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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Dinner Hosted by Congressman Kasich (7 pages)	6/12/93	P5
002. memo w/attach	Chris Jennings to Hillary Clinton Re: Meeting with Congressman Cooper (3 pages)	6/14/93	P5
003. memo w/attach	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senators Leahy and Pryor (8 pages)	6/14/93	P5
004. memo	Chris Jennings/Melanie to Hillary Clinton/Patti Re: Congressional Meetings (2 pages)	6/16/93	P5
005. memo w/attach	Steve Edelstein Hillary Clinton Re: Cosponsors of McDermott Bill (8 pages)	6/17/93	P5

COLLECTION:

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

FOLDER TITLE:

June 1993 HSA [2]

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RESTRICTION CODES

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United States Senate

WASHINGTON, DC 20510

June 11, 1993

The Honorable Daniel Patrick Moynihan
Chairman
Committee on Finance
U.S. Senate
Washington, D.C. 20510

Dear Chairman Moynihan:

We are concerned by recent reports of proposed changes to the President's deficit reduction package that run counter to progressive Democratic principles. We believe that the package must maintain the level of deficit reduction contained in the budget resolution while protecting those who took the brunt of failed Republican trickle-down policies over the past 12 years.

While there may need to be changes in the House-passed reconciliation bill, we oppose changes which fail to meet the following principles:

1) No further cuts in Medicare or Medicaid that would unfairly increase beneficiaries' out-of-pocket costs, reduce access or quality of health care, or threaten enactment of health care reform;

2) No decrease in the share of deficit reduction asked of the wealthiest people in our society; and,

3) No additional taxes on the middle class.

We would hope to work with you during the coming days to ensure Senate passage of the reconcilation bill.

Sincerely,

Russ Feingold   Tom Harkin   Carol Moseley-Braun
Daniel K Akaka   Paul D. Wellstone   Paul Simon
Barbara A. Mikulski   [illegible]   [illegible]
Carl Levin   Patty Murray

<u>Signers</u>

- Senator Tom Harkin (D-Iowa)
- Senator Paul Wellstone (D-Minnesota)
- Senator Russell Feingold (D-Wisconsin)
- Senator Daniel Inouye (D-Hawaii)
- Senator Paul Simon (D-Illinois)
- Senator Howard Metzenbaum (D-Ohio)
- Senator Patty Murray (D-Washington)
- Senator Carl Levin (D-Michigan)
- Senator Barbara Mikulski (D-Maryland)
- Senator Carol Mosely-Braun (D-Illinois)
- Senator Daniel Akaka (D-Hawaii)

Withdrawal/Redaction Marker
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Chris Jennings (Health Security Act)
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FOLDER TITLE:
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June 12, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Kim Tilley KT

SUBJECT: Briefings for Monday, June 14th

Congressman Kasich Dinner Briefing

- White Paper on Health Care Reform by the Republican Members House Committee on the Budget

JOHN KASICH, (OH), RANKING MEMBER
ALEX McMILLAN, (NC)
JIM KOLBE, (AZ)
CHRIS SHAYS, (CT)
OLYMPIA SNOWE, (ME)
WALLY HERGER, (CA)
JIM BUNNING, (KY)
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BOB INGLIS, (SC)
MARTIN HOKE, (OH)
RICHARD E. MAY, STAFF DIR.

COMMITTEE ON THE BUDGET
REPUBLICAN CAUCUS
U.S. HOUSE OF REPRESENTATIVES

278 FORD HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
(202) 226-7270

Put Consumer Back in Health Care Market, Urges Republican Budget Committee Report

May 25,, 1993

(Washington, D.C.) — Successful reform of the nation's health care system will depend on boosting the control and decision-making power of American consumers, according to an analysis released today by Republican members of the House Committee on the Budget.

The committee Republicans' *White Paper on Health Care Reform* also partly blames inefficient government spending for contributing to health care cost inflation, and says that controlling government health outlays — if done in the proper way — can help ease the upward pressure on costs.

"We don't pretend that this report contains the silver bullet on health care reform," said Representative John R. Kasich, Ranking Republican on the House Budget Committee. "We don't presume that our suggestions can solve every problem in the health care market. But it is clear that unless we restore the consumer's role in the market, we will face a future of runaway health care costs, or rationing of services, or both."

According to the report, "The evolution of health care financing in the United States, encouraged by government tax policy, has increasingly isolated and insulated consumers from financial decisions about their own health care. . . . The prevailing third-party financing arrangement creates incentives for overuse of services and, consequently, higher spending — and the market has responded accordingly. Equally important, the arrangement has deprived consumers of real control over their health care decisions."

This situation is a fundamental contributor to the rapid upward spiral of health care spending, the report says. The analysis concludes that unless consumers are restored to their appropriate role in the health care — the same role they play in other markets — health care reform will fail to achieve the twin goals of controlling spending and providing broad access to prompt, high-quality health care.

"Any successful reform of the health care system must promote the vitality of this relationship." The paper notes that the consumer-provider relationship lies at the heart of what are typically called "market-oriented" approaches to health care reform. The analysis also contends that U.S. health care "suffers not from a lack of resources, but from *inefficient use of the resources available.* Health care reform can and should be financed out of existing resources."

[Copies of the *White Paper on Health Care Reform* are available from the House Committee on the Budget Republican Staff, 278 Ford House Office Building, Washington, D.C., 20515, (202) 226-7270.]

White Paper on Health Care Reform

by the
Republican Members
House Committee on the Budget
John R. Kasich, Ranking Repubiblcan

May 20, 1993

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Introduction

Of all the genuine problems related to health care in the United States, one stands out as central to the debate over reforming the system: health care spending is high and appears to be rising at unsustainable rates.

For individual Americans, the rapid pace of national health care spending growth translates into a variety of personal concerns: frustration over their personal health care costs and insurance premiums; a sense that they are receiving less care; concern about the quality of care they receive; and fear that they might find themselves exposed to unexpected, and possibly catastrophic, medical costs. It also has sensitized Americans to the plight of those unable to obtain or afford health insurance coverage.

Various proposals for addressing these problems have been developed over the past several years. The Clinton Administration is expected to release its reform proposals in the near future. Still other alternatives soon will be offered in Congress. Also proposed earlier this year was a health care reform plan developed by the House Republican Leader's Task Force on Health Care.[1] Legislation defining the "building blocks" of the Task Force reform plan currently is being developed.

As a contribution to the Leader's Task Force, this paper seeks to offer a concise assessment of the health care reform issue from the perspective of Republicans on the House Committee on the Budget. The perspective focuses on budgetary considerations, which will be substantial in any reform strategy. But this analysis also takes into account the fundamental economic factors of the health care market, especially those that appear to be driving up spending. The analysis leads to two primary findings:

- ***The government's expanding role in health care financing over the past 30 years has had an inflationary impact coinciding with — and in all likelihood substantially contributing to — the rapid growth of health care spending.*** Therefore, it is unreasonable to believe that expanding the government's role as a purchaser in the market can successfully address the true causes (as opposed to the symptoms) of rising health care costs.

- ***The evolution of health care financing in the United States, encouraged by government tax policy, has increasingly isolated and insulated consumers from financial decisions about their own health care.*** This pattern has interfered with one of the principal relationships on which successful and efficient markets depend — the relationship between the consumer and the provider. Health insurance in the United States is not really insurance but is, instead, a costly system of prepaid health care financed principally by third parties. Prices and levels of service are negotiated chiefly by those financing the system — government or private-sector insurers — and health care providers. The consumer — the patient — is a secondary participant.

  The prevailing third-party financing arrangement creates incentives for overuse of services and, consequently, higher spending — and the market has responded accordingly. Equally important, the arrangement has deprived consumers of real control over their health care decisions. Therefore, any successful reform of the health care system must promote the vitality of this relationship. The consumer-provider relationship lies at the heart of references to "market-based" reforms.

Addressing the two concerns mentioned above will not cure every problem in the United States' health care market. The market truly is complex. The system features a variety of advanced and expensive technologies. The availability of providers and services is not uniform across the country; people in rural areas tend to have fewer choices of health care providers than those in urban areas. Some of the most costly medical services occur near the end of a patient's life, a fact that deepens the gravity of moral and ethical decisions facing families and physicians at such times. Furthermore, restoring more health care decision-making to consumers will not prevent some consumers from making unwise or inefficient decisions. Nor is this discussion intended to suggest that government should have no role at all in health care. Certain problems — such as providing a safety net to insure the poor and persons with serious health conditions who cannot find affordable coverage in the market — may demand a government response.

But neither will additional resources offer the responses necessary. Health care in the United States suffers not from a lack of resources, but from *inefficient use of the resources available*. Health care reform can and should be financed out of existing resources. With that in mind, two essential points should be clear from the analysis below: that policy-makers should not put government first in seeking solutions to the nation's health care problems; and that true reform must include restoring personal responsibility and the vitality of the doctor-patient relationship. Any reform attempts that circumvent these fundamental budgetary and economic factors will fail.

Background and Trends

During the past 25 years, the share of the U.S. economy devoted to health care has more than doubled, from 6 percent of Gross Domestic Product (GDP) in 1965 to about 12 percent in 1990. This year, spending on health care in the United States will total roughly

$912 billion. That figure is projected to grow to almost $1.7 trillion, or 18 percent of GDP, by 2000.[2] Per capita health care spending, in constant 1993 dollars, increased from $443 in 1965 to $2,879 in 1990. It is expected to be $3,604 in 1993, rising to $4,087 in 1995 and $5,568 in 2000 (all in constant 1993 dollars).

The rapid growth of national health spending has coincided with an expanding government role in health care financing. In 1965, federal, state, and local governments furnished 24.7 percent of the total funds paid for health care. This figure roughly matched the share of financing by private insurance (24 percent) and was far less than the portion funded by out-of-pocket payments (45.7 percent). Since then, the public share of national health spending has grown to more than 42 percent of the total, while the portion assumed by out-of-pocket and health insurance funding has declined. As shown in Table 1 below, this trend is expected to continue.

Table 1: Projections of National Health Expenditures to 2000, by Source of Funds.
(By Fiscal Year)

	1965	1983	1987	1990	1992	2000
In Billions of Current Dollars						
Private						
Health Insurance	10	111	155	222	266	499
Out of Pocket	19	81	109	136	153	240
Other	2	18	22	31	36	61
Subtotal	31	211	286	390	455	800
Public						
Federal	5	103	144	195	255	583
State and Local	5	44	64	91	123	249
Subtotal	10	148	208	286	378	832
Total	42	359	494	675	832	1,631
Percentage of Total						
Private						
Health Insurance	24.0	31.1	31.3	32.9	32.0	30.6
Out of Pocket	45.7	22.7	22.0	20.1	18.4	14.7
Other	5.5	5.1	4.5	4.6	4.3	3.7
Subtotal	75.3	58.8	57.8	57.8	54.7	49.0
Public						
Federal	11.6	28.8	29.1	28.9	30.6	35.7
State and Local	13.2	12.4	13.0	13.5	14.8	15.3
Subtotal	24.7	41.2	42.2	42.4	45.4	51.0
Total	100	100	100	100	100	100

Source: Congressional Budget Office.

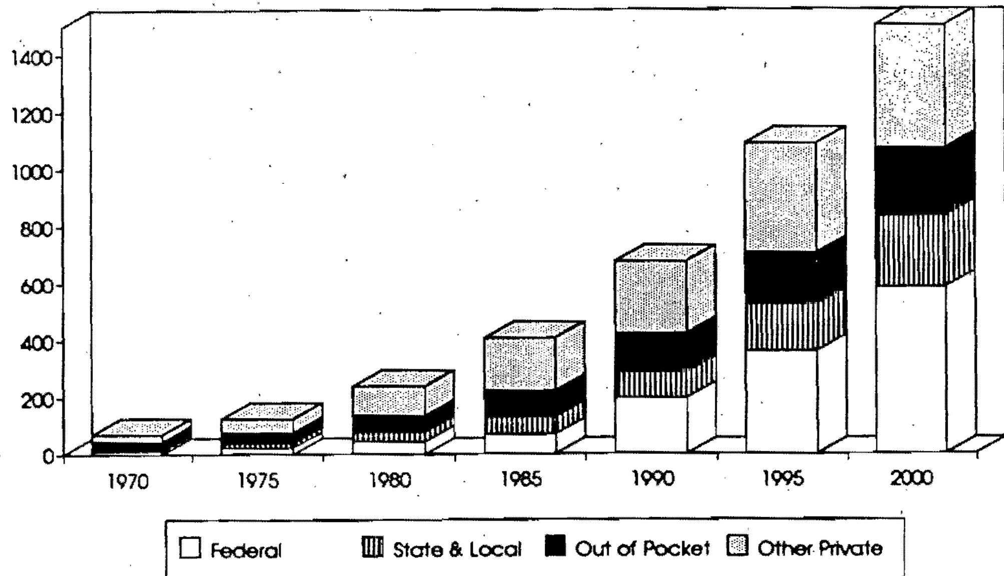
The growth in national health expenditures is partly a natural phenomenon in a mature and wealthy economy. "As national income rises, people may choose to purchase health services that improve their quality of life, as well as the basic services that are essential

to good health," writes the Congressional Budget Office. "In addition, the governments of wealthier countries may be able to spend more on public health and research."[3] Nevertheless, U.S. health expenditures are growing at a rate that far exceeds normal expectations and that may be faster than the economy can sustain.

To federal policy-makers, a principal concern about the trend in national health care spending is its projected impact on the overall federal budget. As shown in Table 2 on page 5, Medicare and Medicaid — the Federal Government's two dominating health programs — are expected to grow from $198 billion in FY 1992 to $608 billion in FY 2002. During this period, the share of total federal outlays consumed by these programs will nearly double, from 14.1 percent to 26.3 percent. By 2002, spending for Medicare and Medicaid will exceed that for Social Security and will nearly match the total for all discretionary programs. Put another way, federal health spending will increasingly crowd out other programs in the competition for federal resources, or will demand substantially higher deficit spending or tax revenues.

Medicare and Medicaid also are projected to be the largest contributor to future federal deficit spending. The Congressional Budget Office projects that "under current policy the federal deficit, after declining in the first half of the 1990s, will swell to more than $500 billion by the year 2002, *largely as a result of increased spending for Medicare and Medicaid.*" [Emphasis added.][4]

Figure 1: Health Care Expenditures by Source, 1970-2000.
(In Billions of Dollars)



Source: *Statistical Abstract of the United States 1992*, U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census; Congressional Budget Office.

This projection is confirmed elsewhere. An April 1993 study by the Committee for a Responsible Federal Budget says, in part: "If government were to raise revenues and reduce non-health care spending enough to balance the budget next year, within a decade we once again would face $300 billion-per-year deficits, unless we did something to restrain the growth in health expenditures."[5]

CBO also warns about the serious economic drag that would result from this level of deficit spending in the following passage:

> Federal borrowing of this magnitude will significantly affect the economy because it will cut into private saving that would otherwise have been used for investment here or abroad. CBO's calculations suggest that if federal spending on Medicare and Medicaid could be held to its 1991 share of GDP, output (real GDP) would be about 2.2 percent higher than the CBO baseline by the year 2002. Incomes (as measured by real gross national product) could rise even more — by about 2.4 percent — because serving costs on debt to foreigners would be reduced.[6]

Table 2: Projected Distribution of Federal Outlays.
(By Fiscal Year)

	1992	1994	1996	1998	2000	2002
In Billions of Current Dollars						
All Discretionary	541	539	554	584	616	650
Social Security	285	319	351	385	420	459
Medicare and Medicaid	198	259	329	405	495	608
[Medicare]	[130]	[167]	[211]	[259]	[316]	[389]
[Medicaid]	[68]	[92]	[118]	[146]	[179]	[219]
All Other Outlays	378	390	409	465	524	595
Total (including deposit insurance, net interest, and offsetting receipts)	1,402	1,507	1,643	1,839	2,055	2,312
In Percentages of Total Outlays						
All Discretionary	38.6	35.8	33.7	31.8	30.0	28.1
Social Security	20.3	21.2	21.4	20.9	20.4	19.9
Medicare and Medicaid	14.1	17.2	20.0	22.0	24.1	26.3
[Medicare]	[9.3]	[11.1]	[12.8]	[14.1]	[15.4]	[16.8]
[Medicaid]	[4.9]	[6.1]	[7.2]	[7.9]	[8.7]	[9.5]
All Other Outlays	27.0	25.9	24.9	25.3	25.5	25.7
Total (including deposit insurance, net interest, and offsetting receipts)	100.0	100.0	100.0	100.0	100.0	100.0

Source: Congressional Budget Office, *The Economic and Budget Outlook: An Update*, August 1992; *Economic Implications of Rising Health Care Costs*, October 1992; *The Economic and Budget Outlook: Fiscal Years 1994-1998*, January 1993.

Causes of the Growth in Health Spending

A variety of factors are typically cited as partial explanations for inefficiencies in the health care market and the special difficulties consumers may have in making market choices. For example, it is often noted that in seeking health care, Americans tend to possess far less information about the choices and costs of treatment than they do for other goods and services. They generally put themselves in the hands of a single medical provider whose judgments and recommendations they accept. Furthermore, they often do so in a time of relative urgency — they are generally ill or in pain. In addition, competition among health care providers is not uniform across the country. People in rural areas have far fewer choices of medical providers than do those in urban areas. Those whose medical costs are funded by public health insurance or health maintenance organizations are often restricted in their choices of providers and services.

But not all of these factors are unique to medical care. People seeking automobile repairs often turn to just one mechanic and are usually much less well-informed than the mechanic about the repairs that are necessary and the appropriate costs. The consumer also may consider the need for auto repairs urgent. Yet consumers can exercise decision-making power in this market, and the market does appear to work more efficiently than that of health care, despite the similarities.

Three other factors do have a special impact on the health care market and are of particular interest for federal budgeting. These factors are the expanding role of government financing; the impact of government tax policy; and — partly as a consequence of the two — the declining role of consumers in decisions about their own health care and health care spending.

1. The Growing Role of Government Financing

As noted above, the public sector has represented an increasing share of health spending over the past 30 years, largely through the expansion of health care programs such as Medicare and Medicaid. This trend will continue in the future. One affect of this trend has been an interference with fundamental market mechanisms that normally would restrain spending growth. As the Congressional Budget Office puts it:

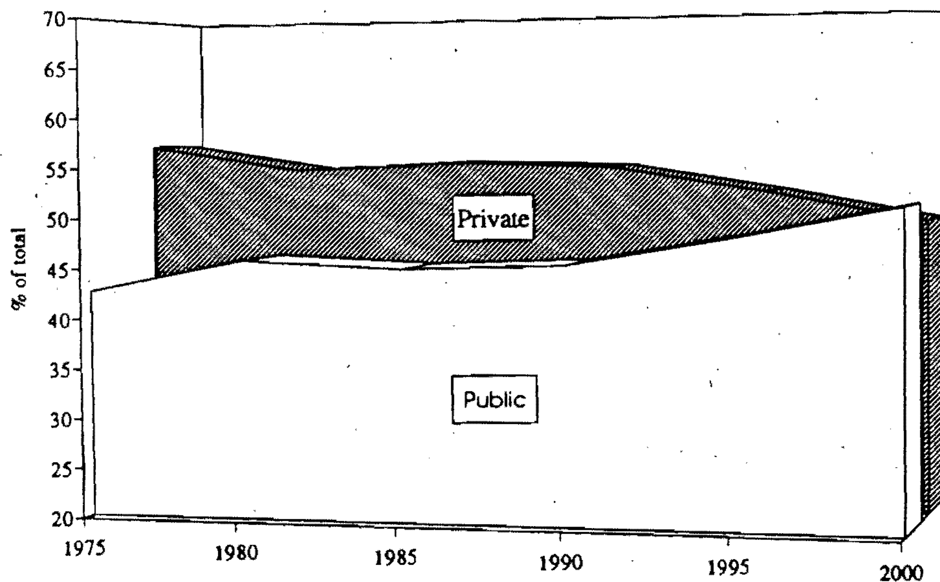
> Although there is strong justification for government involvement in health care, this involvement may cause markets to work less well in conventional terms of efficiency. When the government subsidizes the purchase or becomes the insurer, the budget constraints on consumers of health care are relaxed and, as a result, lose some effectiveness in controlling less-valued spending. Likewise, federal budget constraints for health care do not operate with the same force as they do in the private sector or in much of the rest of the public-sector budget.[7]

In other words, government spending on health care is intrinsically less efficient than private-sector spending. Therefore, overall national health care spending is driven higher because of the government's growing participation in the market. CBO also writes: "Although these programs [government health programs] provide essential — and in some

cases life-saving — medical care to millions of people, the programs also dull the price signals from the health care markets, encouraging overuse of services."[8]

In economic terms, "overuse" translates into higher spending. Considering that government has assumed an ever-increasing share of health care spending — now totalling about 42 percent of all national health care outlays — it seems clear that government spending is largely responsible for the overuse of health care services and, therefore, the rise in health costs. The government has essentially "bid up" the prices of the nation's health care services.

Figure 2: Public versus Private Health Care Spending.
(As Percentages of Total Spending)



Source: *Statistical Abstract of the United States 1992*; Congressional Budget Office

Other cost-drivers in Medicare and Medicaid include the following:

- **Open Checkbooks.** Programs sponsored by the government tend to cover most of the services beneficiaries receive. This tends to discourage cost-consciousness on the part of consumers and providers when evaluating discretionary health care choices. The result is an overuse of government-financed services.

- **Increase in Services.** Policy-makers have expanded the medical services that will be financed by the government through both Medicare and Medicaid. In the case of Medicaid, the expansion of services beyond their original "safety-net" function has created a disincentive for recipients to leave the program because they then risk being left with no coverage.

- **Rising Prices.** Government health programs have had to respond to both medical inflation and general inflation in the economy.

- **Demographic Changes.** The aging of the U.S. population and extended life spans have increased the number of beneficiaries and the number of years for which their health care is financed by the government.

- **Fraud.** Fraud in the system cost the Federal Government an estimated $8.58 billion to $28.6 billion in 1993.[9]

Nor has the public sector been successful in restraining the growth of its own health expenditures. CBO notes that federal entitlement programs have tended simply to rise to meet increasing medical costs. This process clearly has maintained the spiral of rising health costs generally. When the government has attempted to limit spending on health care programs, it has relied mainly on two instruments: lowering reimbursements to hospitals and doctors and placing limits on the expansion of current health care programs. These efforts have had little, if any, discernible effect in reducing health expenditures. In 1983, Congress passed a new payment system for hospital reimbursement. The prospective payment system (PPS) designated 470 Diagnosis Related Groups (DRGs) and set flat fees for each group (with certain cost adjustments). The result was a change in the method of health care delivery, but no cost reduction. One effect of this change in payment is that hospital bed occupancy has steadily declined since 1983, but the intensity and volume of services have increased.

Various budget reconciliation acts have reduced reimbursement rates to doctors and other providers, but have not produced real savings. In some cases, reimbursement rates are now too low to cover the cost of providing services to Medicare patients. This forces cost shifting to private payers, driving up insurance rates. The 1990 Budget Reconciliation Act limited the expansion of entitlement programs, including Medicare and Medicaid, by enforcing a pay-as-you-go funding mechanism. Under the procedure, expansions of federal entitlement programs must be financed either by reductions in other entitlements or increases in taxes. This has done nothing, however, to limit spending increases in the programs that already exist.

Nevertheless, various reform proposals seek to expand the role of government, in most cases to provide insurance coverage to those unable to obtain insurance in the market. Among the government-oriented proposals are conversion to a Canadian-style "single-payer" system, and "play-or-pay" schemes that mandate employers to provide group insurance with an expanded government program to cover those still left unprotected. But the historical experience with government health programs gives ample reason to doubt that expanding the role of government will be consistent with the goal of slowing the upward spiral of health care costs.

2. Tax Policy

Government tax policy encourages employers to furnish health insurance to employees through deductibility of employer-paid premiums. The strategy has been effective in

expanding private health insurance to a large portion of the population. But the expansion has come with an economic price, as described in the following passage by CBO:

> [Federal tax policy] has also encouraged inefficiency because of the resulting failure to confront choices. Favorable tax treatment of employer-paid health insurance premiums reduces the effective price and so increases the amount of health insurance through a hidden subsidy. Such tax breaks cause even higher levels of health expenditure at the expense of tax revenues that would otherwise be collected.[10]

The deductibility of premiums has helped promote health insurance arrangements that are not really insurance but are instead a costly system of prepaid health care (see the discussion of the consumer's declining role below). It also has distorted the perceived value of employer-paid health benefits. According to a study by the National Center for Policy Analysis, federal tax law makes $1.44 of health benefits equivalent to a dollar of take-home pay for employees in the 15- percent tax bracket. This occurs because gross wages of $1.44 would be reduced by 44 cents in taxes. This discrepancy is worse in the 28-percent tax bracket, where $1.97 of health insurance benefits is equivalent to a dollar of take-home pay.[11] It is more valuable to the employee to demand a dollar more in health coverage than in wages. A March 30, 1993 *Medical Benefits* article[12] revealed the cost per employee of health benefits increased from $1,724 in 1984 to $3,968 in 1992 — a 130.2-percent increase in six years.

Tax deductibility is not available to the self-employed, who must pay the full cost of coverage with funds left over after taxes. Large corporations, meanwhile, bid up the price of health insurance through the use of the tax incentive, making coverage even more expensive for smaller businesses.

The structure of tax deductibility also favors the formation of employee-based insurance pools rather than other possible groupings. Many other kinds of insurance — automobile insurance, for example — are organized on the basis of regions. This makes possible the formation of larger and more diverse insurance pools. Such pools mitigate risks to the insurer, allowing for lower insurance premiums than might otherwise occur.

Tax deductibility also has had a significant impact on federal revenues. It is estimated that the effective subsidy of health insurance premiums through the tax code will total $69.4 billion in FY 1994. When this amount is added to direct government outlays for health care, the government's share of health care financing nationally exceeds 51 percent.

It is desirable policy to continue using the tax code to promote the purchase of health insurance. If so, however, recognizing the economic effects of the current structure may help redesign the code for greater efficiency or equity. For example, expanding deductibility to individuals and the self-employed would help correct existing inequities and would lead to greater market efficiency. Tax deductibility also could be refined to encourage more cost-efficient kinds of insurance, such as coverage that protects against catastrophic costs but leaves consumers with more responsibility for discretionary, non-emergency, health care decisions.

3. The Declining Role of Consumers

Government spending and tax policies have contributed to a third, and crucial, problem: With respect to American health care, the principal market mechanism — the relationship between the consumer and the provider — has been distorted. Both public and private health insurance have tended to isolate and insulate consumers from making decisions about their own medical care — decisions that would require them to measure the benefits they expect against the prices they are willing to pay.

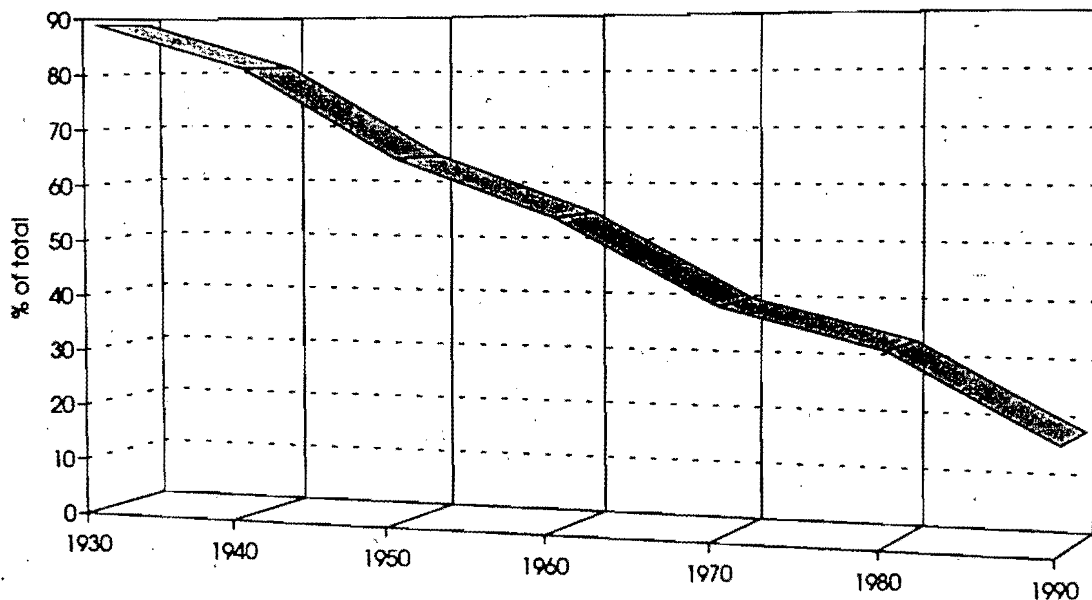
It is understandable that consumers should want protection from the catastrophic costs that come from, say, the need for major surgery or long hospital stays. But similar financial protections have extended to far more routine medical services — an arrangement that amounts to prepaid health care rather than health "insurance" comparable to other kinds of insurance. Consequently, the share of health care costs paid by consumers directly out of pocket declined from 45.7 percent in 1965 to 18.4 percent in 1992 (see Table 1, page 3 and Figure 3, page 11). CBO describes the impact as follows:

> Most health payments are made by a third party — an insurance company or a government program — on a fee-for-service basis, and this reinforces the bias in health care toward higher spending and away from cost control. Neither the patient nor the doctor is likely to care much about the costs of the treatment at the point of service. Fee-for-service arrangements with distant third-party reimbursement ensure that patients have an incentive to accept, as well as providers have to offer, any treatment that may possibly have a positive benefit, with little regard for cost.
>
> These features may encourage spending on health care procedures or services that cost more than the value consumers place on the benefits. The same features may spur the development and use of new, often expensive, medical technologies and drugs even when their benefits may be small compared with the costs. People who have insurance face a low out-of-pocket charge for health services at the point of delivery, and as a result go to doctors more often and have more tests and elaborate treatment than people who are faced with the full prices. One hypothesis is that cost-increasing technology raises the demand for health insurance and, hence, for health care, but the development of cost-increasing technology is itself encouraged by more extensive insurance. Together, it is argued, the two effects produce an upward spiral of health care costs. Because third-party reimbursement, based on provider charges, dominates the market, competitive pressures do not encourage the efficient provision of services. Doctors compete for patient loyalties, and hospitals compete for physician referrals but providers do not tend to compete with one another over fees.[13]

Once a third-party payer seeks to control costs — typically by limiting the kinds and amounts of services that will be financed — the patient begins to lose control over health care services. Negotiations over what services will be provided and at what costs take place between the provider and the payer; the patient is not a player in the process. This situation already occurs in many government and private insurance arrangements.

The most extreme form of third-party payment is a Canadian-style "single-payer" system, in which the government is the insurer. Just as in any third-party arrangement, controlling costs in a single-payer system, negotiations over costs involve the payer and the provider but not the patient. Because patients do not make the spending decisions involved in their treatments, they do not control the treatments they receive.

Figure 3: Percentages of Health Expenditures Paid Out of Pocket.
(As Percentages of Total Spending)



Source: The Heartland Institute, *Why We Spend Too Much on Health Care*, 1992.

To control spending, single-payer systems commonly resort to price controls or "global budgeting." If they did not take such steps, patients would tend to overuse services (because they are not paying the bills), leading to higher spending — spending that would quickly outpace any savings achieved by simplifying or streamlining the system's administration. *This is why resorting to a so-called "single-payer" system — or to other strategies that limit the number of insurance providers — cannot accommodate the twin goals of restraining the growth in spending levels and assuring the patients' control over their own health care decisions.*

Further limits on patient choices will be the certain result of arbitrary schemes such as price controls and global health care budgeting. *These mechanisms seek to limit the amount of aggregate health care spending on the surface, without addressing the factors that truly drive costs upward.* This inevitably leads to rationing of health care services, long waiting lines, and limits on advanced, and often life-saving, treatments. Equally important, it further deprives patients of control over their own health care, because their treatments are still governed, at least in part, by the price the provider receives for the service — and that price is determined by someone other than the patient.

The government is an especially strong contributor to this problem. Because it represents more than 50 percent of the nation's health care spending, the government is a massive

third-party payer (and one that is, as noted above, intrinsically less efficient than its private-sector counterparts). Furthermore, the government has no competitors, and therefore lacks any market incentive to become more efficient. This is another fundamental reason to doubt that broadly expanding government programs can successfully address the basic causes of rapidly rising national health care costs.

But appropriate alternatives to third-party payments — options that can slow the growth of health care spending and also maintain individuals' control over their own health care — involve shifting greater responsibility, and more of the costs, back to consumers. This probably would require higher deductibles in private and government insurance programs, especially for price-sensitive routine or non-catastrophic medical services.

To a large degree, this process already is occurring; insurers have for several years looked to adjustments in deductibles and copayments as methods of containing their own costs. But American consumers are not likely to welcome an expansion of this approach eagerly unless they recognize the personal benefits they would receive from it. Policy-makers will need to help consumers understand that only by assuming greater personal responsibility for their own health care can they achieve the benefits of both restraining the growth in costs and maintaining control over the services they choose. Alternatives that pledge both benefits without demanding greater consumer responsibility offer a promise that cannot be fulfilled.

Additional Concerns for Reform

1. Access to Health Insurance

Although access to health insurance is not a central theme of this analysis, it is an important and often-mentioned concern in the health care debate. But access to insurance is not distinct from issues of cost. Indeed, it is reasonable to conclude that if effective mechanisms for controlling costs were developed, the costs of health insurance could be moderated, making coverage available to a wider population. Hence, gaining control of rising health care costs can itself contribute to expanding access to insurance. Conversely, attempting to expand insurance coverage without genuinely addressing the cost-drivers described above will only transfer cost pressures elsewhere, resulting in rationing, slower improvements in the quality of care, and less control by consumers.

A few additional remarks about access to insurance also are appropriate.

Although a lack of *health insurance* does not necessarily deprive individuals of *health care* — medical ethics and the law require that persons who are without health insurance, or who are unable to pay for their own services, still receive health care when necessary — the uninsured can face considerable difficulties over their care. Some hospitals will not accept them. They are disinclined to seek health maintenance or preventive care, which can lead them to more serious health conditions which then require emergency treatments.

The children of the uninsured often do not receive immunizations and other regular treatments that are important to their development.

The costs of this uncompensated care are covered partially by Medicare and Medicaid payments to hospitals. Some costs also are shifted to private health plans. A certain percentage of every patient's bill can be directly attributed to the unrecovered cost of such services. This may not be the most desirable or efficient means of financing uncompensated care, and it certainly means that such patients have little control over the health care services they receive.

Second is the number of uninsured Americans. The commonly accepted figure asserts that about 37 million Americans have no health insurance all the time. But a U.S. Bureau of the Census report for the most current period for which reliable data are available — January 1987 through the fourth quarter of 1990 — offers the following breakdown:

- Sixteen million people (plus or minus 1.2 million) were uninsured for the entire year.
- Nine million (plus or minus 0.9 million) were uninsured for the full 28-month period of the study.
- Thirty-two million (plus or minus 1.2 million) were not covered by any kind of insurance on average in any given month.
- Seventy-nine percent (plus or minus 0.8 percent) of all people had continuous health insurance coverage for all of 1987.
- Fifty percent of the persons without health insurance coverage in the fourth quarter of 1990 were under the age of 25, a group that accounts for 36 percent of the entire population. This is also the age group that is just entering the job market and therefore subject to probationary waiting periods before becoming eligible for full work fringe benefits such as health insurance.[14]

The breakdown above is not intended to suggest that the problem of access to health insurance is unimportant. The intent is simply to show the true contours of the access issue so that policy reforms can be appropriately designed.

2. Other Factors

Various other factors complicate the problem of medical costs and access to health insurance. Although they are not the primary focus of this paper, they must be acknowledged. Among these factors are the following:

- **State Mandated Services.** States have established mandates that require specific kinds of benefits in health insurance plans sold within their borders. The well-intentioned original goal of these mandates was to protect consumers by ensuring that what they purchased truly was health insurance. But the number of mandates has tended to grow, sometimes requiring coverage that is not critical to entire populations.

Naturally, the expansion of mandates, by requiring greater coverage, has driven up premiums for health insurance.

Some employers escape state mandates by insuring themselves. With this approach, employers' health benefits are covered by the federal Employee Retirement Income Security Act (ERISA). This approach, however, is possible only for large companies that can pool sufficient resources to adequately protect their employees.

- **Malpractice and Defensive Medicine.** According to a study by Lewin-VHI Inc. of Washington D.C., the potential savings from reforming the medical malpractice system could range from $7.5 billion to $76.2 billion over five years. The savings would be achieved by discouraging "defensive medicine," which Lewin-VHI defines as "changes in practice carried out by health care providers for the sole purpose of avoiding malpractice claims."[15]

- **Pre-existing Conditions.** Many Americans have difficulty obtaining or keeping health insurance because of medical conditions that insurers consider too risky. The problem cannot easily be resolved. Requiring insurers to cover such persons would undoubtedly lead to higher premiums for other clients. Alternatively, the government could assume insurance responsibility for these individuals; but then other consumers would still finance the insurance through taxes rather than premiums. Public and social values support providing coverage for such persons. This is an area in which a government response may well be appropriate.

Reform Options

The preceding discussion should make it clear that two basic principles must guide any successful reform of the U.S. health care system. These principles are the following:

- ***The consumer's role in health care decision-making must be promoted.*** Not all consumers will make the wisest and most efficient choices at all times. But in the aggregate, the collection of choices freely made by consumers is the best mechanism for promoting efficiency in the health care economy. Furthermore, the only way to assure that patients control decisions about their own health care is by restoring their direct participation in making those choices.

- ***Restraint of government spending on health care can itself ease the upward pressure on national health costs.*** The expansion of government financing has coincided with the accelerated pace of health care cost increases. Government now finances more than 50 percent of the nation's health care. If government financing is not controlled, it will continue to fuel the upward spiral of health costs.

  But controlling government spending in the proper way also is necessary. Arbitrary mechanisms, such as price controls and global budgeting, fail to address the

underlying causes of cost increases. Consequently, they only lead to rationing and to further limits on the consumer's control over health care. Government spending constraints must address the true cost drivers in health care, mainly by promoting the consumer's participation in the market.

The following account lists various options that would address reform issues analyzed in this paper:

1. Promoting the Consumer's Role

Although private health insurers must be the main players in this process, the Federal Government can legislate specific changes that boost the consumer's participation. Among these are the following:

- **MediSave Accounts**

  MediSave accounts would allow individuals to set up health saving accounts with tax free contributions from either the employer or the individual, or a combination of both. The individual would then purchase health insurance with a high deductible, and hold the balance of deposits in the account to pay for incidental medical expenses. Any unspent funds would roll over and accrue to individual.

  Clearly, a central premise of MediSave is to promote the consumer's decision-making role in purchasing health insurance. To the extent that consumers shopped for policies that best served their needs, a degree of competition and cost-consciousness would be restored to the market. The strategy also could provide consumers with an economic incentive to look after their general health more carefully. Its roll-over provisions would allow consumers to accumulate savings in their overall health care spending — savings achieved through preventive care and health maintenance.

  The National Center for Policy Analysis has argued that when consumers control their own health care dollars, as provided under MediSave, their increased cost-consciousness promotes competition and, therefore, lower prices in insurance premiums and health care services. The strategy also promotes the vitality of the doctor-patient relationship and tends to give patients more control over the services for which they choose to be insured.

  The MediSave strategy is included in the Republican Leader's Task Force Health Care Reform legislation in the current Congress.[16]

- **Tax Deduction for the Self-Employed**

  This option, also contained in the Leader's Task Force plan, would make health insurance premiums paid by the self-employed 100 percent deductible. Policy-makers may also wish to refine the tax code so that deductibility applies to coverage that encourages the purchase of real health *insurance* — which would restore greater consumer responsibility in price-sensitive non-catastrophic services — rather than broad prepaid medical care coverage.[17]

- **Medicare and Medicaid Health Allowance Checks**

  When an individual goes into the hospital under a public insurance program such as Medicare, the doctor performs the procedures and the bill is sent to the insurance providers who administer the Medicare program under the Health Care Financing Administration (HCFA) in Washington. The bill is paid directly to the hospital and doctor and a dizzying array of bills and copies of bills are sent to the patient, billing him or her for various copayments and deductibles. The patient/consumer is basically at the mercy of the doctor, hospital, and HCFA.

  Federal, state, and local government dollars could be re-packaged in such a way so that all senior citizens, poor people, and others deemed eligible for public insurance could receive money from the government based on their economic need. They also could receive a 100-percent tax deduction for the amount they would spend out-of-pocket for health insurance each year up to a national standard for basic health insurance coverage. In such an arrangement, each person could negotiate and bargain with a wide array of insurance companies and purchasing organizations to buy the best kind of health insurance for their own needs. This procedure boost competition and would restore the consumer's role in choosing health insurance.[18]

  The principle works in the existing veterans program with the GI Bill. Each veteran gets an amount of money to attend any college he or she chooses. It also works in the VA Housing program, in which veterans can buy a house based on their choice, not what the government tells them they have to purchase.

- ***Cutting Spending First***

  The House Republican Budget Committee budget proposal for Fiscal Year 1994 — described in the 84-page document titled *Cutting Spending First* — called for $93 billion in Medicare and Medicaid savings over five years. A central feature of these savings was the expanded use of deductibles and copayments by beneficiaries of these large health care programs.

  Such an approach requires that beneficiaries assume more responsibility for their health care choices. But it maintains their control over those choices, producing savings in health care spending without sacrificing consumer choices.[19]

2. Controlling Government Spending

Slowing the growth of government spending in health care can by itself help slow cost increases generally by reducing demand. Among potential strategies are the following:

- **Bringing Competition to Medicare and Medicaid**

  Costs could be reduced by requiring the use of competitive, market-based systems to provide Medicare and Medicaid services. This could be done by integrating the two systems and then requiring health insurance providers to submit competitive bids for the right to serve Medicare and Medicaid patients. Competing for the contract for Medicare and Medicaid would provide a powerful incentive to hospitals, physicians,

and others to carefully consider the way they do business and take steps to reduce costs. Requiring providers to compete with one another would provide an incentive to cut their health care costs.

- **Income Testing Entitlements**

The current Medicare program provides the same level of coverage to all eligible participants regardless of income. Consequently, even wealthy individuals receive medical care at the expense of taxpayers.

Government health care costs could be reduced by targeting health care assistance to the most needy and requiring wealthier persons to assume more of their own costs. Income testing the Medicare hospital coverage deductible for those with adjusted gross incomes of $100,000 or more would save $1 billion in the next four years.[20]

- **Managed Care for Medicaid**

The Arizona Health Care Cost Containment System (AHCCCS, pronounced "access") is run in the fashion of a health maintenance organization (HMO). Every person enrolled in the program joins a managed care plan, meaning a group of doctors and hospitals receive a fixed monthly sum for each patient they agree to treat. Every patient has a personal doctor. Patients and doctors are satisfied, and costs per patient are about 5 percent lower than in other states where the quality of care often is lower.

Arizona has the only state-wide Medicaid managed care demonstration project under waiver authority approved by the Secretary of Health and Human Services. According to the latest evaluation by the Health Care Financing Administration, AHCCCS has held down costs considerably compared to traditional fee-for-service Medicaid plans, despite enrollment increases. For the two years examined, FY 1990 and FY 1991, the average per capita cost increased 26 percent in AHCCCS compared to a 33-percent increase in traditional programs. Over the life of the demonstration (FY 1983 to FY 1991) the average annual increase in AHCCCS per capita cost was 6.8 percent, compared to 9.9 percent for a traditional Medicaid program.

States should be encouraged to pursue this option and not discouraged by a lengthy, tedious waiver application process. The Federal Government should explore broader application of managed care in the Medicaid program.[21]

- **Categorical Spending Targets for Health Entitlements**

In the case of Medicare and Medicaid, Congressional failure to contain spending over the past decade has led to a situation in which Medicare is growing 30 percent a year and Medicaid is growing at 18 percent a year. Categorical targets in these two federal health programs would force Congress to take action to deal with the underlying cost drivers in the health system. If no action is taken to reduce spending, reform existing programs or repeal coverage, the authorization committees would have to propose specific tax increases to finance the spending levels in excess of the targets. If such tax increases also were rejected, then a categorical sequester would take place only on the spending categories that exceeded the spending target for that year.

- ***Cutting Spending First***

  As mentioned above, the House Republican Budget Committee proposal for FY 1994 recommended $93 billion in Medicare and Medicaid Savings over five years. These savings could be achieved without any major overhaul of the health care system, and would ease upward pressure on national health care costs.[22]

3. Other Potential Reforms

Various other reforms have been developed to address related problems in the health care market. Each can make a valuable contribution to reducing costs and improving access without price controls or other government interferences. Among them are the following:

- **State-Based Reforms**

  Medicaid, being a shared federal-state program, binds states because the guidelines are mandated in Washington. To make substantial changes in the way it administers Medicaid, a state must obtain a waiver from the Health Care Financing Administration (HCFA), the department that oversees Medicaid and Medicare. This process is both lengthy and tedious both in obtaining the initial and then in retaining it. Enhanced Medicaid waiver authority would give states more flexibility to manage their health care needs and their budgets.[23]

- **Fraud**

  Although estimates are rough, losses due to health care fraud may range from 3 percent to 10 percent of the nation's total health care bill. This translates to somewhere between $27 billion and $91 billion being lost annually to schemes specifically designed to cheat the system. Legislation titled the Health Care Criminal Offense Act is being developed to specifically target the organized criminal activity in health care. This legislation will give law enforcement the tools it needs to strip away the financial motivation for this kind of criminal activity — namely asset seizure and forfeiture.[24] Such approaches already have proven successful in other areas.

- **Portability**

  All Americans should have access to appropriate health care even if they have pre-existing conditions that deter insurers. The most effective method for reaching this goal is to place the purchasing power of health insurance with the individual, preventing cancellation as a part of a group, and policies that guarantee renewal. Pre-existing condition criteria, waiting periods, and portability issues would diminish with individual based policies. Portability is another health care issue addressed in the Republican Leader's proposed legislation.[25]

- **Purchasing Groups**

  To contain health care cost, pressure must be brought to bear on physicians, hospitals and other health care providers to lower their cost. Purchasing groups can often bring greater pressure on providers to be more cost conscious, thereby reaping savings for participants. Those participants might be individuals, families or small employers.

These arrangements also make health insurance more accessible to more people. Such plans already in existence have found lower health inflation, lower premiums, and increased access.

- **Legal Reform**

  One possibility for easing the problem of malpractice and defensive medicine would be an arbitration system such as that proposed under the Medical Malpractice Reform Act of 1993. The Act calls for patients and medical providers to meet in binding arbitration in contested cases before resorting to the expensive process of lawsuits.

  Reducing the risk of lawsuits would allow medical providers to focus on providing only those procedures that are medically necessary rather than providing a case history to protect the provider against potential lawsuits. Patients would also receive more immediate compensation for injuries caused by incompetence or negligence and a higher percentage of the claim than under current law.

Conclusion

This analysis has sought to focus on aspects of the health care market that lie within the expertise of the House Committee on the Budget. Specifically, the committee has a natural concern with the effect of rapidly increasing health care expenditures on the federal budget — and especially on future budget deficits.

The analysis has concluded that the rapid growth of government financing of health care has itself contributed to the rise in health care costs generally. Therefore, controlling government spending, if done properly, can ease upward pressure on health costs. The analysis also makes clear that a major problem in the American health care market is that consumers have been progressively insulated and isolated from their own health care decisions. The basic relationship between consumers and health providers must be revitalized if health care reforms are to achieve the twin goals of controlling costs and maintaining patients' control over their own care.

This discussion does not suggest that government should have no role at all in health care. Certain problems — such as insuring the poor and persons with serious health conditions who cannot find affordable coverage in the market — may demand a government response. But neither will additional resources offer the responses necessary. Problems with health care in the United States derive not from a lack of resources, but from inefficient use of the resources available. Health care reform can and should be financed out of existing resources, through greater efficiency in the use of those resources.

With all the above in mind, two fundamental points emerge from this analysis: policy-makers should not put government first in seeking solutions to the nation's health care problems; and true reform must include restoring personal responsibility and the vitality

of the doctor-patient relationship. Any reform attempts that circumvent these fundamental budgetary and economic factors will fail.

Budget Committee Republicans strongly recommend that these arguments be taken into account in any reform strategy, and stand ready to assist the Republican Leader's Task Force on Health Care in this effort.

Endnotes

1. Michel, Bob, et. al., the Action Now Health Care Reform Act (H.R. 101), 103rd Congress.

2. Congressional Budget Office.

3. Congressional Budget Office, *Projections of National Health Expenditures*, October 1992, p. 8.

4. Congressional Budget Office, *Economic Implications of Rising health Care Costs*, October 1992, p. 8.

5. Committee for a Responsible Federal Budget, *Health Care Reform Project — Phase I: Cost Containment and Incremental Reform*, April 1993.

6. Congressional Budget Office, *Economic Implications of Rising Health Care Costs*, October 1992, p. 8.

7. Congressional Budget Office, *Economic Implications of Rising Health Care Costs*, October 1992, pp. 19-20.

8. Ibid., p. 19.

9. According to the National Health Care Anti-Fraud Association, fraud accounts for 3 percent to 10 percent of health care spending. When applied to total national health spending, both public and private, these percentages would translate to $27 billion to $91 billion.

10. Congressional Budget Office, *Projections of National Health Expenditures*, October 1992, p. 11.

11. Gary Robbins, Aldona Robbins, John C. Goodman, *How Our Health Care System Works*, National Center for Policy Analysis, February 1993.

12. "1992 Health Care Benefits Survey: Medical Plans," *Medical Benefits*, March 30, 1993, p. 2.

13. Congressional Budget Office, *Projections of National Health Expenditures*, October 1992, pp. 10-11.

14. Short, Kathleen, "Health Insurance Coverage 1987-1990: Selected Data from the Survey of Income and Program Participation," *Current Population Report, Household Economic Study* (Series P-70, No. 29), Department of Commerce Economic and Statistics Administration, Bureau of the Census.

15. Rubin, Robert J., M.D., and Mendelson, Daniel N., *Estimating the Costs of Defensive Medicine*, Lewin-VHI Inc., January 27, 1993.

16. Michel, Bob, et. al, the Action Now Health Care Reform Act (H.R. 101), 103rd Congress.

17. Ibid.

18. For a discussion of this arrangement as it would apply to Medicaid, see *Bridging the Gap: Health Care Coverage for Low-Income Families*, by the House Wednesday Group, March 30, 1992, p. 23.

19. See *Cutting Spending First*, by the Republican Members, House Committee on the Budget, March 10, 1993, pp. 31-39.

20. See *Cutting Spending First*, pp. 33-34.

21. See *Cutting Spending First*, p. 32.

22. *Cutting Spending First*, pp. 31-39.

23. See the Action Now Health Care Reform plan.

24. See Kolbe, Jim, et. al., the Health Care Fraud Act (H.R. 4930), 102nd Congress.

25. Michel, Bob, et. al., the Action Now Health Care Reform Act.

Appendix I

Myths and Facts about Health Care

The American public and its leaders seem to have reached similar conclusions on the major problems facing the health care system — soaring spending and inappropriate coverage. But just below the surface, this consensus breaks down and confusion abounds. The following myths and facts may help clarify some of these misunderstandings.

MYTH #1: Thirty-seven million Americans permanently lack health insurance coverage.

FACT: According to a U.S. Bureau of the Census Current Population Report written by Kathleen Short, for the most current period of time for which reliable data is available, January 1987 to the fourth quarter of 1990, the following facts are:

- Sixteen million people (plus or minus 1.2 million were uninsured for the entire year.
- Nine million people (plus or minus 0.9 million) were uninsured for the full 28-month period of the study.
- Thirty-two million people (plus or minus 1.2 million) were not covered by any kind of insurance on average in any given month.
- Seventy-nine percent of all people (plus or minus 0.8 percent) had continuous health insurance coverage over the entire 1987 year.
- Fifty percent of the persons without health insurance coverage in the fourth quarter of 1990 were under the age of 25, an age group that accounts for 36 percent of the entire population. This is also the age group just entering the job market and subject to probationary waiting periods before becoming eligible for full fringe benefits.

This is not to suggest that the problem of the uninsured is unimportant. Regardless of the number, the uninsured often can face difficulties with their care. Some hospitals will not accept them. They are disinclined to seek health maintenance or preventive care, which can lead them to more serious health conditions which then require emergency treatments. The children of the uninsured often do not receive immunizations and other regular treatments that are important to their development. The details above are intended simply to illuminate the characteristics of the uninsured population.

MYTH #2: Not enough resources are being spent on health care in America.

FACT A: America will spend close to $998 billion, or more than 15 percent of Gross Domestic Product (GDP) on health care in FY 1994. This represents a per capita expense of about $3,992. This is more than 25 percent higher than the next industrialized country, Canada, which spends 11 percent of GDP on health care.

FACT B: Medicare cost per enrollee for FY 1994 is expected to be more than $5,235.

FACT C: Medicaid cost per recipient for FY 1994 is expected to be more than $6,461. The federal share is about $3,615; the state and local matching share is more than $2,884.

MYTH #3: There is not 100-percent access to health care in America today.

FACT: Individuals who do not have any health insurance or health coverage or are unable to pay currently receive care by law. These costs are covered partially by Medicare and Medicaid payments to hospitals and cost shifting to private health plans. A percentage of every patient's bill can be directly attributed to the unrecovered cost of such services.

This does not mean, however, that the lack of insurance among some Americans, is not a problem. Although a lack of ***health insurance*** does not necessarily deprive individuals of ***health care*** — medical ethics and the law require that persons who are without health insurance, or who are unable to pay for their own services, still receive health care when necessary — the uninsured can face considerable difficulties over their care.

MYTH #4: Poor people receive most of the federal entitlement dollars budgeted for health care.

FACT A: People making more than $30,000 of income received close to 40 percent of all Medicare dollars, or more than $60 billion, allocated in FY 1993.

FACT B: Less than 42 percent of the Medicaid budget goes directly for health care for recipients; the bulk of the Medicaid budget goes to hospitals and providers each year in the form of grants or allowances for construction and other projects.

MYTH #5: Medicare beneficiaries pay the full cost of Medicare through their Part B (SMI) premiums for physicians services at a cost of $36.60 per month.

FACT A: The federal taxpayer subsidizes 75 percent of the cost of Medicare Part B through general revenues, or more than $133 billion for FY 1994.

FACT B: When Medicare was passed into law in 1965, half of Part B coverage was paid by the enrollee through a premium, and half was paid by the government. If the original ratio were still in place today, $77.6 billion would be saved over the next five years according to CBO. Part B premiums would be $73.20, rather than $36.60, per month.

FACT C: The market value of a health insurance plan similar to that received by a Medicare beneficiary could range from $350 to $700 per month or more in the market.

MYTH #6: Most of the federal entitlement health program money goes toward routine primary physician health care, disease prevention and wellness.

FACT: Twenty-eight percent of the Medicare budget is spent on recipients in the last year of a beneficiary's life with the majority of it being spent in the last 30 days.

MYTH #7: The eligibility age for Medicare is due to go up to age 67 when the eligibility age for Social Security goes up.

FACT A: The eligibility age for Medicare is *not scheduled to increase.* Social Security is scheduled to begin to go up in the year 2000 by two month increments per year until 2005 when age 66 will be the retirement age until the year 2016. Then it will go up again in two month increments per year until the retirement age for Social Security becomes age 67 in the year 2022.

FACT B: If the eligibility age for Medicare were to rise from age 65 to age 67 on January 1, 1994, $77.7 billion would be saved over the next five years according to CBO.

MYTH #8: The cost of medical malpractice in the medical care system is very small, accounting for less than $1 billion per year.

FACT: According to a study by Lewin-VHI Inc. of Washington D.C., the potential savings from reforming the medical malpractice system could range from $7.5 billion to $76.2 billion over five years. The savings would be achieved by discouraging "defensive medicine," which Lewin-VHI defines as "changes in practice carried out by health care providers for the sole purpose of avoiding malpractice claims."

Mainstream File
(Principles for HCR

Summary

Financing (rough estimates)

1. Medicare cuts ($86 bill over 5 years)
   cigarette excise tax(75 cent increase/$54 bill over 5 yrs)
   tax cap (as described below -- unknown)
   Medicaid capitation-acute care only ($12 bill over 5 yrs)
   Phase out Medicaid disproportionate share payments ($44bill)
   Postal Service Retirement ($13 bill)
   State and Local HI tax ($8 bill)
   Total over 5 years $250 billion
2. Depending on premium levels, speed of coverage phase-in, and new benefits for other populations, additional spending cuts and/or revenue increases may needed.

Fail-Safe Mechanism

1. There will be a fail-safe mechanism to prevent new spending from adding to the federal deficit.
2. The mechanism will encompass revenue increases and decreases, cuts and increases in spending for health care entitlements, and new spending under health reform.
3. If expected spending and savings result in a net increase in the deficit in any year, automatic changes will result. The "pain" associated with these changes will be evenly distributed. The Benefits Commission will be required to recommend alternatives to Congress. If Congress does not act within a set number of days, the automatic changes will be instituted.

Benefit Package

1. Standard benefit package with categories of coverage set in statute. Categories include: medical and surgical services, prescription drugs, prevention services, rehabilitation and home health services related with an acute care episode, hospice, substance abuse and severe mental illness (undecided: other mental health services), and emergency transportation services in frontier areas.
2. A Benefits Commission will clarify benefits. The flexibility of the Commission to "load up" the package will be limited by including in the statute a standard the Commission could not exceed. The standards under consideration include the average plan in FEHBP or the average plan currently offered to small business.
3. The tax treatment of health insurance premiums and direct subsidies to low-income Americans will be based on the benefit package.

Universal Coverage

1. Framework will continue the current system of employer-based insurance coverage. Employers mandated to offer, but not pay for health insurance coverage for their employees.
2. Subsidies for the purchase of insurance will be phased-in on

the basis of family income. Full subsidy to families with incomes below 100% of the federal poverty level. Sliding-scale subsidies to those with incomes between 100% and 240% of poverty. Goal is to have all subsidies phased in by the year 2000.

3. Hard Trigger -- After 2002 (or two years after the subsidies are fully phased in) if more than 96% of the population has not obtained insurance, an annual "free-rider" penalty will be imposed on those not carrying coverage

Purchasing Groups

1. States will define health coverage geographic areas for the purposes of insurance reform. These areas will affect individuals not affiliated with the workplace and those employed by businesses with fewer than 100 employees. States may increase this threshold by including larger businesses.
2. Individuals and businesses with 100 or fewer employees will be pooled within a geographic area and will be subject to an age adjusted community rate with an overall variance of 2:1 (transition issues to be decided.)
3. Businesses with 100 or fewer employees are prohibited from self-insuring. (Multiple employer arrangements to be discussed.)
4. Some Federal guidelines will be established for purchasing groups forming in the individual and small business coverage areas (i.e. default to voluntary nature), but states will have maximum flexibility to impose other rules.

Tax Changes

1. Favorable tax treatment of health insurance premiums will be limited to a reasonable amount (the "tax cap").
2. The tax cap will initially be set at the weighted average of all plans located in an area. In subsequent years, the cap will be lowered to a level that will approximate an average of the lower costing plans in the area. The question of whether it is imposed on employees and/or employers is still open.
3. The self-employed and individuals purchasing insurance directly will be eligible to deduct 100% of premium costs up to the cap. This will be phased in over time.
4. MSAs will be allowed, but only if used in conjunction with a high-deductible insurance policy. Initially, taxpayers will be able to make MSA contributions in an amount equal to the deductible of the high-deductible policy. Subsequent contributions will be limited to the tax cap, less the amount of the high-deductible policy premium. Contributions to an MSA will not be allowed once the account reaches a certain level (e.g. five times the annual deductible). Penalties will be imposed on non-medical distributions from the account.
5. The long-term care tax provisions in the Chafee bill will be included in the proposal.

Very Preliminary Draft

($ in billions)

25-May-94

	1996	1997	1998	1999	2000	96-00
FINANCING						
Hospital Inpatient Update	0.0	-0.8	-2.3	-4.2	-6.4	-13.8
Hospital Inpatient Capital	-0.8	-1.0	-1.2	-1.6	-2.1	-6.7
Phase Down Hospital DSH	-0.4	-1.3	-3.5	-3.8	-4.2	-13.2
Reduce Hospital IME	-1.8	-2.5	-2.9	-3.3	-3.7	-14.1
Extend OBRA 93 SNF Savings	-0.1	-0.2	-0.2	-0.2	-0.2	-0.8
MD Fees: Real Per Capita GDP	0.0	-0.3	-0.8	-1.6	-2.5	-5.1
MD Fees: Cumulative Targets	0.0	-1.7	-3.3	-4.4	-5.9	-15.3
MD Fees: Conv Factor	-0.4	-0.5	-0.5	-0.5	-0.6	-2.5
Income-Related Premium	-1.0	-1.0	-2.0	-2.0	-2.0	-8.0
Extend 25% Part B Premiums	0.0	0.0	0.0	-1.3	-3.6	-4.9
Extend OBRA 93 Home Health	0.0	-0.3	-0.6	-0.7	-0.7	-2.2
10% Home Health Copay	-1.2	-1.4	-1.6	-1.7	-1.8	-7.6
Extend Secondary Payor	0.0	0.0	-0.2	-1.5	-2.1	-3.7
Home Health Median Limit	0.0	0.0	-0.3	-0.6	-0.7	-1.5
Part B Deductible	-0.1	-0.2	-0.3	-0.4	-0.5	-1.5
Interaction	0.9	1.6	2.9	4.2	5.5	15.2
Subtotal Medicare	-4.9	-9.3	-16.7	-23.6	-31.4	-86.0
Medicaid DSH	-2.2	-4.8	-8.0	-11.8	-16.9	-43.7
Medicaid Capitation	0.5	0.8	0.3	-5.8	-7.9	-12.0
Subtotal Medicaid	-1.6	-4.0	-7.7	-17.6	-24.8	-55.8
Postal Service Retirement	-2.0	-2.0	-3.0	-3.0	-3.0	-13.0
Subtotal Spending Reductions	-8.5	-15.4	-27.4	-44.2	-59.2	-154.7
Tax Cap	-2.5	-5.0	-7.5	-10.0	-12.5	-37.5
Tobacco	-11.0	-11.0	-11.0	-11.0	-10.0	-54.0
HI State/Local	-1.6	-1.6	-1.5	-1.5	-1.5	-7.6
Subtotal Revenues	-15.1	-17.6	-20.0	-22.5	-24.0	-99.1
TOTAL FINANCING	-23.6	-32.9	-47.4	-66.7	-83.2	-253.8

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo w/attach	Chris Jennings to Hillary Clinton Re: Meeting with Congressman Cooper (3 pages)	6/14/93	P5

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.

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

FOLDER TITLE:
June 1993 HSA [2]

gf88

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]
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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]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. memo w/attach	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senators Leahy and Pryor (8 pages)	6/14/93	P5

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. memo	Chris Jennings/Melanie to Hillary Clinton/Patti Re: Congressional Meetings (2 pages)	6/16/93	P5

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. memo w/attach	Steve Edelstein Hillary Clinton Re: Cosponsors of McDermott Bill (8 pages)	6/17/93	P5

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