u>not</u> provide increased choices for consumers.*
3. *It does <u>not</u> provide a simpler system.*
4. *It does <u>not</u> guarantee savings -- it continues the cost shift and raises the deficit.*
5. *And it asks responsibility from <u>no one</u>. In fact it gives no one any reason to be responsible.*

COOPER: *"[The plan does not] compel employers to pay the health plan premiums of their employees."*

Translation: **In fact, the Cooper plan doesn't require anyone -- not employers, not individuals, not the government -- to take responsibility for health care. Therefore, it doesn't provide health care coverage for everyone and guarantees no one security.**

There are only a few ways to guarantee coverage for all Americans. One is to raise a broad-based tax, and have the government finance and deliver health care. The second is to require employers to contribute to coverage for all of their workers. The third is to require all individuals to purchase insurance for themselves. Whether it's the government, employers, individuals, or some combination... for everyone to have coverage, someone has to pay.

The Cooper plan assumes that between better incentives and government help for the poor, more Americans will be covered. But individuals can still decide that health care isn't their responsibility-- it's yours and mine. They can still go without coverage, show up at the emergency room, and shift the cost to those with coverage. Employers can continue to drop workers who are costly, or not cover any of their workforce. In fact, this plan encourages employers with low wage workers to drop the coverage they now provide-- and let the government pick up their care. The result? After Cooper-style health reform, **22 million Americans will still be uncovered.** [Congressional Budget Office, July 1993]

In fact, the Cooper plan provides incentives for employers to drop coverage for many workers leading CBO to warn of 6 million newly uninsured Americans.

By providing government vouchers for low-income workers who now have coverage through the workplace, this plan could encourage some employers to drop their workers coverage, knowing the workers would be picked up by the government program. According to the Congressional Budget Office, "Enactment of the law is likely to cause a few employers to drop their health insurance plan and allow the government to assume the cost of covering their low income workers." [CBO, "*Estimates of Health Care Proposals from the 102nd Congress*," p. 52, 7/93]

COOPER: *"If an individual loses his job, he can remain in the HPPC and pay premiums himself."*

Translation: For millions, when you lose your job, you lose your coverage.

- If you lose your job, this plan does not guarantee you any protection at all.
- If you're locked into a job because you don't want to lose benefits, you're still trapped.

COOPER:: *"A national commission will establish a uniform set of effective health benefits."*

Translation: This plan does not even specify -- much less guarantee -- a comprehensive set of benefits, nor does it protect American families from exorbitant out-of-pocket costs.

The Cooper proposal shifts the responsibility for defining the benefits package to a National Board -- to be determined after the legislation has passed and become law. How can the public be asked to support a bill when they don't know what health care they'll receive? The millions of Americans who want and need health care reform have made clear that health care reform must mean comprehensive benefits.

This approach does not answer a single important question about benefits:

Which services will covered, and which will be denied?
Are preventive services fully covered? which ones?
How much is a family liable for in a given year?
Is mental health care covered?
What about lifetime limits?

No American consumer would pay up front for a new car, only to have the dealership decide later on the type of engine in the car, on the features that were included, or what kind of warrantee the car came with. There are certain things the American people have a right to know up front: guaranteed, spelled out benefits are one of them.

COOPER: *". . . to discourage inflationary "Rolls Royce" health policies, which don't control costs, the bill caps tax deductibility at the cost of the lowest price AHP plan . . . "*

Translation: You could be penalized if you pick your own doctor and pay a "choice tax" to belong to certain plans or see certain doctors.

This proposal doesn't just target the "Roll Royce", it targets the family station wagon. Millions of Americans will pay new taxes for the same benefits. By trying to reward consumers for choosing tightly managed, cost-efficient plans like HMOs, the proposal punishes individuals and their employers for any other choices. If you want to continue to get health care the way you do now -- or to see the same doctor you've always seen outside of an HMO -- you get taxed.

If you choose not to go into an HMO or HMO-type organization, you and your employer both pay new taxes on your health care premiums. HMOs are a fine alternative for many Americans, but they are not for everyone. Free choice of doctor is an American tradition, and is the only type of health care delivery in many areas of the country. The "one-size-fits-all" approach doesn't work for health care, and HMOs are not the best fit for many people who don't want to see such major change in their health care.

Under this plan:

- Those who currently have restricted choices will find their choice is still limited or more limited.
- Those who currently have a free choice of doctor will lose that choice, or pay a tax to maintain it.

COOPER: *"Employers will be allowed to deduct the cost of the most efficient health plans but not the cost of excess benefits or wasteful spending."*

Translation: **The Cooper plan encourages employers to reduce benefits by levying tax penalties on employers that give their workers comprehensive coverage.**

Does Congressman Cooper consider prescription drugs "excessive benefits"? Does he consider investments in mental health and long-term care "wasteful spending"?

Today employers can deduct the cost of any and all health benefits as a business expense. The Cooper proposal would set a "tax cap" at the lowest cost plan in the area -- a plan with benefits that are less generous than what most people have today.

So even though this plan says that "*individuals would choose*", employers would have every incentive to force their workers into only one plan -- the cheapest plan. This trend exists today...workers are increasingly locked into one plan by their employer, forcing them to give up relationships with doctors they trust.

COOPER: *"This is financed by . . . reducing the increase in provider fees under Medicare. . . "*

Translation: **The Cooper plan worsens today's cost shifting, raising private sector costs and endangers access for Medicare beneficiaries.**

Most experts agree that there is room to slow the growth of spending in Medicare. But responsible lawmakers and senior advocates believe that there are two important conditions: first, if seniors are asked to pay more, they should get more. And second, if costs are controlled on the public side, they must be controlled on the private side.

This plan fails to meet both those conditions. It slows growth in Medicare spending, both by reducing rates to providers and by dramatically increasing Part B premiums for upper-income Medicare recipients. And yet it dedicates none of that money to new benefits or increased protections for seniors ... not one thin dime.

Secondly, it slows Medicare spending without controlling spending on the private side. The result? Private sector health care will continue to be threatened by ever-rising costs, as the budgeted public programs shift costs to the unbudgeted private sector. Second, as the gap between Medicare rates and private sector rates continues to widen, more doctors will choose not to see Medicare recipients, and more Medicare patients will find they have less and less choice of doctor as a result.

BUT

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