DETERMINED TO BE AN ADMINISTRATIVE
MARKING Per E.O. 12958 as amended, Sec. 3.2 (c)
Initials: 173 Date: 8.18.05

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton December 7, 1993
FR: Chris J.
RE: Info requests re premium caps and minimum wage camparisons
cc: Ira, Distribution

Last week you requested information that would provide a more balanced perspective (to the Congress and others) on the issues of employer mandates and premium regulation. More specifically, you wanted (1) information that illustrated the past track record of minimum wage increases (politically and economically) and (2) how state insurance commissioners currently regulate insurance premium increases. (On the mandate issue, you also wanted to get a sense of how much the required employer health care contribution would cost and compare that with past percentage increases in the minimum wage).

In response to the minimum wage question, I asked the Department of Labor to provide some background information. Enclosed is a one page cover document, with some attached supporting information.

In short, the percentage increases in payroll associated with the Health Security Act (approximately 3.5% to 8.0% -- 15-34 cents per hour) would be equal to, or in most cases far less than, what previous increases in the minimum wage have been. (Obviously, it is important to note that most small firms already providing decent insurance coverage would pay no more, if not less than, what they are currently paying.)

Equally as important, minimum wage increases have never been clearly correlated with any significant job impact problem. To the contrary, as the attached information illustrates, there has been only one significant downturn following a minimum wage increase (1991) and that occurred when the economy was in an overall slump anyway.

Also attached is a background piece on the state regulation of insurance premiums by Gary Claxton. As I mentioned to you on the phone, most of the premium approvals done at the state level are for individual -- not group -- premiums. (Gary thinks this regulatory approval process applies to policies held by no more than 10-20 percent of the public.) Having said that, it is true that the policies that are subject to prior review or approval of rate increases go through a much greater and more invasive regulatory process than anything the Health Security Act envisions. We, therefore, believe it is fair game to make this comparison when responding to critiques about the regulatory nature of our plan.

MANDATED HEALTH CARE COSTS AND EMPLOYMENT EFFECTS

Criticism:

In past years when an increase in the minimum wage has been proposed, critics have argued that any increase would result in a significant loss of low wage jobs. Today, the critics are making essentially the same case, arguing that a mandated health care expenditure would have the same kind of adverse effects on employment.

Response:

Historically, whenever any kind of employer mandate has been proposed, opponents have made dire predictions of huge job losses that would result. The most frequent example has been the minimum wage increases, which have always included predictions of significant job losses. Yet, historical evidence suggests that such claims have typically overstated the consequences of wage increases. More importantly, recent and better studies have strongly suggested that the effects of increases have had negligible effects on employment. Although the analogy between minimum wage increases and an employer mandate resulting from the Health Security Act are not perfect, these recent studies suggest strongly that critics of the Health Security Act are overstating their case. **The best research on minimum wage increases strongly suggests that employer cost increases associated with the Health Security Act, equivalent to approximately a 3.5% to 8.0% increase in the minimum wage, would be highly unlikely to cause significant job losses.**

- If the minimum wage today had the same purchasing power as it did in the 1970s, it would equal about $5.40. Its inflation adjusted value today is 22% lower than it was in the 1970s and nearly 21% lower than in the 1960s. Thus, even if the employer costs associated with the Health Security Act (15 to 34 cents per hour) are added to the current minimum wage (which is $4.25), it would still be of less value than it has been over most of the last 30 years.

Attached are summaries of the evidence to support this argument. A summary of the historical arguments against the minimum wage is Attachment A; a summary of recent studies is Attachment B.

12/7/93

Attachment A
Minimum Wage And Employment Effects: Historical Evidence

Summary

Business organizations have historically made dire predictions about the adverse consequences of a minimum wage increase on employment and inflation. As can be seen in the from the most recent minimum wage increase, much more significant factors in the economy can easily overwhelm the relatively minor effects that might be attributed solely to a change in the minimum wage. Traditionally, minimum wage studies have been based on macroeconomic data, requiring heroic assumptions to isolate the effects of the wage increase from many other events occurring simultaneously in the economy.

The relatively new methodological approaches utilized (Attachment B) in the past few years are a much better measure of the effects of a minimum wage change. By undertaking micro-economic studies and analyzing disaggregate data, they have been able to much more effectively isolate the effects of a wage change. This recent work strongly suggests that the increase in the wage has negligible, and in some circumstances even positive, effects on employment.

Historical Arguments

Although Congress has periodically reaffirmed its commitment to a minimum wage which is a living wage, the opposition has historically made predictions about significant adverse employment effects whenever revisions have been proposed. The first minimum wage was enacted in 1938 as part of the Fair Labor Standards Act. The following is a summary of the major changes in the minimum wage, the dire predictions of opponents before-hand and the reality after enactment.

1949 Amendments

Congress raised the minimum wage from 40 to 75 cents, an 87.5% increase.

During the deliberations, business organizations consistently warned of significant increases in unemployment and inflation if the increase was enacted.

- Overall unemployment fell from 5.9% in 1949 to 5.3% in 1950. Total employment increased from 1949 to 1950.

- Youth unemployment fell from 13.4% to 12.2%.

1955 Amendments

Congress raised the wage from 75 cents to $1.00, a 33% increase.

Again, business predicted serious unemployment and inflation. The U.S. Chamber of Commerce said in testimony that "Low paid workers who are covered by the law will have been barred from jobs by members of Congress."

- o Overall unemployment fell from 4.4% to 4.1%. Total employment increased more in 1956 than in the prior two years in which there had been no increase.
- o Youth unemployment increased slightly, from 11.0% to 11.1%.

1961 Amendments

The wage was increased to $1.15 (a 15% increase), and in 1963, it was increased to $1.25 (a 9% increase). Moreover, coverage was expanded to cover retail and service establishments.

In testimony, the U.S. Chamber of Commerce asserted that "Whatever good might result from minimum wage legislation would be far outweighed by the unemployment and inflation the legislation would provoke."

- o Between 1960 and 1961, retail and service employment, which was then not covered, grew by 1.2%; between 1961 and 1962, the first year of coverage, employment jumped by 3.3%.
- o Overall unemployment fell from 6.7% to 5.5%.
- o Youth unemployment fell from 16.8% to 14.7%.
- o Inflation increased at a lower rate in the year after the increase in the minimum wage took effect than in the year prior to the increase.

1966 Amendments

The minimum wage increased from $1.25 to $1.40 in 1967 (a 12% increase) and to $1.60 in 1968 (a 14% increase), and coverage was expanded.

Again, business organizations testified that significant adverse employment effects and inflation would result.

- o Unemployment fell from 3.8% in 1966 to 3.6% in 1968.

- o Youth unemployment fell from 12.8% to 12.7%

- o In 1970, Secretary of Labor Schultz reported to Congress: "In retail, services and state and local government sector--where the minimum wage had its greatest impact in 1969, since only the newly covered workers were slated for Federal minimum wage increases--employment rose substantially."

- o In 1971, Secretary of Labor Hodgson reported to Congress, "...it is doubtful whether changes in the minimum [wage] had any substantial impact on wage, price, or employment trends."

1974 Amendments

The minimum wage was increased to $2.00 in 1974 (a 25 percent increase), $2.10 in 1975 (a 5% increase) and $2.30 (a 10% increase) in 1976.

The American Retail Federation testified that their members would be forced to reduce the number of workers, including "marginal employees" and "employees who are no longer productive but who we are currently carrying."

- o During the 1975 recession, unemployment rose from 5.5% in 1974 to 7.6% in 1976.

- o Youth unemployment increased from 16% to 19%.

- o Retail jobs, however, increased by 655,000, a 5.2% jump.

1977 Amendments

The minimum wage increased in four steps: $2.65 in 1978 (a 15% increase), $2.90 in 1979 (a 9% increase), $3.10 in 1980 (a 7% increase), and to $3.35 (an 8% increase) in 1981.

The U.S. Chamber of Commerce predicted the increases would result in about 2 million lost jobs. They also projected a loss of 387,000 teenage jobs, and minority teenage unemployment would almost 6% in the first year alone.

- o The unemployment and youth unemployment rates dropped in 1978 and 1979 and rose back to their 1977 (pre-increase year) in 1980.

- o Unemployment and youth unemployment increased in 1981 and 1982, which was when the economy was experiencing one of the worst recessions since World War II.

1989 Amendments

The wage was increased from $3.35 to $3.80 (a 13% increase) in 1990 and to $4.25 (a 12% increase) in 1991. (Congress had initially proposed an increase to $4.65, which was the basis for much of the pre-enactment analysis.)

A study funded by the U.S. Chamber of Commerce in 1987 calculated that 1.9 million jobs would be lost by 1995 and that there would be a 0.4% increase in unemployment (based on a $4.65 minimum wage). This and another Chamber funded study estimated job loss among teenagers to range from 113,000 to 420,000 (based on $4.65 minimum). Indeed, one of the studies predicted Connecticut would experience the loss of several thousand jobs; yet, Connecticut already had a state minimum wage that exceeded the proposed federal increase and therefore would have been unaffected.

In another study, the Retail Industry Task Force estimated that 364,000 people in the retail industry would lose jobs at a $4.65 minimum.

- In 1991, the national and global economy went into a recession. The economy lost nearly 1.25 million jobs between 1990 and 1991, and gained only 125,000 jobs between 1991 and 1992.
- Retail trade lost 418,000 jobs in 1991 and 122,000 jobs in 1992.
- Teenage employment fell by almost 900,000 jobs between 1990 and 1992.

Although there was significant job loss after this most recent wage increase, no one seriously attribute the losses to the increase; rather, the job losses were a function of a national and global recession.

Source: Senate Labor and Human Resources Committee, Committee Report on the Minimum Wage Restoration Act of 1988 (July 26, 1988). The summary and 1991-92 data are added.

Attachment B

Summary of Recent Studies on the Minimum Wage Effects

1. Time series studies (using national data) completed in the 1980s suggest that the effects of an increase in the federal minimum wage were small.

Critics of the proposed minimum wage increases in the mid- late 1980s generally ignored these studies, and instead, relied on high range estimates from studies conducted in the 1960s and 1970s, which were both less technically sound and relied on data reflecting a much different kind of economy.

More importantly, the use of national data can be misleading because it is very difficult to separate the effects in employment due to changes in the minimum wage from other changes in the economy.

- o The federal Minimum Wage Study Commission in 1981 found the effects of a minimum wage increase were small: a 10% increase in the minimum wage was associated with a 1% decrease in teenage employment and a 0.25% decrease in the employment of young adults (20-24 year olds), and no significant evidence of job loss for adults over 25 years old.

- o Two studies using data from the through the 1980s show even smaller effects: a 10% increase in the minimum wage resulted in a decrease of one-tenth to six-tenths of one percent employment among teenagers and no significant effects on employment among workers over age 20.

2. Studies of the effects of federal and state increases in the minimum wage levels during the 1980s generally found that increases did <u>not</u> reduce employment.

These studies strongly suggest that recent increases in both federal and state minimum wages have had little, if any, effect on employment. However, these findings are tempered by the fact that the value of the minimum wage was at its lowest value in the 1980s since 1960.

- o David Card of Princeton examined the effects of the increase of the federal minimum wage from $3.35 to $3.80 in April, 1990, on states with differing proportions of low-wage workers. High wage states, such as New York and California, had relatively few workers that would have been affected by the increase, whereas low wage states, such as Alabama and Mississippi, had as much as 50% of their teenagers earning wages that would be increased by the change.

December 1, 1993

To: Chris Jennings

From: Gary Claxton

Re: State approval of health insurance rate increases

Questions: The questions are what provisions exist under current State law for approval of health insurance premium increases and how those provisions compare to the premium caps in the Health Security Act.

Answer: State laws regarding approval of health insurance premium increases differ significantly by State, by line of insurance (e.g., individual v. large group), and by type of insurer (Blue Cross plan v. commercial insurer). In general, most people probably are covered under policies that are not subject to prior review or approval of rate increases.

When States exercise approval over premium increases, they generally use one of two types of laws. Prior approval laws require approval of a rate increase before it can be put into effect. File and use laws generally require insurers to file a request for a rate increase 30 to 90 days prior to its effective date; the insurer can take the increase unless it is disapproved by the State.

States generally exercise rate approval only over health insurance sold directly to individuals, although a few states also exercise approval for small group coverage.[1] Approval generally is based on compliance with loss ratio requirements, i.e., a type of policy is required to return a specified percentage (e.g., 65%) of premiums as benefits.

In a few States (such as Michigan), a higher standard of review is applied to Blue Cross and Blue Shield Plans than is applied to commercial health insurers. Health maintenance organizations also are subject to higher standards for review in some States.

In the last few years, a number of States have increased their regulation of small group and (to a lesser extent) individual premium rates. For the most part, these provisions restrict rate variation and rate increases by regulating the maximum difference

---

[1] Many States would appear to have greater authority over health insurance premium rates (See attached chart from National Association of Insurance Commissioners), but insurers have found methods to avoid State rate approval laws. A common method is writing coverage through associations or trusts situated in States that do not require approvals.

between premium rates charged to similar groups (or individuals) for similar coverage. Insurers generally are required to file an actuarial certification with States certifying that they are in compliance with the State's law and regulations. Insurers also are required and to keep information about rating practices on file so that State regulators can audit compliance. State approval of premium increases generally is not required.

Insurers subject to State approval of rates often complain that regulators do not act quickly enough and do not approve all of the requested premium increase. Blue Cross plans, especially those that act as insurers of last resort, claim that they are disadvantaged by over-regulation of premium increases and inadequate rate increases. Insurers argue that obtaining prior approval of rate increases across a number of States is very cumbersome and difficult.

The system envisioned by the Health Security Act is very different than the regulations that apply today. Compared to the provisions that apply to those lines of insurance that now are subject to State approval laws, the proposed system is simpler. In alliances with average premiums under the cap, insurers can raise their rates as much as the market will allow. In alliances that exceed the cap, the reduction in premiums (and provider payments) that applies to insurers with excessive premium increases is automatic and fairly predictable.

One advantage that the Health Security Act offers over current law is that it provides a mechanism to lower an insurer's costs if its rates are constrained by the premium caps. Insurers now complain that States force them to lose money by not approving adequate rates -- their income is constrained but their expenses are not. Under the Health Security Act, if an insurer's rates are reduced due to the premium caps, its payments to providers are proportionately reduced. This better protects insurer solvency, although some insurers worry that providers will not continue to do business with them if they are paying reduced rates to providers.

For insurers, there are several aspects that make the provisions of the Health Security Act potentially less desirable than current law. First, the premium caps would apply to all of an insurer's health insurance business; current State approval laws apply only to part (and for some insurers, a small part) of their health insurance business. Insurers see premium caps as making more of their business subject to regulation (and therefore riskier). The premium caps also are absolute limits in cases where the alliance exceeds its cap. Under current law, regulators have some flexibility to approve larger premium increases to assure solvency. Finally, insurers are concerned that the rate of increase permitted by the caps is too low. Current loss ratio regulation limits premiums increases as a function of the actual benefits paid by the insurer. The premium caps limit premium increases relative to a formula that is external to the claims

experience of the insurer. Insurers would argue that this gives them far less control over their business and financial status.

In summary, the premium caps proposed under the Health Security Act are less intrusive and administratively burdensome for insurers than expanding existing prior approval provisions to all health insurance business. The premium caps give substantial flexibility to insurers in alliances that do not exceed the cap. For other insurers, the caps provide a predictable and automatic process for reducing both premiums and provider payments.

NAIC
HEALTH INSURANCE RATE FILING REQUIREMENTS IN THE STATES

State:	Citation:	Filing Requirement:	Applies to:
Alabama	Reg. 24	filing not required	
Alaska	3 AAC 28.220	filing not required	
Arizona	Reg. R4-14-607	file and use	individual health
Arkansas	§ 23-79-109	prior approval (30 day deemer)	individual health
California	§ 10290 Reg. T. 10 § 2213	file and use (30 days)	all health
Colorado	§ 10-16-107	file and use (30 day deemer)	all health
Connecticut	§ 38a-481	file and use (30 days)	all health
Delaware	tit. 18 §§ 3333, 2504	file and use (90 days)	all health including Med Supp and BC/BS
District of Columbia	§ 35-517	file and use (30 days)	all health
Florida	Reg. 4-149.001	file and use	all health
Georgia	§ 33-20-20	prior approval	all health
Hawaii	No provision		
Idaho	§ 41-2136	file and use	individual health
Illinois	215 ILCS 5/355	file and use	all health
Indiana	§ 27-8-5-1	file and use (30 days)	all health
Iowa	Reg. 191-36.9	file and use	individual health including Med Supp
Kansas	§ 40-2215	file and use (30 days)	individual health
Kentucky	§§ 304.17-380 to 304.17-383	prior approval	individual policies unless contain loss ratio guarantee
Louisiana	R.S. 22:211	file and use (30 days)	all health

NAIC COPYRIGHT 1993

NAIC
HEALTH INSURANCE RATE FILING REQUIREMENTS IN THE STATES

State:	Citation:	Filing Requirement:	Applies to:
Maine	24-A §2736	file and use (60 days)	individual health, Med Supp, LTC
Maryland	Reg. 09.30.44.02	file and use (90 days)	all health
Massachusetts	Ch. 175 § 108	file and use (30 days)	all health
Michigan	§ 500.3474	file and use	individual health
Minnesota	§ 62A.02	file and use (60 days)	all policies
Mississippi	Reg. LA&H 73-4	file and use	all health
Missouri	20 CSR 400-8.200	file and use (60 days)	all health
Montana	No provision		
Nebraska	§ 44-710	file and use (30 days)	all health
Nevada	§ 689A.360	file and use	individual health
New Hampshire	§ 415:1	file and use (30 days)	all health
New Jersey	Reg. 11:4-18.1	file and use	individual health
New Mexico	§ 59A-18-13	prior approval	all health
New York	§ 3216	file and use	individual health
North Carolina	§ 58-51-95 § 58-51-85	file and use (90 days) file and use	all health group health
North Dakota	§ 26.1-30-19	prior approval	all health
Ohio	§ 3923.021	file and use (30 days)	all health
Oklahoma	tit. 36 § 4402	file and use	individual health
Oregon	§ 743.018	file and use	all health
Pennsylvania	40 P.S. § 751	prior approval	all health
Rhode Island	Reg. XXIII, Part XI	prior approval	all health
South Carolina	§ 38-71-310	prior approval (90 day deemer)	individual health

NAIC COPYRIGHT 1993

NAIC
HEALTH INSURANCE RATE FILING REQUIREMENTS IN THE STATES

State:	Citation:	Filing Requirement:	Applies to:
South Dakota	§ 58-17-4.1	file and use (30 day deemer)	individual health
Tennessee	§ 56-26-102	prior approval (30 day deemer)	all health except experience rated groups
Texas	Art. 3.42	file and use (60 day deemer)	individual health
Utah	Reg. R590-85	file and use	individual health
Vermont	Title 8 § 4062	file and use (30 days)	all health
Virginia	§ 38.2-316	file and use (30 day deemer)	all health
Washington	No provision		
West Virginia	§ 33-16B-1	prior approval (60 day deemer)	all health
Wisconsin	§ 625.13	use and file (30 days)	individual health
Wyoming	§ 26-18-135	file and use	individual health

Every effort has been made to make this chart correct and complete. For more information you should consult the statutes and regulations cited.

NAIC
12/93

W:\CHARTS/HEALTH/RATES

NAIC COPYRIGHT 1993

DETERMINED TO BE AN ADMINISTRATIVE
MARKING Per E.O. 12958 as amended, Sec. 3.2 (c)
Initials: [illegible] Date: 8·18·05

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton December 21, 1993
FR: Chris J.
RE: Recent polling data and getting the good news out
cc: Melanne, Ira, Steve, Jack

Yesterday you informed us that you will be doing a series of end of the year interviews. You asked to receive some general talking points and wanted to get a summary of the most recent polling data. You also asked about the status of our efforts to "get out the information" to the Hill.

Attached is a draft of the Dear Colleague that Senator Daschle is planning to send out to every Senator. (It will be slightly revised and is now going under final review). The question now is that most Members and staff have left town and the DPC believes the information would get more widespread notice and use if the letter is put on hold of until early January. (I tend to agree with their assessment and, with your permission, would like to suggest that we get the Dear Colleague ready for immediate distribution for Monday, January 3.)

Also attached for your use is a one pager, authored by Christine H., which gives a brief description of the development and status of the health care reform proposal. We thought it might be useful for your interviews.

Behind this document is a summary of the recent polls, and a more specific break-out of the Wall Street Journal poll that was recently released. We hope you find this information to be useful.

DRAFT

December 20, 1993

Dear Colleague:

As we prepare for the new year ahead, health care reform will be one our most urgent legislative priorities.

Last week several national polls indicated the importance of passage of President Clinton's health care plan in 1994. The findings of the polls include the following points, which I thought you might find helpful as you return home to discuss health care with your constituents during the recess:

- Americans want comprehensive reform. A recent Battleground '94 poll showed that when asked to name the President's top accomplishment, more people name ""proposing a national health care reform package" than any other accomplishment, including the deficit-reduction bill, NAFTA, and the Brady bill.

- Americans support a health plan that guarantees coverage for all, better benefits and cost controls. Respondents of the Battleground poll, 69% to 20% favored the Clinton proposal over a plan that is less expensive and relies on competitive buying of insurance. Battleground '94.

- Americans support an employer mandate with discounts for small firms, according to The Wall Street Journal/NBC poll that showed 65% of Americans supported the employer mandate.

- Americans believe that universal coverage is essential. A recent Times Mirror poll showed that those who support the President's plan overwhelmingly cite health security and universal coverage as the reason for support. The Times Mirror poll shows support for the President's plan is up to 49% from 41% in October.

Enclosed is a fact sheet on the recent poll data for your information. As we look ahead to 1994, let us make comprehensive, health care reform a historic accomplishment for the American people. I look forward to working with you in the new year to secure universal health care for all Americans.

Sincerely,

We've had a very busy-- and very productive-- year in health care reform, and as a result have a thorough and complete proposal that acheives what Americans are looking for: guaranteed private insurance and real control of health insurance costs.

The President made clear when he took office that health care was one of this Administration's highest priorities-- and we assembled a team of some of the best doctors, nurses, consumer advocates, department representatives and health care experts to get it done. Our charge: develop a proposal that would build on what works and fix what's wrong with today's health care system.

I and other members of the Administration spent a good deal of time during the spring and summer travelling around the country to hear the concerns and ideas of American who face a health care system that is failing them. We brought their stories back with us to Washington and drafted a plan that would address these problems, guarantee all Americans health care security, and do so without new broad-based taxes.

This fall the President delivered our legislation to the Congress, and the Health Security Act has been introduced with more than 130 co-sponsors. And in addition to the President's bill, there have been several other health care reform bills submitted this year--- nearly 400 members of the Congress have signed their name to some piece of health reform legislation. ***The debate is no longer whether or not to reform health care -- it's now how to best reform health care.***

We feel very confident that the Health Security Act most closely reflects the type and level of health care reform people are looking for. It achieves universal coverage by building on the employer-based system. It not only brings coverage to those workers and their families not now insured; the President's plan also reforms insurance so that people who have coverage can't be dropped from their insurance, or be overcharged because of previous illnesses.

Recent polls reflect that the American people feel health care reform is the most important issue we face, and that introducing health care reform legislation is our most important accomplishment this year. They also point out that most Americans feel that building on our current, employer-based system makes the most sense, and that universal coverage must be a part of real health care reform. (see attached poll data)

RECENT POLLS ON HEALTH CARE

Wall Street Journal/NBC News poll

- 65% of Americans support an employer mandate with discounts for small firms.
- 78% of Americans support guaranteed coverage for all Americans regardless of health or employment status.
- When asked which health care plan people favored,

  Plan A: A congressional plan that is less expensive than the Clinton plan because it relies on competitive buying of insurance, but which might leave more than ten million Americans without coverage.

OR

  Plan B: President Clinton's health care plan, which may cost more than the Congressional plan, which provides more benefits and cost controls, and guarantees coverage for every American.

respondents favored the Clinton plan, 69% to 20%.

Times Mirror poll (published in LA Times)

- Support for the President's health care plan is growing, up to 49% from 41% in October.
- This support came despite the fact that just 54% knew that the plan provides universal coverage, and 44% know that it guarantees coverage for workers if they lose or quit their jobs .

Battleground poll (published in USA Today)

- When asked to name the President's top accomplishment, more people name "proposing a national health care reform package" than any other accomplishment, including the deficit-reduction bill, NAFTA, and the Brady bill.
- And when asked to name what they were most disappointed about that the President did not get done his first year in office, Americans cited health care reform more than any other issue.

15a. From what you have heard or read, do you favor or oppose President's Clinton's health care program?

	12/93	10/93	9/22/93*
Favor	47	47	51
Oppose	32	37	18
Need to know more (VOL)	15	12	17
Not sure	6	4	14

*Asked in NBC News survey.

15b. Do you think Bill Clinton's health care plan should be passed by Congress pretty much as is, should Congress make major changes to President Clinton's plan, or should Congress not pass the plan at all?

President Clinton's plan should be passed as is	24
Congress should make major changes to President Clinton's plan	36
Congress should not pass the plan at all	15
Congress should make minor changes to President Clinton's plan (VOL)	11
Not sure	14

15c. Which of the following do you see as the most important health care issue at the present time?

	12/93	10/93	9/93	3/93
The cost of health care	43	42	42	48
People who are not covered by insurance	33	35	41	35
The quality of health care	13	14	10	8
All equally (VOL)	9	7	5	8
None of these (VOL)	1	1	1	–
Not sure	1	1	1	1

15d. Here are some specific provisions of the Clinton health care reform plan. For each one, please tell me if you favor or oppose that specific provision of the plan.

	Favor Provision	Oppose Provision	Not Sure
Requiring all businesses to pay at least eighty percent of medical coverage for their employees and giving small firms some government funds to subsidize this coverage	65	29	6
Having the government cover retirees under age 65, instead of their previous employer as is now the case	43	47	10
Providing exactly the same comprehensive benefits package for everyone	65	29	6
Imposing overall limits on how much the United States spends on health care	51	37	12
Charging all Americans the same for health care, regardless of factors like their age and where they live	52	42	6
Guaranteeing coverage for all Americans regardless of health or employment status	78	17	5

15e. Which of the following three approaches do you think would be the best way to provide health coverage for all Americans?

Proposal A: A system in which insurance companies would continue to provide health insurance coverage, with some government regulation to keep costs under control, and in which all employers would be required to provide health insurance for their workers.

Provision B: A system in which the government would provide coverage to all Americans, and would collect all insurance premiums and pay all health care costs, without the involvement of employers or insurance companies.

Proposal C: A system in which consumers and businesses would join buying pools to get a better deal on health insurance and the government would give subsidies to help the poor, but in which there would be no government price controls and no guarantees that all Americans would have health coverage.

Proposal A/Insurance companies and employers provide coverage	43
Proposal B/Government provides coverage	28
Proposal C/Consumers and businesses join pools	19
None (VOL)	4
Not sure	6

15f. Which one of the following health care plans would you favor more?

PLAN A: A congressional plan that is less expensive than the Clinton plan because it relies on competitive buying of insurance, but which might leave more than ten million Americans without coverage.

OR

PLAN B: President Clinton's health care plan, which may cost more that the congressional plan, which provides more benefits and cost controls, and guarantees coverage for every American.

Plan A/less expensive congressional plan	20
Plan B/more comprehensive Clinton plan	69
Neither (VOL)	6
Not sure	5

THE WHITE HOUSE

WASHINGTON

December 9, 1993

TO: **Interested Parties**

FR: **White House Health Care Team**

On December 8, 1993, the independent research group, Lewin-VHI released a study that shows the soundness of the financing of the President's Health Security Act. The study confirms that the Health Security Act is fully financed and that it will reduce the deficit over the period from 1995-2000.

Included in this packet are:

1. A copy of the Lewin-VHI executive summary
2. A copy of the Lewin-VHI press release
3. Formal statement by Deputy OMB Director Alice Rivlin
4. Transcript of briefing conducted by Treasury Secretary Lloyd Bentsen and OMB Director Leon Panetta.
5. Selected newspaper articles

If you need more information, please feel free to contact the Health Care Delivery Room at 202-456-2566.

EXECUTIVE SUMMARY

President Clinton's health reform proposal, the Health Security Act, would fundamentally reshape the United States health care system. The Health Security Act assures that all Americans have access to comprehensive health insurance coverage and clearly defines the roles of employers, governments, and individuals in financing this coverage. The Act also redefines the role of insurers in providing coverage to all Americans while realigning the provider incentives that have contributed to the rapid rate of growth in health spending in the United States. Moreover, it would, for the first time, place limits on the growth in health spending through a combination of price competition and premium growth limits over time.

In this analysis, we focus upon the financing implications of the President's health reform plan. We present estimates of changes in health spending by employers, governments, and individuals under the plan in 1995 through 2000. We also compare our estimates with those developed by the administration.

A. Overview of the Health Security Act

OVERVIEW

- ***In general, all persons not covered under Medicare obtain coverage through a program of Health Alliances***
- ***Medicaid recipients participate in Health Alliances***
- ***Employers must contribute to coverage for workers and dependents***
- ***Non-workers must purchase coverage***
- ***Premium subsidies provided for low-income persons and certain employers***
- ***Prescription drug coverage under Medicare***
- ***Expanded long-term care coverage***
- ***Controls on overall health spending***

The Act establishes quasi-public entities called "Health Alliances" in each region of the country which aggregate consumer buying power to negotiate the best premiums with health plans. In general, all persons not otherwise covered under Medicare would select from among alternative plans offered through the Health Alliance. These plans would be required to offer a uniform benefits package covering a standard list of services with standardized patient cost-sharing requirements. These plans are also required to accept all applicants and are not permitted to vary premiums with health status ("community rating"). This market structure limits insurers' ability to target healthier populations, thus forcing insurers to compete for market share on the basis of price, provider network, and quality of services provided. All states are required to participate in the program by 1998, although states are permitted to participate as early as 1996.

© 1993

Employers are required to contribute at least 80 percent of the cost of the average plan in the area for each full-time worker, leaving the employee to pay the remainder. (The employer has the option of contributing more.) Non-working individuals also obtain coverage through the program. The Act provides premium subsidies to low-income individuals and employers (primarily small firms with lower wage workers). In addition, the Federal government will pay 80 percent of the average cost premium for early retirees. However, these subsidies are provided only up to an amount equal to the average cost plan in the area to encourage consumer price consciousness when selecting a plan.

AVERAGE ANNUAL PREMIUMS IN REGIONAL ALLIANCE IN 1998	
Individuals	***$2,732***
Couples	***$5,464***
Two-Parent Families	***$5,975***
One-Parent Families	***$5,172***

Medicaid coverage would be continued for persons receiving cash assistance although they would obtain coverage through the Health Alliance. Medicaid coverage would be eliminated for all other persons not receiving cash assistance (except those on Medicare); these individuals would obtain coverage through the Health Alliance where they will qualify for subsidies according to the same criteria that apply to other families. However, states are required to make a "maintenance of effort" contribution to the Federal government to fund subsidies under the program the amount of which is based upon the state share of savings for the non-cash Medicaid population.[1]

Under the Act, the Medicare program is retained in its current form, although coverage is extended to cover prescription drugs. Long-term care coverage is also expanded under the Act. However, working Medicare recipients would become covered in the Regional Alliance by virtue of the employer coverage requirement. In addition, the program includes provisions which limit the growth in health spending for both public and private programs by controlling the rate at which premium payments could increase.

B. Change in National Health Spending

National health spending would increase over the 1996 through 1998 period as states begin to participate under the program and extend coverage to the uninsured (Figure ES-1). Under the Act, health spending would eventually fall below levels projected under current

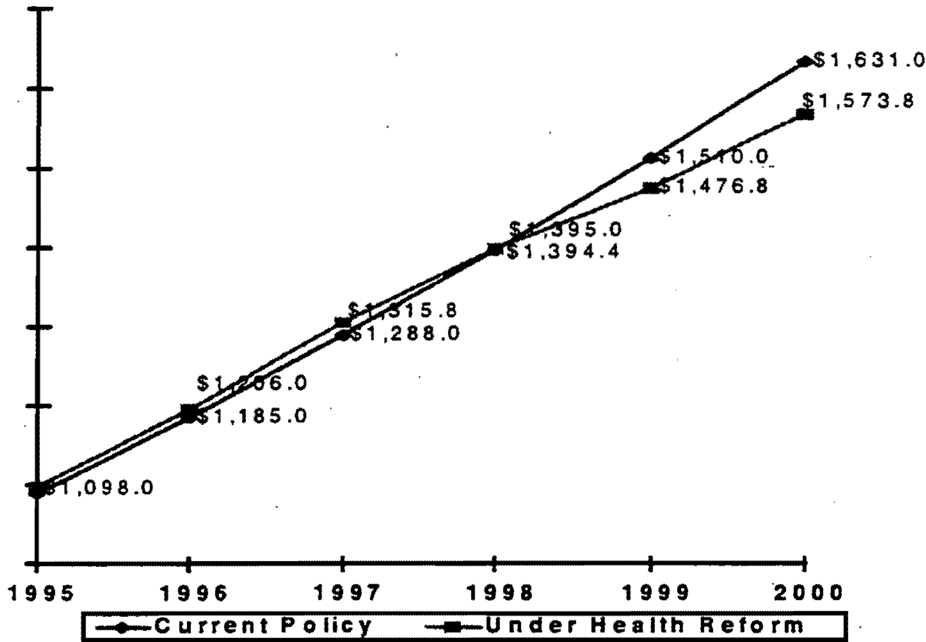
[1] The amount of this maintenance of effort contribution will be based upon current spending for the non-cash Medicaid population indexed to health spending growth (i.e., reflects budget caps).

© 1993

policy beginning in 1999 as the effect of the health expenditure constraints increases over time. Under the Health Security Act, health care will comprise about 18.0 percent of gross domestic product (GDP) by 2000 compared with 18.7 percent under current policy (without reform).

FIGURE ES-1

CHANGES IN HEALTH SPENDING UNDER THE HEALTH SECURITY ACT IN 1995 THROUGH 2000



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Health spending in the first full year of implementation (1998) would be roughly the same as under current policy ($0.6 billion less) (Table ES-1). However, as discussed below, health spending by individual payers will change substantially under the Act. The $0.6 billion reduction in health spending reflects an array of complex changes in coverage and service delivery under health reform. This includes increases in utilization of acute care services for previously uninsured persons of $47.0 billion; increased long-term care utilization of $11.6 billion; increased funding for public health of $5.4 billion; and increased administrative costs of $6.9 billion. These new costs will be offset by savings attributable to increased use of managed care.

© 1993

TABLE ES-1

CHANGES IN HEALTH SPENDING IN 1998 (IN BILLIONS)

		CHANGE IN HEALTH SPENDING
CHANGES IN HEALTH SPENDING		
Federal Government Health Spending		$6.0
New Program Costs	$76.4	
Offsets to New Program Costs	($70.4)	
State Government Health Spending		($12.4)
New Program Costs	$1.2	
Offsets to New Program Costs	($13.6)	
Local Government Health Spending		$3.4
Savings to Public Hospitals	($14.8)	
Loss of Disproportionate Share Funds	$16.6	
Local Government Worker Health Benefits	$1.6	
Private Employer Health Spending (Net of Subsidies)		$28.9
Firms That Now Insure	($0.4)	
Firms That Do Not Now Insure	$29.3	
Household Health Spending		($26.5)
Premiums Payments	($26.2)	
Out-of-Pocket Payments	($15.8)	
Tax Payments	$15.5	
NET CHANGE IN HEALTH SPENDING		
Net Change in Spending b/		($0.6)
Utilization for Uninsured/Underinsured	$47.0	
Managed Care Savings	($14.9)	
Long-Term Care	$11.6	
Public Health	$5.4	
Administration	$6.9	
Expenditure Control Savings	($56.6)	

a Does not include wage effects and resulting changes in tax payments because these values are not included in the national health accounts. These effects are estimated below.

b A detailed analysis of changes in national health spending under the Health Security Act is presented in Appendix A.

Source: Lewin-VHI estimates.

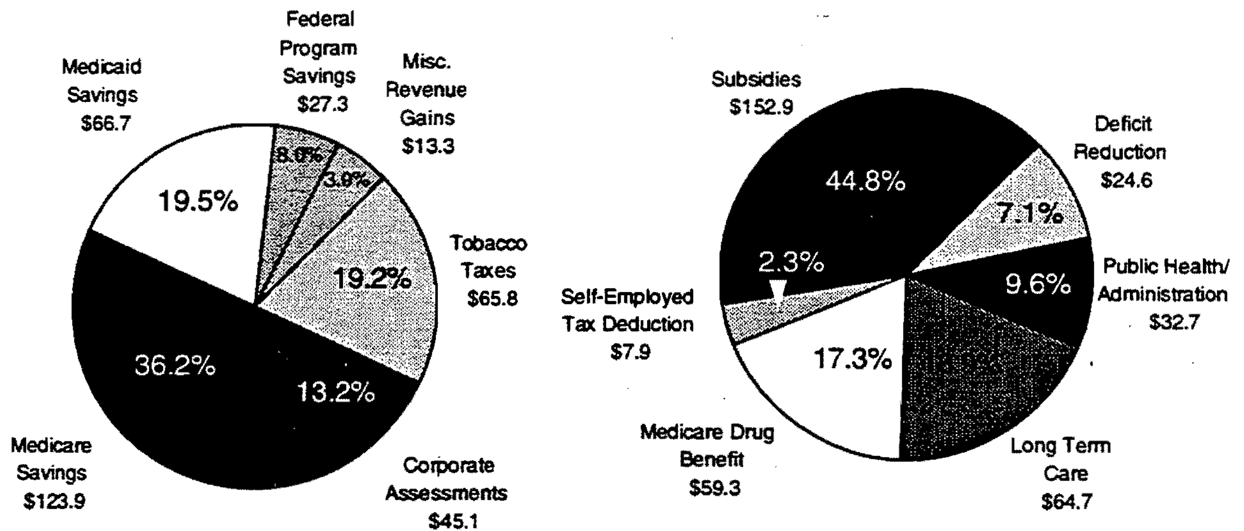
C. Federal Health Spending Under the Health Security Act

New Federal programs under the Health Security Act would be financed largely with savings in existing Federal health benefits programs. The Federal government would provide premium subsidies to households and businesses, expand long-term care coverage, provide prescription drug coverage under Medicare, and expand public health activities. These programs would be financed with savings under Medicare, Medicaid and other Federal programs together with other taxes on households and employers. Under the assumptions used in this analysis, the program would result in a net reduction in the Federal deficit over the 1994 through 2000 period of about $24.6 billion.

Total uses of Federal funds under the Health Security Act would be $342.1 billion over the 1994 through 2000 period (Figure ES-2). This includes new program spending of $317.5 billion and $24.6 billion in deficit reduction. The $317.5 billion in new program spending includes premium and cost-sharing subsidies (net of offsets) of $152.9 billion; net Medicare drug benefit payments of $59.3 billion; and long-term care expenditures of $64.7 billion. The program also includes $7.9 billion in increased health insurance tax deductions for self-employed persons, and funding for public health and administration of $32.7 billion.

FIGURE ES-2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE HEALTH SECURITY ACT 1994 - 2000 (IN BILLIONS)



Sources of Funds = $342.1 Uses of Funds = $342.1

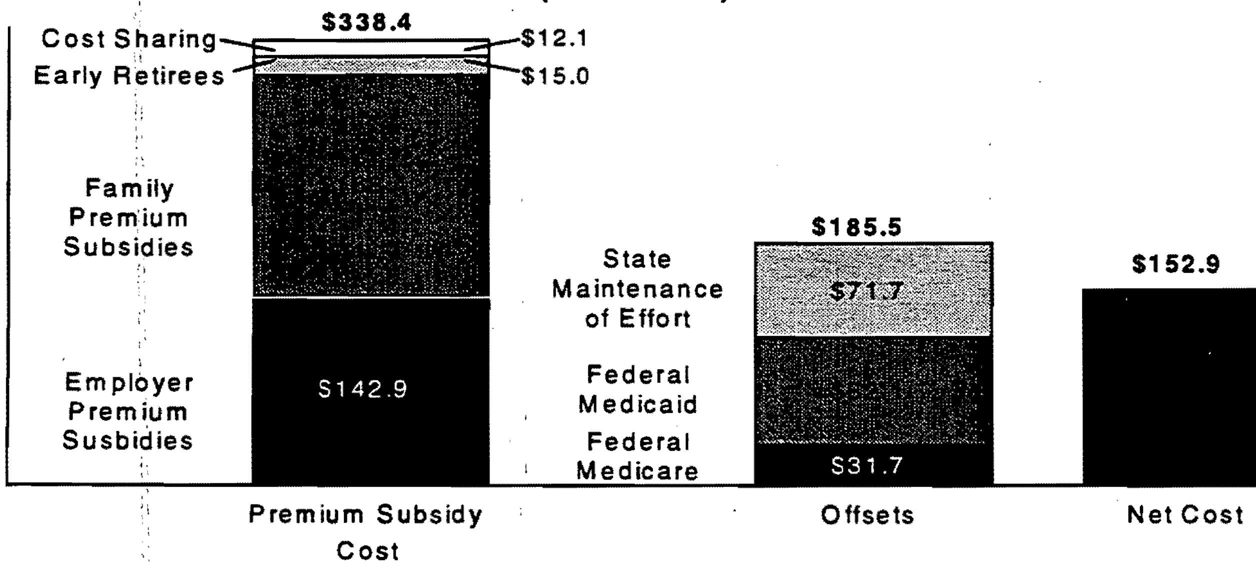
Total funding under the Health Security Act would be $342.1 billion over the 1994 through 2000 period. About two thirds of these funds would be raised through savings in existing programs such as Medicare, Medicaid, FEHBP, Veterans and other programs. These savings reflect the impact of the premium cap, shifts in coverage from public programs to private plans and Medicaid savings resulting from the elimination of Disproportionate Share Payments (DSH) to hospitals. About 36 percent of the program would be financed through new tax revenues of which about half would be attributed to a three fold increase in Federal excise taxes on tobacco products ($65.8 billion). The program would also be financed partly by corporate assessments of $45.1 billion. This includes the one percent payroll tax paid by

© 1993

employers who elect to form a Corporate Alliance and employer savings for early retirees receiving subsidized coverage under the Act.[2]

A major portion of new spending under the Act will be Federal subsidies to businesses and households of $152.9 billion. Total subsidy payments would be $338.4 billion over the 1996 through 2000 period which includes: employer premium subsidy payments of $142.9 billion; premium subsidies to families of $168.4 billion; cost-sharing subsidies of $12.1 billion; and early retiree subsidies of $15.0 billion (Figure ES-3). These costs will be offset by: 1) Medicare savings for working aged persons covered under the Health Alliance ($31.7); 2) the Federal share of savings for the Medicaid non-cash recipients shifted to the Health Alliance ($82.1); and 3) state maintenance of effort payments for the non-cash Medicaid population shifted to the Health Alliance ($71.7 billion).

FIGURE ES-3
SUBSIDY PAYMENTS UNDER THE HEALTH SECURITY ACT: 1996 THROUGH 2000 (IN BILLIONS)



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

D. Employer Health Spending

Private employer health spending (net of subsidies) would increase gradually over the 1996 through 1998 period as states participate in the Health Alliance (Figure ES-4). The net increase in employer spending in the first full-year of implementation would be $28.9 billion.

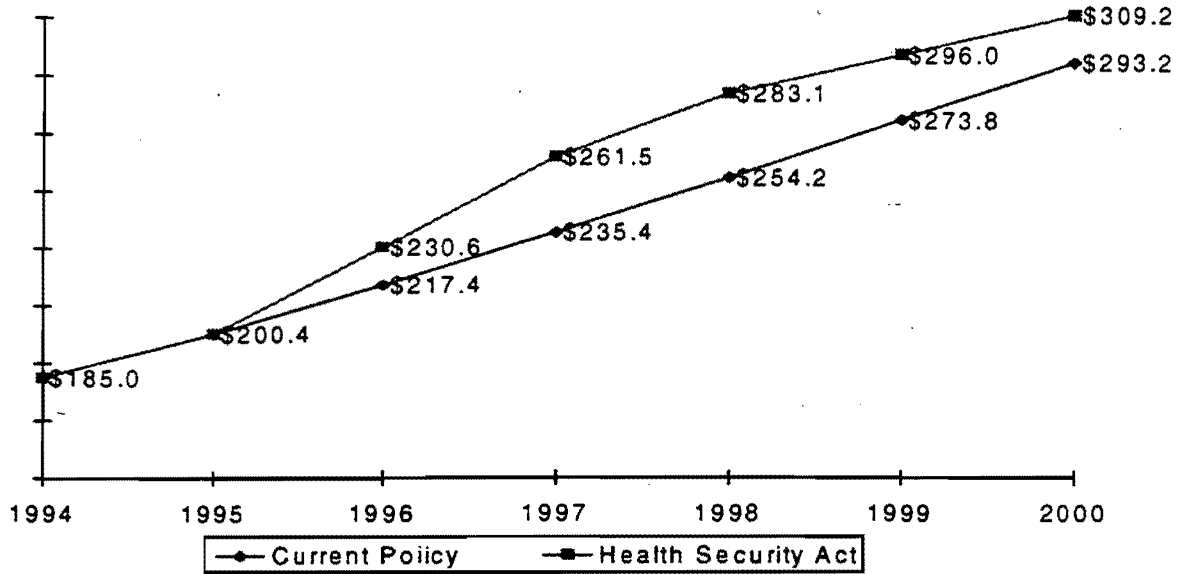
---

[2] Firms with 5,000 or more workers are permitted to form a Corporate Alliance but must pay a one percent payroll tax beginning in 1996. We assume that firms with unionized workplaces will elect this option as will other eligible firms that will find it to their advantage to do so.

Employer health spending would continue to be higher than projected under current law through the end of the century. However, the rate of growth in private employer health spending would be substantially lower than under current projections due to the premium caps.

FIGURE ES-4

PRIVATE EMPLOYER HEALTH SPENDING UNDER CURRENT POLICY AND THE HEALTH SECURITY ACT (IN BILLIONS)[A]



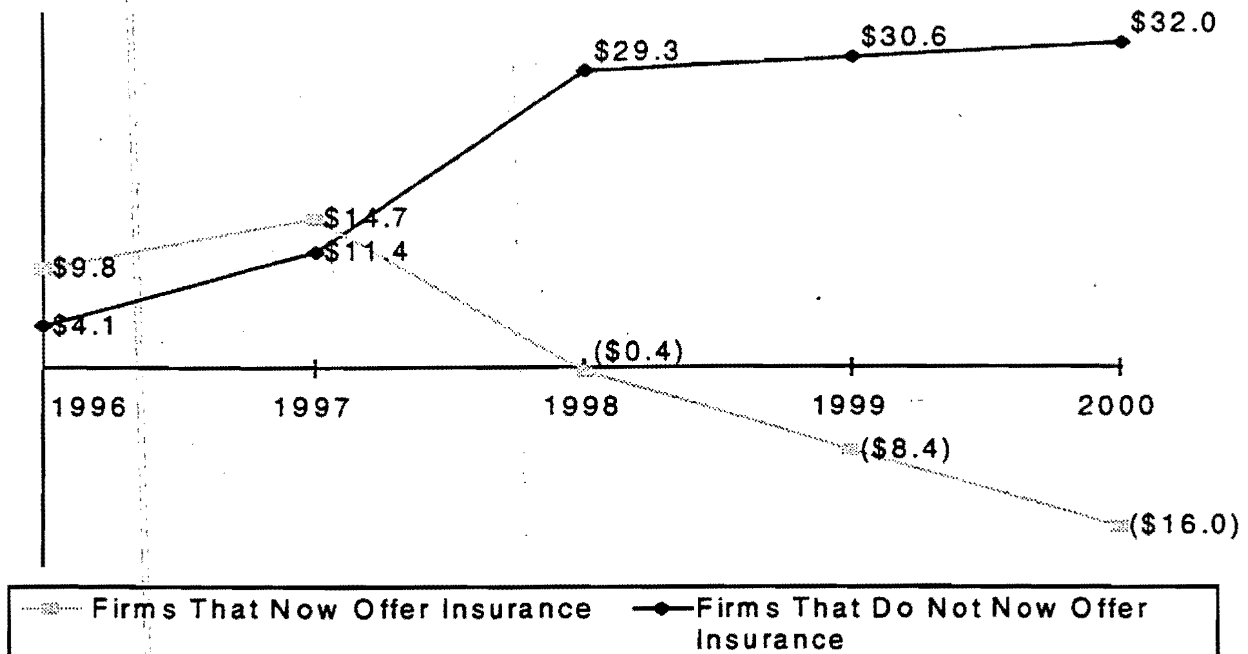
a Includes benefits for workers, dependents, and retirees net of program subsidies.
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The increase in employer spending under the Act reflects the cost of covering workers who currently do not have coverage on their job offset by cost containment savings under the Act. Among employers who now offer insurance, costs would increase initially due to the cost of covering workers now excluded from coverage in these firms, the cost of upgrading coverage to the minimum standard under the Act, and the one percent payroll tax paid by firms that decide to form a Corporate Alliance. Once all states participate under the Act in 1998, spending for these firms would decline below currently projected levels due to: 1) cost controls; 2) Federal coverage of early retirees under the Health Alliance; and 3) the fact that coverage for working dependents in employer plans would in effect be financed by his/her own employer resulting in savings to firms that now provide insurance (Figure ES-5).[3]

[3] The federal government will pay 80 percent of the Alliance premium for early retirees resulting in savings to employers who provide early retiree benefits.

FIGURE ES-5

CHANGE IN EMPLOYER HEALTH SPENDING FOR FIRMS OFFERING AND NOT OFFERING INSURANCE



a Includes benefits for workers, dependents, and retirees net of program subsidies.
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Smaller firms that now offer insurance will tend to see a reduction in health spending due to the higher level of premium subsidies provided to these groups. For example, insuring firms with less than ten workers save an average of about $868 per worker under reform. Among firms that do not now offer insurance, employer spending would increase by about $1,908 per worker. Among firms that now provide insurance, expenditures will decline in industries such as construction, manufacturing, transportation, wholesale trade, and finance.

E. Impact on State and Local Government Health Spending

State and local governments are a major source of financing for many programs that provide care to low-income and medically indigent populations. These programs, especially at the state level, will generally see substantial savings under the Health Security Act as coverage is extended to all Americans. However, the discontinuation of Disproportionate Share Hospital (DSH) payments under Medicaid will have a significant impact on many hospitals that are heavily dependent upon DSH payments. The employer coverage requirement could also result in a significant increase in expenditures for many state and local governments that do not now cover substantial portions of their public employee workforce.

State and local government health spending would be reduced by about $9.0 billion in 1998 under the Health Security Act. State government expenditures would be reduced by about $12.4 billion in 1998 due to savings in Medicaid and other indigent care programs sponsored by state governments. Local government spending would actually increase by about $3.4 billion in 1998 largely due to the loss of DSH payments to public hospitals and the cost of conforming to the employer coverage requirement for government workers under the Act.

F. Impact on Households

The Health Security Act would affect households in four ways. First, the plan generally would result in substantial changes in family premium payments. Second, expanded coverage under the plan would generally reduce family direct payments for care. Third, lower-income households would receive subsidies for patient cost-sharing and household premium payments. Fourth, the Act would result in increased tax payments resulting from the excise tax on tobacco products and the exclusion of health benefits from cafeteria health plans.

In 1998, overall health spending by households would be reduced by about $26.2 billion under the Act (Table ES-2). Family premium payments would be reduced by about $25.9 billion and direct payments for care (copayments, uncovered services) would decrease by about $15.8 billion. These savings would be offset by increased tax payments of about $15.5 billion, about two-thirds of which would be due to an increase in tobacco taxes under the Act.

© 1993

TABLE ES-2
IMPACT OF HEALTH REFORM ON HOUSEHOLDS IN 1998 (IN BILLIONS)

		CHANGE IN SPENDING
PREMIUM PAYMENTS		
Employee Share of Employer Premium		($15.2)
Payments to Alliance a/	$62.9	
Premiums Under Current Plans b/	($74.7)	
Worker Premium Subsidies c/	($4.9)	
Premium for Supplemental Benefits d/	$1.5	
Non-Employment Premiums		($14.9)
Premiums to Alliance e/	$57.5	
Non-Group Premiums Under Current Policy f/	($26.6)	
Premium Subsidies e/	($45.8)	
MEDICARE PREMIUM		
Medicare Part B Premium g/		$3.9
Increased Premium for Higher Income Persons	$1.1	
Part-B Spending Cap	($1.6)	
Prescription Drug Program	$4.4	
DIRECT PAYMENTS FOR CARE		
Direct Payments		($15.8)
Out-of-Pocket Spending for Acute Care h/	($15.9)	
Direct Payments for Long-Term Care i/	($1.6)	
New Copayments Under Medicare j/	$5.0	
Patient Cost Sharing Subsidies k/	($3.3)	
TAX PAYMENTS		
Tax Changes		$15.5
Tobacco Taxes	$10.8	
State and Local HI Tax Payments l/	$0.7	
Cafeteria Plan Restrictions m/	$4.1	
Reduced Medical Expense Deduction n/	$2.3	
Deduction for Self Employed o/	($2.4)	
NET CHANGE IN HOUSEHOLD SPENDING		
Net Change in Spending		($26.5)

a The employer is required to pay an amount equal to at least 80 percent of the average cost plan in the area with the employee paying the remainder.

b Premium payments for existing coverage are eliminated.

c Premium subsidies are provided to workers below 150 percent of poverty.

d Some employers are assumed to continue coverage for services not covered under the minimum benefits package at the current employee premium contribution level for these benefits (e.g., adult dental, eyeglasses).

e Non-workers not otherwise covered under Medicare are required to purchase coverage through the Health Alliance. Subsidies are provided for lower-income families.

f The subsidized non-worker coverage provided under the Health Alliance eliminates the need for other non-group insurance payments for this population.

g Medicare premiums are increased for higher income persons. The premium is increased to cover roughly 25 percent of the cost of the prescription drug benefit. This premium increase will be partly offset by premium reductions due to the budget cap.

h Family out-of-pocket payments for health services will be reduced under the program due to: 1) reduced patient cost-sharing requirements under the plan and 2) expanded coverage for services often excluded under existing plans.

Footnotes continued on next page

i Includes tax incentives for long-term care insurance.
j Includes increased copayments for home health and laboratory services.
k The program reduces patient cost-sharing for persons below 150 percent of poverty.
l All state and local workers will be required to pay the Medicare HI tax (individual share).
m Increased personal incomes taxes due to exclusion of health benefits from cafeteria plans.
n Reductions in direct payments for care will lead to reduced medical expense income tax deductions.
o The insurance deduction for self-employed persons will result in reduced tax payments for some persons.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The greatest decline in health spending would occur among older persons. Health spending for persons age 55 to 64 would decline by about $782 per family, largely due to the retiree coverage provision and prescription drug coverage for the Medicare disabled population. Health spending would decline by $487 among families headed by a person age 65 or older, again largely due to prescription drug coverage. Among persons who would spend $10,000 or more out-of-pocket under current policy, family spending would be reduced by about $6,093 per family

The plan would reduce spending across all family income groups except those with incomes of $100,000 or more. Families with annual incomes below $10,000 would see savings of about $742 per family. Average savings would generally decline as income rises. Health spending would increase by an average of $289 per family for families with incomes of $100,000 or more largely due to the increase in premiums for high income Medicare beneficiaries and the exclusion of health benefits from cafeteria plans.[4]

G. The Importance of Community Rating

Under the Act, all individuals in a given health plan pay the same premium for their type of family (i.e., individual, two-parent family, etc.) regardless of their age or health status. This means that younger healthier populations will cross-subsidize the cost of care for older and sicker groups. In particular, it implies that employers and workers will cross-subsidize non-workers. For example, the average monthly per capita cost of the uniform benefits package would be roughly $160 for workers and dependents while the monthly per-capita for non-workers, would be about $319 (Figure ES-6). The overall community rated per-capita premium would be about $182 per month, which is about 14 percent higher than the actual cost for workers and dependents.

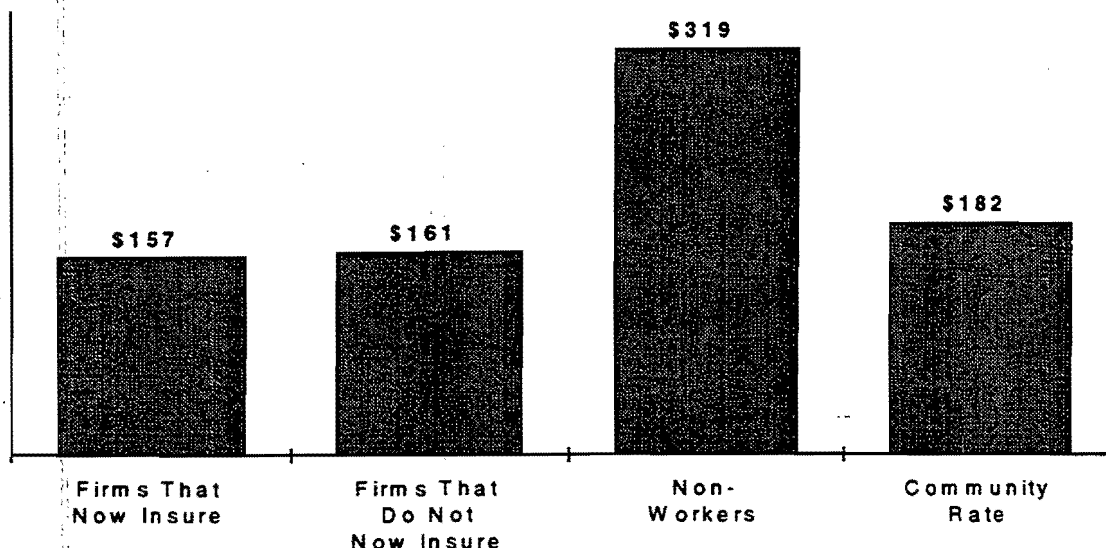
---

[4] The Act prohibits employers from including employee contributions for health insurance and other health expenses in tax exempt cafeteria plans, resulting in an increase in tax revenues (after adjusting for likely shifts in compensation to other non-taxable forms of compensation).

© 1993

FIGURE ES-6

AVERAGE MONTHLY PREMIUM COST PER PERSON UNDER THE REGIONAL ALLIANCE IN 1998



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

This employer cross-subsidy of non-workers reduces substantially the Federal cost of assuring universal coverage. This is because the non-worker population, which includes early retirees and Medicaid non-cash recipients shifted to the Health Alliance, will generally receive premium subsidies under the Act. However, due to this community rating cross-subsidy, the Federal government will subsidize premium purchases for non-workers at $182 per month rather than at their actual cost of $319 per month. Thus, in effect, employers and the Federal government share in the cost of insuring the lower income non-working population. This is one of the primary reasons why the Federal cost of assuring universal coverage under the Act is less than might have been expected. It is also one of the primary reasons why employer health spending would remain well above currently projected levels into the next century despite constraints on the rate of growth in health spending.

H. Distributional Impacts

A comprehensive reform of the U.S. health care system such as the Health Security Act will involve a substantial realignment and standardization of coverage affecting both employers and individuals. This will inevitably result in net changes in health spending for many employers and individuals.

About 52 percent of all households would see a reduction in annual health spending under the Act of $20 or more (Figure ES-7). About 29 percent of families would see an

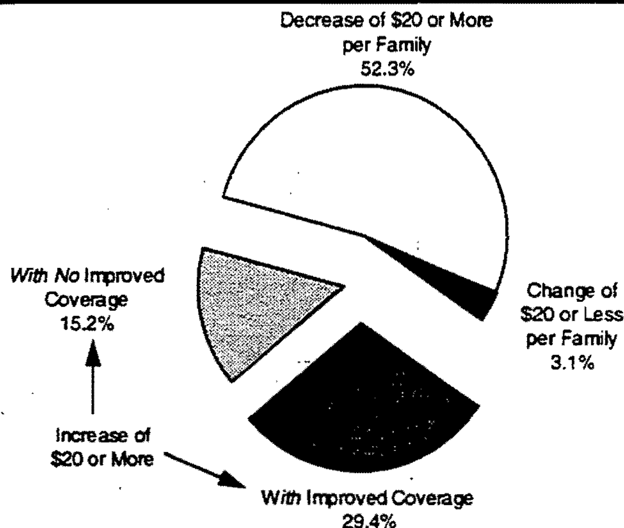
© 1993

FIGURE ES-7
DISTRIBUTIONAL IMPACTS OF HEALTH REFORM ON HOUSEHOLDS AND EMPLOYERS IN 1998

IMPACT ON HOUSEHOLDS

Families Whose Spending Would Decrease By:	All Households	Percent In Group With Improved Coverage
$1,000 or More	23.2%	72.3%
$500 - $1,000	10.4%	62.3%
$250 - $500	7.8%	58.2%
$100 - $250	6.2%	54.0%
$20 - $100	4.7%	45.8%

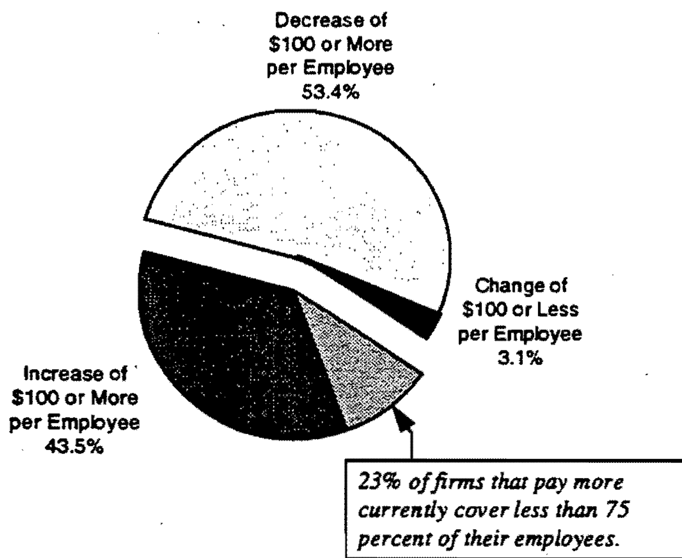
Families Whose Spending Would Increase By:	All Households	Percent In Group With Improved Coverage
$1,000 or More	14.6%	79.7%
$500 - $1,000	11.5%	86.2%
$250 - $500	8.2%	77.1%
$100 - $250	6.5%	63.6%
$20 - $100	3.8%	56.4%



IMPACT ON EMPLOYERS WHO NOW PROVIDE INSURANCE[b]

Businesses That Would Decrease Annual Employee Spending By:	
$2,500 or More	16.3%
$1,000 - $2,500	15.8%
$500 - $1,000	11.8%
$250 - $500	7.5%
$100 - $250	2.0%

Businesses That Would Increase Annual Employee Spending By:	
$2,500 or More	0.5%
$1,000 - $2,500	20.5%
$500 - $1,000	12.5%
$250 - $500	6.4%
$100 - $250	3.6%



a Includes changes in premiums, out-of-pocket expenses, and taxes earmarked to fund health reform. Excludes institutionalized persons.

b Includes the impact of premium subsidies and changes in retiree expenses. Counts based upon number of employers so that each employer holds the same weight in this analysis regardless of the number of employees in each firm.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

increase in spending of $20 or more per year due to the fact that their insurance coverage is improved under the Act; and about 15% would experience spending increases of $20 or more without improved coverage, notably younger persons, high income persons, and users of tobacco products. About 38 percent of families would see a change in spending of $1,000 or more, one way or the other. About 80 percent of those who see an increase in spending of $1,000 or more per family will have improved coverage.

There will be substantial shifts in spending among employers who provide insurance as well. About 53 percent of all employers who now provide insurance will see an annual decrease in spending of $100 or more per worker, while about 43 percent of these employers will see an increase in spending $100 or more per worker. However, about 23 percent of employers who spend more will be firms that currently cover less than 75 percent of their employees. Overall, about 53 percent of employers will see a change in spending -- either an increase or a decrease -- of $1,000 or more per employee.

These wide shifts in household and employer health spending are the inevitable consequence of standardizing coverage and premium contribution requirements. More over, shifts of this type can be expected in any health reform initiative that seeks to redress what are arguably vast inequities in the current health care financing system.

I. Comparison with Administration Estimates

The primary difference between our estimates and those developed by the Administration are the premiums in the Regional Alliance. Our analysis indicates that premiums in the Regional Alliance would be about 17 percent higher than estimated by the Administration. Higher premiums lead to substantially higher levels of employer and household spending than are currently projected by the Administration under the Act. This, in turn, leads to larger premium subsidies. We estimate that net subsidy payments will be $153 billion over the 1996 through 2000 period compared with the Administration estimate of $116 billion (Table ES-3)

© 1993

TABLE ES-3

COMPARISON OF ADMINISTRATION AND LEWIN-CHI ESTIMATES, 1995-2000 (IN BILLIONS)[a]

	Administration	Lewin-VHI	Difference
SOURCE OF FUNDS			
Medicare Savings	$124	$124	$0
Medicaid Savings	$65	$67	$2
Federal Program Savings	$40	$27	($13)
Tobacco Tax Increase	$65	$66	$1
Corporate Assessments (1% Payroll and Retiree)	$35	$45	$10
Tax Effects of Mandate	$23	($18)	($41)
Other Revenue Effects	$37	$31	($6)
TOTAL	**$389**	**$342**	**($47)**
USES OF FUNDS			
Subsidies	$116	$153	$37
Contingency Cushion	$45	$0	($45)
Medicare Drug Benefit	$66	$59	($7)
Long-Term Care	$65	$65	$0
Public Health/Administration	$29	$33	$4
Self-Employed Tax Deduction	$10	$7	($3)
Deficit Reduction	$58	$25	($33)
TOTAL	**$389**	**$342**	**($47)**

Source: Presentation by Alice Rivlin and Lewin-VHI estimates.

In particular, the higher premium in our estimates leads us to different conclusions about the Plan's impact on employers. We show a net increase in employer spending through 2000 while the Administration projects a net reduction in employer health spending by 1999. Moreover, the Administration projects an increase in wages due to reduced employer spending with an associated increase in Federal income and payroll taxes of $23 billion (Table ES-3). By contrast, our projected increase in employer spending under the Act is likely to result in offsetting reductions in wages which would be associated with a $18 billion loss of Federal tax revenues due to the mandate.

For these reasons, we show a substantially smaller net reduction in the deficit under the Health Security Act than does the Administration. The Administration estimates that total deficit reduction over this period would be $103 billion of which about $45 billion is reserved as a cushion against unanticipated increases in spending under the Act. We estimate that this reserve cushion would be exceeded and that the net deficit reduction under the Act would be about $25 billion over this period.

© 1993

J. Caveats

Like most current health reform proposals, the President's health plan would implement a program that has never before been attempted on a broad scale in the United States. Consequently, there is little data on the likely outcome of such a program that can be used to estimate its impacts. Although the estimates in this paper are based upon the best data available at this time, they should be considered illustrative of potential impacts rather than point estimates of actual policy outcomes.

Moreover, this analysis does not consider some potentially important second order effects of the Health Security Act. For example, it does not consider the potential hidden costs associated with slowing the growth in health spending on technological developments and quality of care. The analysis does not take into account the potential impacts of reform on employment, international competitiveness, and general productivity growth. It also does not consider the potential impact that the early retiree provisions under the Act could have on retirement behavior and the economy over time. In particular, the study does not consider some of the potential social and economic benefits of health reform.

Our analysis indicates that the ultimate impact of the plan on the Federal deficit and employer spending is very sensitive to assumptions on the effectiveness of expenditure controls. Moreover, these estimates are very sensitive to employer and consumer behavioral responses under the new incentives created under the Act. Consequently, policy makers should recognize that any major health initiative is likely to require continued refinement in program financing over time.

© 1993

LEWIN-VHI, INC.

a Value Health company

9302 Lee Highway, Suite 500
Fairfax, Virginia 22031
(703) 218-5500
(703) 218-5501 (FAX)

Contact: Janet Ochs Wiener
(301) 652-4389

LEWIN-VHI REPORT FINDS ADMINISTRATION COST ESTIMATES OVERLY OPTIMISTIC BUT STILL REDUCES BUDGET DEFICIT

WASHINGTON, D.C., December 8, 1993 - In the first complete independent analysis of the financing of President Clinton's Health Security Act, Lewin-VHI says the administration's plan to provide universal coverage will cost the country and the business sector more than advertised.

However, according to Lawrence S. Lewin, Chairman and CEO of Lewin-VHI, the internationally recognized health care policy and management consulting firm, the report "shows that the plan's financing structure works: it meets the President's requirement of providing universal coverage, and it does so without relying on an increase in broad-based income taxes.

"We think it is time first to focus on the validity of the assumptions underlying the plan, modify it as necessary, and then get on with the passage and implementation of a Health Care Reform Plan, says Lewin-VHI's President Robert J. Rubin, M.D., former Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services in the early 1980s.

"The broader issue -- finding ways to control costs while expanding access and retaining high quality care -- should not be lost in a contest of predicting winners and losers," Rubin adds, noting that "any restructuring of this magnitude is bound to create gains for some, and losses for others."

This analysis came as a part of a press conference today at which Lewin-VHI announced publication of a detailed 196-page study "The Financial Impact of the Health Security Act" explaining the Plan's complex financing scheme. The report's findings and an analysis of its impact on providers of care, federal and state governments, employers, households, and the pharmaceutical and biotechnology industries will be presented at an all-day public meeting tomorrow, "Health Care Reform by the Numbers" at the Omni Shoreham, in Washington, DC. The purpose of releasing these independent estimates, is "to inject a measure of objectivity into the debate;" according to Lewin.

"These findings come at a time when there is growing skepticism about whether the President's plan could work. "This report", Lewin adds, "validates the logic of the plan's financing; it also clearly reveals how critical the underlying assumptions are". The Lewin-VHI study includes calculations showing the sensitivity of the bottom line to different behavioral assumptions. The "bottom line" here is the impact the plan's financing has on the federal budget deficit.

The calculations in this report rely on Lewin-VHI's Health Benefits Simulation Model (HBSM) the most commonly used model for estimating the impact of health care reform proposals.

The Lewin-VHI analysis also shows that American families as a group are the major beneficiaries under President Clinton's health care reform package, with employers, especially those not now providing insurance, bearing most of the cost of expanded national coverage.

"The 'magic' in the administration's plan, is community rating" says John Sheils, author of the study and an architect of Lewin-VHI's Health Benefits Simulation Model, created ten years ago to estimate the impacts of alternative health reform plans. Community rating is the phenomenon through which the costs of relatively sicker individuals are spread across a larger population. "This is quite simply a return to the way insurance used to work before insurers competed to avoid risk" Sheils said.

(MORE)

Under the Health Security Act, all individuals in a given health plan would pay the same premium for their type of family, regardless of age or health status. By putting individuals with high utilization into the larger community pool, younger, healthier populations and their employers would share in the cost of their care. While community rating spreads these costs among employers and individuals, the federal government contributes subsidies to those employers and families unable to pay.

"Our analysis indicates that premiums in the Regional Alliances would be about 17 percent higher than those estimated by the administration and this influences much of the resulting financing." says Sheils. Lewin-VHI's estimate of higher premiums results in federal subsidies to employers and families of $1[illegible] billion from 1996 through 2000, a figure that is $37 billion higher than the Administration's five-year estimates.

Because of the higher premiums and the expansion of coverage to the 40 million uninsured, private employer health spending (after subsidies). will increase gradually from 1996 through 1998 and will be higher through the end of the century than under current policies. However, the growth rate of private employer spending is expected to decline after 1998.

The Act relies upon price competition among insurers as the primary means of cost containment. As a backstop measure, however, the plan places limits on the rate of growth in premiums to assure that the rate of growth in health spending is constrained.

"There is ample evidence that the kind of managed care the Health Security Act envisions can slow health care spending growth, but whether it will do so on a national scale and to the extent the President's plan requires, remains a bet, not a certainty," says Lewin. "On the other hand, premium caps, while a sure thing on paper, have to be achievable in practice, and will depend on the political will of elected officials and the voting public; so they are not a sure thing either."

The administration estimated a total deficit reduction between 1994 and 2000 of $103.0 billion including $45 billion reserved as a cushion against unanticipated increases in spending. The Lewin-VHI estimates predict that the reserve cushion will be exceeded and that the net deficit reduction will be about $25 billion over the same period.

(MORE)

In addition to detailing the financial effects of the plan, Lewin speakers at the all-day workshop will describe their analyses of the effects on key sectors of the health care economy. Highlights are:

States:

- States will spend less ($12.4 billion in 1998) under HSA but will have the responsibility of supervising the Regional Alliances.
- Strong incentives to begin implementing alliances in 1996 will tax the capacity of most state governments.
- Alliance budgets will exceed the current state budget in a majority of states.

Local Governments

- Local governments will spend $3.4 billion more in 1998 than they would under current policy, primarily due to the loss of DSH and the mandate to cover local workers.
- The HSA, although, addressing many of local governments historic needs, leaves gaps: many mental health and substance abuse services, prisoners and undocumented immigrants.

Providers of Care

- Hospital spending will be $23.8 billion less in 1998, chiefly because of the impact of reduced utilization due to managed care and cuts in Medicare
- Physicians will see $20 billion more in 1998, due to the impact of managed care and providing coverage for those currently uninsured, however, there will be distributive effects among physicians.

(MORE)

- Physicians will face a ban on balance billing and other regulatory restraints if they remain in a fee for service setting.

- HSA will accelerate the current trend of provider integration.

Empl[illegible]ers

- HSA's effect on employers is varied and complex. As a group they will pay more through the year 2000 then under current policy - a finding different than the Administration's.

- In general, firms that now offer insurance will see a reduction in spending while those that do not will see an increase.

- Manufacturing, transportation, communications, and utility companies will see a reduction in costs by 1998 while retail trade and service companies will see increases.

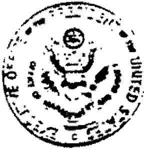
Pharmaceutical Industry

- The HSA expands access to pharmaceuticals and will result in a 6 percent increase in spending by 1998; there will however be an increase in regulation of drug prices especially new products.

Lewin-VHI, a subsidiary of Value health, Inc. is a health care consulting firm providing health policy, research and management consulting services to government agencies, health care providers, health industry suppliers, Insurers and Investors. It has offices in the Washington, D.C. and San Francisco bay areas.

Value Health, Inc. is a leading provider of specialty managed care benefit programs and health care information services.

(MORE)



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

<u>FOR IMMEDIATE RELEASE</u>
December 8, 1993

Contact: Barry Toiv
(202) 395-7254

STATEMENT BY DR. ALICE RIVLIN
DEPUTY DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

The Lewin-VHI study essentially verifies our estimates and the soundness of the financing of our proposal. The study confirms that the Health Security Act is fully financed and that it will reduce the deficit over the period from 1995-2000.

Our initial review of the Lewin-VHI study indicates that it substantially confirms our estimates of the financial impact of the Health Security Act. Because of slightly different assumptions, the study yields slightly different results. Despite these differences, the important point is that Lewin-VHI's estimates of the costs of the Health Security Act are roughly the same as the Administration's estimates; and their estimates of the savings that will be realized from the Health Security Act are roughly the same as the Administration's.

Lewin-VHI's estimates of the cost of the discounts for small, low-wage employers and for low-income workers are slightly lower than our estimates. Therefore, the Lewin-VHI analysis confirms that the entitlement caps we have placed in the Health Security Act are not likely to be exceeded.

We look forward to having an opportunity to review the Lewin-VHI study more thoroughly.

###

Note: The Lewin press release appears to contain an inadvertent factual error. The Lewin estimate of the discounts is $153 billion; the Administration's estimate is $161 billion, which is the amount of funding assumed in the entitlement caps in the Health Security Act. Therefore, contrary to a statement in the Lewin release, the study actually concludes that the cost of the discounts for individuals and businesses will <u>not</u> exceed the entitlement cap in the legislation.

THE WHITE HOUSE
Offic: :f the Press Secretary

For Immediate Release December 9, 1993

PRESS BRIEFING
BY
SECRETARY OF THE TREASURY LLOYD BENTSEN
DIRECTOR OF OMB LEON PANETTA

The Briefing Room

3:12 P.M. EST

SI ETARY BENTSEN: Good afternoon. We've only had a short time to study this ewin report, but I must say it is most encouraging. There were a lot of people that said we couldn't have one of these, that we couldn't have universal coverage. But the Lewin report says we can. It says that we meet the overall ob ives of the administration's plan. And not only that, that we do it withou a broad-based tax and then in turn we make a contribution to the deficit.

I think it's encouraging -- you know, projections on a new program like of this with this scale, it's a challenge. We have plenty of experience in government making estimates of program --. But with this one we're looking at years into the future. So we had a number of agencies in the government work on it -- HCFA, Treasury, we had our estimators, we had our actuaries -- to try to be sure that we were right in this regard. And I think that they were very cautious in doing that. Our economists and our estimators at the Treasury Department looked at this one with a magnifying glass. We've had actuaries and estimators from the five largest accounting firms checking on the methodology -- to be right -- be sure we were right in that regard.

And the conclusions overall buttress each other, reaffirming my confidence in the estimating job that we've job. We're finding we agree on a number of points about the financing of health care reform. We agree that our plan is paid for. And we agree that there will be a deficit reduction. -- we don't come up with the same deficit number, but it's a major contribution on each on them insofar as cutting that deficit.

And I better point out that the estimates in this study of the subsidies that are required under the plan of the government spending, are less than we in the administration had reached, which I think shows how cautious and conservative we were in coming up with those numbers.

Americans deserve a comprehensive health care reform that covers everyone. And they expect the truth about what it will cost. And, once again, those estimates are buttressed by the Lewin Report.

DIRECTOR PANETTA: From the beginning of process of developing comprehensive health care plan, it's been our intent to produce a plan that was fully paid for and that had the most accurate estimates of costs available so that the American people could be confident that they could get universal coverage, and that they would get a plan that is fully paid for.

That has not been an easy process. As I indicated before, we began this year developing models that did not exist before in terms of determining a lot of the estimates with regards to cost. We believe we have the most accurate estimates, and we think that the Lewin Report in effect confirms that. We now have, I think, as a result of the Lewin Report -- and the people that are associated with that review and that analysis -- the same judgment that this plan is financially sound. As the Secretary has pointed out, I think, if there's anything that the American people were asking themselves when the President kept saying, "We can have comprehensive coverage of health care. We can have cost controls. We can reduce the deficit, and it doesn't demand a broad-based tax," we now have confirmation that, in effect, this can be accomplished. And I just would read for you a quote from the Lewin Report: This report shows, and I quote, "shows that the plan's financing structure works, it meets the President's requirement of providing universal coverage, and it does so without relying on an increase in broad-based income taxes."

Now, if I can, I would like to kind of point to where the areas of difference are, and generally how they arrive at their conclusions. This is about a 200-page report with about 80 pages of indexes, and we are still in the process of reviewing it. But to the best of our ability, these appear to be the principal differences with regards to the chart on my left that basically establishes what's in the President's plan in terms of cost, and the revenues that we will raise in order to cover those costs, and obviously the deficit reduction that would then result.

If I can draw your attention to the right side of the chart. On that chart there is a difference here with regards to the proposed premium -- they believe that the premium will be about 12 percent higher -- I think they say 17 -- but we estimate that using the right mathematics here it would be about a 12 percent increase in the premium. If you combine the $117 billion and the $44 billion, which is what we project on the premium cost plus the cushion, that number would be $161 billion. The number that the Lewin report came out with is $153 billion, so that even with the increase that they project in the premium -- we don't agree with that -- that it would involve that higher premium; we nevertheless are below the caps that we established with regards to the premium side.

On the Medicare drug benefit, we estimate the cost of that at about $66 billion. They estimate the cost at less -- $59 billion, which shows again that we tried to accept the most conservative judgments of the costs in these areas.

On long-term care they estimated the cost at $62 billion -- we estimated the cost $62 billion; their estimate is about $65 billion -- but I have to tell you that they were working off a version that we provided earlier that involves a $65 billion number. So, we think we're very close on the cost estimates with regards to long-term care.

The one area that we are not sure of what their estimates are, at least in a preliminary analysis, is on the public health part of this where we have public health and administration costs. We have estimated that at $[illegible]3 billion; and this is the one are we're not sure how they come to their costs estimates and that's something we've got to continue to review.

On the revenue side, the Medicare savings are exactly alike. We have said $124 billion on Medicare savings; their judgment is that we're right on the button with regards to our Medicare savings of $124 billion. On Medicaid savings, we projected $65 billion; their estimate is $67 billion. So, they assume that we will achieve some additional savings, not much, but in these numbers, but nevertheless, they show that we will get about $2 billion more in savings from Medicaid.

On the tobacco tax, our estimate on the tobacco tax is $65 billion; theirs is $66 billion. So, they're estimating, again, we're all in the right ballpark here -- about $1 billion more on the tobacco tax.

On the corporate assessment which is part of this we really have not been able to determine what they estimate specifically with regards to revenues from the corporate assessment. On the federal savings, this is an area of difference -- we're assuming about $40 billion in savings from various federal programs as a result of implementing this plan; they estimate $27 billion. But I have to tell you that at least our sense of this is that the reason you're having less savings here is because of their higher premium estimate and what that then does with regards to savings, particularly with regards to federal employees.

Lastly, on other revenue effects on the $86 billion that we estimate, we think there are differences here as well; and we are still in the process of trying to analyze specifically what those differences are. But when you add up where they're at in terms of revenues versus the cost, they arrive at a deficit number of $25 billion as compared to our $58 billion. Again, I think the point is this -- that they have essentially confirmed that we are well within the ballpark that we are working with here in terms of the estimates for this plan; and that the plan we have presented is indeed financially sound as we presented it.

What I hope we will do is be able as a result of this -- and I hope there will be continuing analyses that are done of these numbers. We have always said that these are out best estimates, and we hope that there are additional people who will look and analyze the numbers that we presented.

But we hope that in this process that the American people will derive as we have a degree of comfort here that we are in fact working with the right numbers in terms of the estimates and the costs; and that we can shift the debate here in the health care area to what exactly should be in the plan. I've often mentioned in the budget battle the credibility of our numbers was not questioned. It was a question of what should or should not be in the plan -- should there be additional revenue, should there be additional cuts. That's a fair debate. But we were right in terms of the numbers. And that's essentially the kind of debate we'd like to have on the health care plan. And we also hope that other plans will be subject to the same kind of review -- that Lewin will look at the other plans that are on Capitol Hill and make the same kind of analyses that he did with the President's plan.

I think the bottom line is that we derive a great deal of comfort as a result of this first analysis that we're on the right track when it comes to health care reform for this country.

Q How sensitive are these figures to the current interest rate environment -- I mean, you know, if the Fed ends up having to be on a tightening path as the economy picks up steam, how sensitive is this analysis to interest rates staying where they are now?

SECRETARY BENTSEN: First, let me say that I think you're going to see certainly long-term interest rates stay at the same relative level that they are now, because what we are seeing in the way of excess capacity and excess labor gives us some cushion in that regard. So I'm optimistic on it. Insofar as short-term rates, over a period of time, obviously they're going to raise some --they're going to rise some. But I would not estimate that that would be anything major.

DIRECTOR PANETTA: Let me just -- there really is not that much that's included here that is interest rate-related in the sense of cost estimates with regards to either the drug benefits and others. I mean, obviously there would be some impact, particularly, I think, on the revenue that might flow in depending on obviously incomes and earnings and what have you. But other than that, I think that certainly in this interest rate climate, these numbers are right on track.

Q Can you tell us what the mechanism for the cushion is? How is that to be appropriated by Congress? And second, can you tell us how many businesses with how many employees do you expect --be paying the corporate assessment?

DIRECTOR PANETTA: Do you have the number on the amount of businesses that would be paying the corporate assessment?

MR. THORPE: We don't have it with us. Again, the cushion in the --

DIRECTOR PANETTA: You want to come up here.

MR. THORPE: The cushion as we've shown it up here, as you'll know, in the capped entitlements that we have in the legislation that what we have under the premium discounts and the cushion is indistinguishable. So built into the capped entitlements are the $161 billion in discounts. So they're really indistinguishable in terms of the legislation.

Q So would Congress appropriate $44 billion or not?

MR. THORPE: (Ken Thorpe, Assistant Secretary, HHS) No -- yes, it is included -- absolutely -- is included within the yearly capped entitlements.

DIRECTOR PANETTA: You need to have the cushion appropriated so that we're protected with regard to the cap that's established in this program.

Q Lewin's numbers and yours assume you're going to bring health costs under control in par with your premium caps, Lewin predicts you'll get $57 billion in reduced health spending by virtue of those caps in '98 alone. But there's a lot of doubt about whether you'll get those caps through Congress. How much confidence can people have that your numbers actually will hold up to the political realities facing you?

DIRECTOR PANETTA: Well, you know, as always. we present this plan as a comprehensive plan. And the cap is a part of that plan. And so we intend to go to the Congress and fight for that provision because we think it's very important to our ability to say to the American people that we're going to control costs. Now, obviously the debate in the Congress is going to take place and we're going to fight our way through the committees and on the floor. But the position of the administration is to fight to protect that because we think it's an important discipline when it comes to holding down costs.

Let me tell you something from just the budget perspective. And I'm right in the middle of working on the budgets right now. We are very much on track with regards to where the deficit is headed. We are now in a situation, having passed the budget plan, that we expect that we are going to not only meet but perhaps even exceed the deficit targets we're looking at. But it is absolutely essential if we're going to stay on track to pass health care reform. The only way you can keep us on track on the deficit so that we can bring that deficit hopefully below $100 billion and eventually to balance is to pass cost controls on health care. And frankly the cap is a part of that process.

Q Director Panetta, on the deficit issue, the mayors were here this morning, they told us that the President told them that crime is now the number one domestic agenda issue. They have asked for huge increases in crime spending. Are you going to be able to do that and still meet your deficit targets?

DIRECTOR PANETTA: We are operating under a hard freeze cap. That basically means that what we spent in '93 is what we're going to spend for the next five years in the federal government. That means that if there are areas in which we are going to increase spending, we're going to have to find savings elsewhere. And that's the process we're going through. On crime, essentially what the Congress is doing and I think what the President envisions is that whatever we commit to pay for the war against crime in this country is going to come within the caps established by the Congress. And we will have to find savings elsewhere in order to pay for that priority.

Q -- said a few minutes ago that you're on track in terms of the deficit and you may even exceed your target. Now, as I remember for '94 your deficit number in your last forecast was like 260, and the '93 figure came in much lower than you had thought. Can you give us -- I realize you can't give us an exact number -- can you give us some idea of what the '94 deficit -- what your general ballpark estimate is now for the '94 deficit?

DIRECTOR PANETTA: Right now, we think we'll be below the mid-session projection on the deficit. I can't tell you how much. We're still getting the projections coming in. But by '98 we think that frankly instead of looking at $180 billion deficit, it'll be more like $150 billion.

Q The President talks a lot about personal responsibility in terms of welfare reform. There's a lot of talk on the Hill about personal responsibilities when it comes to health care reform and placing that requirement or the obligation up to the individual to obtain the health insurance. Would the President accept a plan if it had universal coverage and comprehensive package of benefits if the mandate is up to the individual rather than the employer to obtain other --

SECRETARY BENTSEN: I don't believe under those conditions you'd get universal coverage. So we look at the practicality of the application -- what would be forthcoming. And I think the employer mandate is a prerequisite.

Q So you think the Chafee approach would be unacceptable to you?

SECRETARY BENTSEN: I beg your pardon?

Q Does that mean then the Chafee approach would be unacceptable to you because it leaves it up to the individual --

SECRETARY BENTSEN: Well, I've already told you what I thought the administration's point of view is, and we feel that quite strongly, that we think it has to be an employer mandate to be able to bring about universal coverage. And I think these things that we've seen in the way of estimates are fortifying our position as to be able to accomplish it without any broad-based tax and end up paying for it in full with some leftover to curtail the deficit.

Q Do you think you are losing a lot of ground lately that there's has been sort of a backsliding in support for the plan in terms of the AMA and the public at large?

SECRETARY BENTSEN: I heard that same talk on the budget and on NAFTA. No, I think we're going to put together one where we accomplish it next year, and we'll get a package through that is satisfactory to the administration.

MS. MYERS: Thank you.

END 3:30 P.M. EST

Health Plan Funding Passes Muster

Independent Group Says Clinton Proposal Is Financially Sound

By Spencer Rich
Washington Post Staff Writer

An independent research group that included officials of the Reagan administration has concluded that the proposed funding system for President Clinton's national health plan is basically sound.

"If the question is whether they can finance this program with the revenues they will get under their plan, the answer is yes, and they will still end up with $25 billion for budgetary deficit reduction," said Lawrence S. Lewin, chairman of Lewin-VHI, which conducted the study released yesterday. "It meets the president's requirement of providing universal coverage, and it does so without relying on an increase in broad-based income taxes."

"Our funding estimates are in the same ballpark as theirs," said Robert J. Rubin, assistant secretary of health and human services in the Reagan administration and now president of Lewin-VHI, which conducts studies to determine the costs of various health programs. Don Moran, former top aide to Reagan-era Office of Management and Budget Director David A. Stockman, also worked on the report.

The Clinton administration greeted the study with delight. For months it has been battered by assertions from congressional Republicans, such as Rep. Thomas J. Bliley Jr. (Va.), and from numerous groups representing businesses and providers of medical services that the financing mechanisms for the president's health plan could result in massive underfunding and perhaps a need for new taxes and premiums far beyond what the White House has estimated.

Even some Democrats who favor the plan, including Rep. Henry A. Waxman (Calif.), have questioned some of the numbers.

Alice M. Rivlin, deputy director of the Office of Management and Budget, said, "The Lewin-VHI study essentially verifies our estimates and the soundness of the financing for our proposal," confirming that the plan "will reduce the deficit over the period from 1995 to 2000."

In addition to its broad finding that the "financing structure works," the study also found that:

- Health insurance premiums under the president's plan in 1998, used as an example year, would be about 17 percent higher than the administration estimated, requiring more federal premium subsidies for businesses and poor individuals.
- In 1998, employers (primarily small firms that do not now insure their workers) would pay a net of $28.9 billion more for health care than under current law because of the requirement that they provide insurance to their workers, but households would pay a net of $26.5 billion less because the government and employers would be picking up much more of their costs. The extra payments by employers would gradually drop as cost controls took effect.
- The plan's cost controls eventually would slow the growth of health spending. By 2000, it would account for 18 percent of gross domestic product instead of the 18.7 percent figure expected under current conditions, a saving of $57 billion.

The study, conducted primarily by Lewin-VHI vice president John Sheils, was financed by the firm itself, Lewin said.

Lewin, Rubin and Sheils all emphasized strongly that no study of an untested new system can be taken as an absolute prediction or guarantee that the plan will work as envisioned. Lewin said the findings are based on their best estimates and predicated on the assumption, which could be optimistic, that the states, Congress, the proposed national health board and all others will have "the political will" to adopt and enforce difficult aspects of the president's plan. That would include requiring all employers to insure their workers and limiting insurance premium increases.

Looking at the federal portion of the funding for the plan, the study said the White House had claimed that it would raise $389 billion in federal funds from 1995 to 2000 to cover $286 billion in federal costs for the basic plan plus $103 billion for contingencies and deficit reduction. Sheils said the basic plan would actually cost the federal government $317 billion, not $286 billion, and the proposed funding would raise $342 billion. That would be enough to cover the $317 billion cost with $25 billion left over for deficit reduction—but nothing for contingencies, the study said.

Sheils concluded that in 1998 the average annual premium for an individual would be $2,732; for a couple, $5,464; and for a two-parent family, $5,975.

In a separate development yesterday, presidential pollster Stan Greenberg, appearing on an American Enterprise Institute panel, said the administration had considered proposing a value added tax (VAT) to pay for the health care reform program but found virtually no public support for it in polls conducted on the issue.

Greenberg said the administration looked at the VAT as an alternative to mandating employers to pay 80 percent of their employees' health insurance costs. He said it was one of at least two instances where polling had been used to determine public attitudes toward particular tax policies.

Staff writer Dan Balz contributed to this report.

THE WASHINGTON POST

THURSDAY, DECEMBER 9, 1993

THE WALL STREET JOURNAL THURSDAY, DECEMBER 9, 1993

Health-Plan Cost Outlook Is Too Rosy, But Basic Financing Works, Firm Says

By HILARY STOUT
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON—A respected health-research firm said the Clinton health-care plan will cost employers and individuals more than the White House projects, but it said the administration's overall financing proposals are sound.

The company, Lewin-VHI, a unit of Value Health Inc., released a 186-page analysis of President Clinton's proposal to guarantee health coverage to all Americans. It concluded that the White House can successfully pay for its plan through its strategy of wringing savings from current public health programs, raising the excise tax on cigarettes and other tobacco products and holding down medical costs through competition and controls on health insurance premiums.

"The plan's financing structure works," said Lawrence Lewin, chairman and chief executive of Lewin-VHI. "It meets the president's requirement of providing universal coverage, and it does so without relying on an increase in broad-based income taxes."

But Lewin-VHI disagreed with the White House on what premiums would be required to pay for the health benefits it proposes. The administration projects that the average premium once the system is fully phased in would be $2,386 for an individual; the company's estimate is $2,732. The White House projects the premium for a two-parent family with children would be $5,388; Lewin-VHI puts it at $5,975.

As a result of the higher premium projections, Lewin-VHI estimates that the subsidies proposed for businesses and low-income individuals would cost $37 billion more during the first five years of the plan than the administration says – $153 billion instead of the White House estimate of $116 billion.

However, the legislation that the president submitted to Congress adds a $45 billion cushion to the overall subsidy figure. Counting that, the Lewin-VHI subsidy estimates come in $8 billion lower than the White House projections.

Lewin-VHI, based in Fairfax, Va., is one of the few organizations outside the government with the computer models needed to analyze complex health-care legislation. Administration officials, members of Congress, and numerous public interest groups respect the firm, and believe its evaluations to be credible.

White House officials, who had been nervous about the Lewin-VHI review, said they were pleased by the conclusions. "To have someone come out and confirm the fact that our estimate of the [subsidies] are conservative and that we get substantial deficit reduction is, I think, really a critical finding," said Kenneth Thorpe, the Department of Health and Human Services economist who oversaw the administration's number-crunching operation.

The White House predicts the savings in public health spending through the year 2000 will result in a $58 billion reduction in the federal budget deficit. Lewin-VHI says the shrinkage will be $25 billion.

The administration's financing estimates have been criticized by lawmakers in both parties. And despite the report's conclusions, Lewin-VHI officials expressed some doubt at a news conference about the feasibility of some of the administration's savings projections. "There is a lot of potential fat in the system. Whether you can get it out this way, no one knows," said Robert Rubin, Lewin-VHI's president. "I've been on record saying that I think it will be difficult, but not necessarily undoable."

The report contains a number of other estimates that could cause political difficulties for the White House. For example, the administration has been saying that overall employer spending on health won't rise under the Clinton plan, even though the White House is proposing to require all firms to contribute to paying their workers' health premiums. Lewin-VHI estimates that the total cost to employers in 1998, the first year the Clinton plan would be fully phased in, would be $29.3 billion higher than under the current system. Almost all of the increase, however, would come from firms that currently don't insure their workers.

Lewin-VHI officials said the company analyzed the Clinton plan on its own initiative, and paid for the project itself. The undertaking wasn't sponsored by "any government agency or private group," Mr. Lewin said.

Encouraging checkup for Clinton health plan

But study also disputes some administration figures

By Judi Hasson
USA TODAY

The White House, which has been criticized for its health-reform arithmetic, was relieved Wednesday to get a stamp of approval from an independent consulting firm.

Skeptics, many of whom support competing health bills in Congress, have charged that the administration's revenue and cost projections don't add up. They also argue that the White House expects unrealistic savings in the Medicare and Medicaid programs and underestimates the cost of providing benefits to every American.

But a study by Lewin-VHI, a health policy research firm, says some administration calculations are on target.

"There's a lot of potential fat in the system which you can get out," said Lawrence Lewin, the firm's chairman.

But the study — the first comprehensive outside analysis of the Clinton plan — also disagrees with some White House figures.

The study found that:

▶ The average cost of premiums would be 17% higher than the White House is projecting. Administration officials dispute that conclusion.

▶ There would be a deficit reduction of $28 billion, about half the administration's $58 billion projection.

▶ It would take until 2002 before employers save money. The administration says employers' health insurance costs would decline before 2000.

▶ It would cost about $153 billion in subsidies between 1996 and 2000 to help small businesses insure low-wage workers. The administration estimates spending $116 billion in subsidies.

Even so, the White House was pleased.

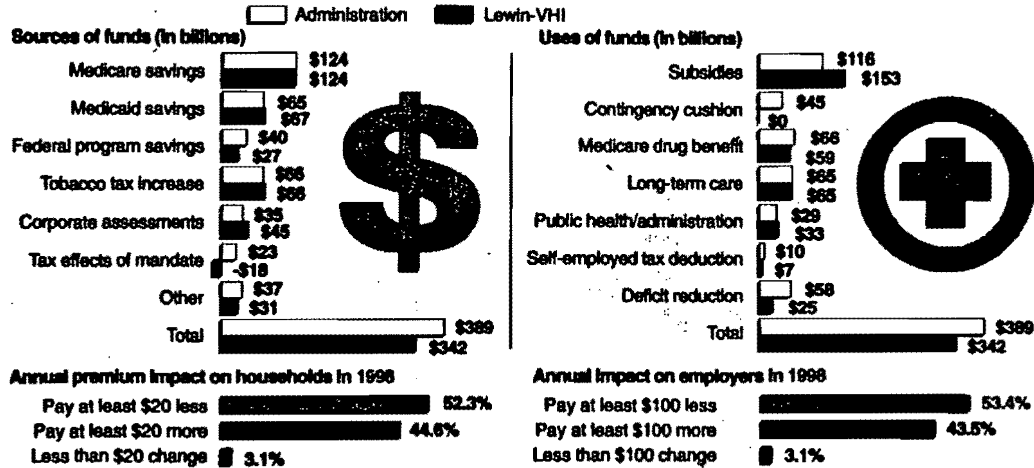
"Because of slightly different assumptions, the study yields slightly different results," said deputy budget director Alice Rivlin.

"The important point is that Lewin-VHI's estimates of the costs ... are roughly the same as the administration's estimates," she said.

White House health adviser Kenneth Thorpe said the administration would release its own financial analysis of the plan today or Friday.

A comparison of health-care costs under the Clinton plan

The Clinton health-care reform plan needs insurance premiums 17% higher than the White House has estimated to pay for the plan through the year 2000, an independent health research firm says. Where Lewin-VHI differs with the administration:



Source: Lewin-VHI, Inc.

By Nick Galifianakis, USA TODAY

The Lewin study concluded that most families would pay less for medical care — including insurance premiums plus all out-of-pocket expenses — under Clinton's plan.

Only 7.1% — those with household incomes of more than $100,000 — would pay more, $281 a year. However, other consumers could pay more if they chose optional higher-cost health plans.

Families with annual incomes below $10,000 would save an average $742 a year, the report said.

Others whose total health spending would go down, according to the report: those age 55 to 64, who would save $782 per family, largely because the federal government would pick up 80% of premium costs for early retirees.

The report found $20 billion more would be spent in 1998 on visits to doctors' offices, because with insurance, more people would go to doctors, including poor people who now rely on emergency room care.

Other findings:

▶ Employers that currently do not insure workers would pay $161 a month per worker in 1998 to provide insurance.

▶ The plan would save $15 billion by encouraging more people to join health maintenance organizations and other forms of managed care.

Health plan passes reality check

Cost estimates are off, but workable

BY R.A. ZALDIVAR
Free Press Washington Staff

WASHINGTON — President Bill Clinton's health care plan would cost billions more than the administration projects but still could provide health insurance for all without broad new taxes, according to a major study released Wednesday by independent analysts.

In what amounts to a reality check of the White House plan, the health care research and consulting firm of Lewin-VHI found that the administration underestimated the cost of its benefits package.

About 45 percent of households would pay more for health care under Clinton's plan than they would otherwise, while the remainder would pay less or about the same.

The report found that older Americans would save the most from the Clinton plan, while costs for some young adults would go up.

But, to the relief of administration officials, the Lewin report concluded that the bill would accomplish Clinton's central goal: universal coverage without stiff new taxes. That's because Clinton's planners had allowed for a $45-billion cushion in case their cost estimates were off.

"The plan's financing structure works," said Lawrence Lewin, chairman of the Washington, D.C.-area company, whose expertise in health care economics has been widely used by all sides in the reform debate.

"We're really happy with this," said White House spokesman Bob Boorstin. "Above all, it confirms that the act is fully financed, that the numbers are real, and that it will reduce the deficit."

See HEALTH CARE, Page 9A

*DETROIT FREE PRESS
12/9/93

Health plan passes independent review

Costs are off, but goal reachable, says firm

HEALTH CARE, from Page 1A

Nonetheless, the report is likely to provide fodder for both sides in the debate. Among its main conclusions:

■ The White House significantly lowballed the cost of Clinton's comprehensive benefits package. Lewin estimates the package will cost $2,732 for individuals and $5,975 for a two-parent family in 1998 — the first year during which all Americans would be covered. The administration has estimated the benefits will cost $2,388 for an individual and $5,388 for a two-parent family.

■ About 26 percent of American households would pay at least $500 more for health care in 1998 under the Clinton plan than they would otherwise. Another 15 percent would pay at least $100 more. But 34 percent of households would save at least $500, while 14 percent would save at least $100. Most of those paying more would be getting better benefits than they now have.

The White House says less than 40 percent of insured individuals would pay higher premiums, but has offered no figure comparable to Lewin's for how the plan would affect households.

■ Employers would not start saving money on health care costs until 2002, versus 1998 in administration projections. About 44 percent of companies that now provide coverage would pay at least $100 more per employee in 1998; 53 percent would pay at least $100 less, and 3 percent would see virtually no change. Clinton's plan requires all employers to provide coverage.

■ White House projections that Clinton's bill cuts the deficit by $58 billion between 1995 and 2000 are too optimistic. The Lewin report estimated the bill would reduce the deficit by $25 billion, but warned that even slight changes in the rate of increase of health costs could wipe out any gains and result in more red ink for the government.

Lewin-VHI prepared the report independently, not for a particular client.

Marilyn Moon, a health policy specialist with the nonpartisan Urban Institute in Washington, said Lewin is one of the few research organizations with the capacity to estimate health care costs for society as a whole.

"I don't view them as trying to stack the deck — they have good credibility out there," said Moon. "They seem pretty consistent with the administration, but more pessimistic."

As far as impact on individuals, the Lewin report concluded that older people stand to gain the most from the Clinton plan, particularly the 55-64 age group. Clinton's proposal to pay 80 percent of the health insurance costs of early retirees would save the average household headed by a person in that age group $781 in 1998.

The average household headed by a person over 65 years old would save $488, largely due to new Medicare coverage of outpatient prescriptions.

Younger people would save much less, and many would pay more. Premiums for younger, healthier people who now get discounts would increase as the nation shifts to a system of "community rating," where everybody in a given area pays the same for health coverage. The average household headed by a person between 25 and 34 would save only $199.

Among households, the biggest losers would be those with incomes of more than $100,000. On average, they would pay $281 more a year. This is due to the repeal of a health care tax break for working-age people and higher premiums for well-to-do Medicare beneficiaries.

As for businesses, the Lewin report concluded that the brunt of Clinton's requirement that all employers provide coverage would fall on retail, service and construction industries.

State governments would spend less because of changes in the Medicaid program for the poor, but city governments would face higher costs because Clinton's plan would eliminate some federal payments to hospitals.

2/2

Outside Analysts: Clinton Health Plan Can Avoid Broad Tax Hike
Eds: This also moved on general news wires.
By CHRISTOPHER CONNELL= Associated Press Writer=

WASHINGTON (AP) An independent analysis of the Clinton health plan concludes that it can cover everybody without a broad-based tax increase and still reduce the federal deficit.

But the deficit reduction would be much less than the White House forecast and the insurance premiums Americans pay would have to be higher, according to the 196-page study issued Wednesday by the health consulting firm of Lewin-VHI.

The White House was pleased, even though the study disputed some administration calculations.

It ``essentially verifies our estimates and the soundness of the financing of our proposal,'' said deputy budget director Alice Rivlin. It ``confirms that the Health Security Act is fully financed and ... will reduce the deficit.''

The report by the respected Fairfax, Va., firm estimated that Clinton's health reforms could cut families' medical bills including premiums and out-of-pocket costs by $26 billion in 1998.

At the same time, businesses would have to spend $29 billion more for health care, with virtually all of the extra money coming from companies that now fail to insure their workers.

Lawrence S. Lewin, chairman of the Fairfax, Va., firm said, ``The bad news is that there isn't nearly as much cushion as they said there would be. The good news is that they still haven't crossed the line into requiring new taxes.''

The study estimated that premiums in 1998 would have to be:

$2,732 for individuals.

$5,464 for couples.

$5,172 for one-parent families.

$5,975 for two-parent families.

Lewin said that is 17 percent higher than the administration is projecting.

Kenneth Thorpe, a deputy assistant secretary of health, disputed that and said the gap was only 12 percent.

The Lewin study estimated Clinton's proposal would reduce the deficit between now and the year 2000 by $25 billion, not the $58 billion the White House estimated.

But assuming that Clinton's proposed caps on health insurance premiums work, ``then the rest of it plays out,'' said Lewin. ``There is no smoke and mirrors here.'

``We think their estimates have been overly optimistic, but they still achieve deficit reduction,'' he added.

Clinton would require all employers to help pay for health insurance, and levy a 1 percent tax on big corporations that self-insure their workers. Everyone else would get their coverage through giant new insurance-purchasing pools.

The White House is counting on big savings in Medicare and other health spending. Its only major tax hike would be on tobacco.

``It confirms what we've said all along: Our numbers are on the conservative side,'' said Thorpe.

He noted that the Lewin team figured premium subsidies for small businesses would cost $153 billion over six years, or $8 billion less than the White House estimated.

The study, ``The Financial Impact of the Health Security Act,'' also concluded:

Employers will spend more on health care through 2000, but their costs will climb at a slower rate.

The changes will trigger an $18 billion loss in income and payroll taxes, not the $23 billion increase the White House predicted.

Total health spending would grow from $912 billion in 1993 to just under $1.4 trillion in 1998. Without reform, the health bill would be $600 million higher in 1998.

The plan would save $15 billion by encouraging more people to join health maintenance organizations and other forms of managed care.

It said that in 1998 alone:

The premium cap would save almost $57 billion.

Families would pay $26.5 billion less.

Businesses would pay $29 billion more.

Federal health spending would climb by $6 billion.

State governments would pay $12.4 billion less in health costs.

Local governments would pay $3.4 billion more.

Hospital spending would be almost $24 billion less.

Physicians would get $20 billion more in revenues.