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Senior staff member for Public Policy Education

HENRY AARON

Aaron is the Director of Economic Studies at the Brookings Institution. He is heavily published on the issue of health care reform, and he is known for his independent views. He is a Democrat who is slightly more liberal than Bosworth. Aaron is thoughtful and well informed.

While he has been helpful to the Administration responding to the economist letter on price controls, he has maintained a constructively critical distance from the Administration's plan. However, Aaron has also strongly criticized the alternative health care proposals being considered by Congress. Many could have seen Aaron as the Chairman of the Council of Economic Advisers under a Democratic Administration.

Health Care Related Activities:

- In a February 13, 1994 op-ed in the *Washington Post*, Aaron blasts the Cooper plan for its lack of a commitment to universal coverage, unspecified benefits package, and impractical subsidy structure which would serve as a disincentive to work for those with limited incomes. Aaron concludes the Cooper plan "will not bear serious scrutiny."
- On January 12, 1994, Aaron and Barry Bosworth testified before the Senate Finance Subcommittee on health reform and the competitiveness of U.S. companies. They concluded that health reform is not likely to have a large long-term impact on U.S. competitiveness, although the impact will be more pronounced in the short term and will vary by company.
- In his paper delivered to the American Economic Association, "Issues Every Plan to Reform Health Care Financing Must Confront," Aaron supports the goals of universal coverage and cost containment. He argues for the community rating of insurance premiums, and, while fearful of the complexity of any mandate, supports an employer mandate over an individual mandate.
- In "Economic Issues in Reform of Health Care Financing," co-authored with Barry Bosworth, Aaron discusses the economic implications of expanding access to health care, slowing the rate of cost increase, and implementing the community rating of insurance premiums. The authors note the difficulty of a move from experience to community rating, and the varying affects of reform by industry.

- In November, 1993, Aaron sent you a copy of his paper, "Can the United States Reform its Health Care System." This paper examines the prospects for health reform from more of a political and practical perspective than an economic one. While Aaron argues that the Clinton plan is overly ambitious, he is more critical of the Chafee plan and other more conservative alternatives. He concludes that a modest compromise law can be passed in 1994 that serves as a seed for further efforts. Aaron published a version of this paper, called "Sowing the Seeds of Reform in 1994," in the January edition of *Health Affairs* magazine.
- In September, 1993, two days after the health reform proposal, Aaron stated: "But the plan, at least in the draft, rests on unrealistic assumed savings from cost control. Those assumptions need to be scaled back in the interests of realism and safety. . .it is clear that most savings would have to come from changes in medical practice. Physicians would have to administer fewer tests, hospitalize less often, do less surgery and prescribe fewer medications." Aaron suggested phasing in universal insurance. Hence, he believes, savings and new benefits would come more slowly but more reliably.

Background:

Aaron initially joined Brookings as a Senior Fellow in 1968. From 1967 until 1989, he taught at the University of Maryland. In 1977 and 1978, he served as Assistant Secretary for Planning and Evaluation at the Department of Health, Education, and Welfare. He chaired the 1979 Advisory Council on Social Security. Aaron was an undergraduate at the University of California at Los Angeles and holds a Ph.D. in economics from Harvard. He is the editor or co-editor of nine books and the author or co-author of fourteen others.

CHARLES L. SCHULTZE

Schultze is a Senior Fellow of the Economic Studies Program at the Brookings Institution. He was the Chairman of the Council of Economic Advisers under the Carter Administration, and Director of the U.S. Bureau of the Budget under Johnson. Schultze is a traditional Democrat, perhaps more liberal than Bosworth, but less so than Aaron. He is a deficit hawk and is considered an expert on budget issues. Schultze appears to be less active on health care than Aaron, Weiner, and Bosworth.

Health Care Related Activities:

- In February 5, 1994 commentary for the "Nightly Business Report (NBR)," a public television business program, Schultze argued that it is premature to conclude that the rise in health care costs has permanently slowed. Schultze warned that ever increasing utilization of expensive new treatments will make it difficult to keep down costs. According to Schultze, "We face a dilemma -- either devise some form of control on total health care spending or keep paying more for health care."
- In commentary for NBR in July, 1993, Schultze said, "ultimately, some form of rationing will have to be imposed -- we cannot continue to make every high tech procedure, no matter how expensive."
- In *The Washington Times* on February 15, 1994, Schultze was quoted: "My judgment is that nothing that can reasonably be done in the way of health care reform, even if successful in the long run, is going to control the growing cost of medical care sufficiently to give us a desirable budgetary picture around the turn of the century."

FIRST LADY HILLARY RODEHAM CLINTON
REMARKS TO THE BROOKINGS INSTITUTION TRUSTEES DINNER
WASHINGTON, DC
MARCH 1, 1994

DRAFT

[Acknowledgments]

It's an honor to be here tonight at an institution that has had such a profound impact on our political landscape. For 78 years, Brookings has been a fixture in Washington and, depending on the political era, either a thorn in the side or the wind in the sails of many a President.

I think I'm correct in saying that the New Dealers had no use for the place. A few decades later President Kennedy liked you. And so did President Johnson. But Richard Nixon was so put off by the institution's "liberal Democratic" agenda that he prohibited his aides from talking to anyone here -- and reportedly wanted Brookings burned to the ground.

Let me assure you that, as a certified wonk, our current President has no plans to firebomb the building. In fact, this Administration already has relied heavily on Brookings for brainpower and manpower. Not only have we borrowed many of your good ideas, Brookings' fellows and associates are sprinkled throughout the government, from the Cabinet on down [Shalala is a Brookings trustee; Rivlin et. al.].

Today our nation is engaged in a great and unprecedented discussion about health care reform. That discussion has flourished not only because ordinary citizens have come forth to express their views about our health care system, but because economists and social scientists and public policy experts have participated in this discussion so vigorously -- and so candidly.

I thank you for your enduring interest in issues vital to our government and our nation. Not just the work that Henry Aaron and his group have done on health care, but also the ideas that have germinated here on deficit reduction, NAFTA and GATT, the break-up of the Soviet empire and so many other important issues.

GENERAL AREAS OF AGREEMENT ON HEALTH CARE REFORM

I know from reading the op-ed pages and various public policy journals recently that there is great excitement about health care reform, as well as some questions about how it will

be achieved.

As you know, the President's proposal was not dreamed up overnight. It emerged after months of discussion with ordinary citizens and health care experts. And today it continues to be scrutinized and analyzed by some of the most respected economists and policy experts in the nation -- including some in this very room. That's why we're confident that the proposal is realistic . . . that it is built on sound ideas and sound economics . . . and that it can be achieved.

The President is optimistic because there are so many points that everyone -- Democrats, Republicans, and even all the economists and public policy experts -- seem to agree on.

First, that we are spending \$1 trillion a year on health care and not getting our money's worth. With so much money pouring into an inefficient health care system, we have fewer resources for investment and higher wages.

Second, that our health care system is a major drain on our economy and a key culprit in our ballooning deficit.

Third, that the current system is broken. Today, the incentives are backwards, stifling competition, breeding inefficiency and encouraging waste.

Fourth, that there are substantial savings to be garnered from within the system.

And fifth, that we don't cover every American and are not providing real health security to our citizens.

ECONOMIC AND SOCIAL GOALS DRIVE THE PRESIDENT'S PLAN TO PROVIDE HEALTH SECURITY FOR EVERY AMERICAN

In thinking about these realities -- and about how we can fix what is wrong without undermining what is right in our health care system -- the President wanted to come up with a plan that made economic sense, as well as social sense. It wasn't good enough simply to crunch some numbers and leave it at that. He wanted a plan that heightened individual and collective responsibility -- a plan in which everyone would be asked to contribute in return for access to comprehensive, lifetime health care.

There is widespread agreement that covering everyone is the only way to achieve real reform. Not only is it morally right, but without universal coverage, cost-shifting will continue unabated and we'll have no hope of slowing the growth of government programs. Worst of all, health security will remain an idle fantasy for millions of Americans.

The President's approach -- by far the most detailed, most substantive of those under discussion in Congress -- fixes the current structure so that we can control spending, restore competition, end discrimination in the insurance market, and reap additional savings through premium caps.

THE PRESIDENT'S APPROACH BUILDS ON OUR CURRENT SYSTEM OF PRIVATE HEALTH INSURANCE

* The President's proposal is rooted in the private sector, with most of the financing of premiums -- about 75 percent -- coming from businesses and individual households, just as it does today.

* What is different is that his approach asks employers and individuals who are not paying to take responsibility and pay their fair share. In other words, no more free lunch for those who now exploit the system.

AN EMPLOYER MANDATE IS THE BEST STRUCTURE FOR ACHIEVING UNIVERSAL COVERAGE AND PAYING FOR THE SYSTEM

* We have three choices of how to cover everyone: government sponsored insurance; an individual mandate; or an employer mandate.

* A government system would require huge tax increases.

* Individual mandates would encourage employers who now cover their employees to drop them.

* An employer-based system makes the most sense. Nine out of ten Americans who have private insurance today get it through their employer. It's a system that works for the vast majority of Americans, and that's why the President decided to expand it to cover all of our citizens.

FINANCING OF THE PRESIDENT'S PLAN IS ACHIEVED IN THREE WAYS

There is no great mystery about how we pay for care today. More than half of Americans' annual health care bill -- including public and private funds -- comes from employers and individuals. They are the ones who create the jobs, work hard, and play by the rules. And they are the ones who pay almost the entire cost of our health care system through exorbitant insurance premiums, out-of-pocket expenses and taxes that cover public programs like Medicare and Medicaid.

The President's plan offers three methods of financing:

* First: It asks all Americans who work and have no

insurance, and their employers, to contribute something to their own health care.

* Second: It limits the growth of federal health care programs. That doesn't mean cutting them, but reducing the rate of increase in Medicare and Medicaid.

* Third: It imposes a tax on tobacco. Not a broad-based tax, but a tax directly related to improving health in this country.

* Alternate plans not only fail to offer universal coverage and comprehensive benefits, they offer virtually no credible methods of financing. They ask for cuts in Medicare and Medicaid, which would exacerbate cost-shifting.

THE PRESIDENTS APPROACH FIXES THE CURRENT SYSTEM BY ENCOURAGING REAL COMPETITION AND INCREASED EFFICIENCY AND ENHANCING CHOICE

* The president's plan relies on market competition between private health plans to provide consumers with the widest possible array of choice. That maximizes choice for consumers and minimizes government interference. Those who want a Cadillac won't have to settle for a Hyundai. And those who want a Hyundai won't have to pay for a Cadillac.

* By establishing regional health alliances -- I like to call them buyers' clubs -- insurers will be forced to compete for consumers and prices for premiums will be more competitive.

WE NEED COMMUNITY RATING SO THAT PEOPLE WITH INSURANCE REALLY HAVE INSURANCE.

* Currently, health insurance is often discriminatory. It is based on experience -- that is, on the consumer's expected use of health services. That means prices are determined by one's health status or age or even their gender. So if you're an older American with diabetes, you're a pariah. If you're a young adult with an iron constitution, you're the cat's meow.

* With community rating, everyone in a group is charged the same amount thus spreading the cost of care across the population. Under this system, the price paid by each individual for coverage would be the average cost of such coverage for the population.

* With community rating, insurance really is insurance. No one can be discriminated against because they have a pre-existing condition or because of their age. And with regional health alliances -- or buyers' clubs -- people can shop around for the plan that best suits their needs.

COMMUNITY RATING MUST BE ENFORCED

* There is a catch. Community rating won't work if it isn't vigorously enforced. [We're still working on specifics of the New York example to be inserted here]

* Again, the President's plan is the only one that offers a realistic approach to full-scale community rating. Alternate plans include only minor insurance reform. Insurance companies would still be able to exclude some people with pre-existing conditions and would be able to market to low-risk groups and individuals.

THE PRESIDENT'S PLAN OFFERS A BACK-UP COST CONTROL MEASURE THROUGH THE USE OF PREMIUM CAPS

* Premium caps are needed to build discipline and certainty into the health care system.

* If businesses and individuals are going to be asked to contribute to the cost of health care and the government is going to provide discounts to those who cannot afford their full share, then everyone must be assured that increases in their premiums will not rise out of control.

* Critics charge that premium caps are unrealistic because the rate of growth needed to reach them has never been attained in any other industrialized nation. That misses the point. As we phase-in universal coverage, there will likely be a major expansion in health expenditures -- perhaps from the current rate of about 14.5 percent of the GDP to 16.9 percent by the year 2000. That amounts to a more rapid increase in the share of resources devoted to health care than has occurred in any other nation over a comparable period of time. It is AFTER that expansion that we predict the rate of growth will slow and come in line with our GDP.

THE IMPORTANCE OF DEBATE AND CRITICAL ANALYSIS IN ACHIEVING REFORM

In the coming weeks and months, Congress will have the chance to act on health care reform. This is an historic opportunity, one that should not be undermined by political cynicism and gamesmanship.

That's where Brookings can play a vital role. One reason we have had a healthy debate about reform is because people at institutions like this one have risen above the fray and have been willing to examine public policy proposals with a rigorous and candid eye.

At such a crucial moment in our history, this institution

HAC

Status quo biggest enemy
you have. Today acceleration
to managed care.

today we underpay primary
care physicians.

we have to change how we
pay physicians.

Preservation of the best

5) are we getting unreasonable
returns?

function: adds cost but not
value. underwriting cherry
picking

4) Corps will kill research &
teaching hospitals.

- we provide more funding over time to teaching
hosp.
- huge \$ into drugs co.

must continue to inject honesty and substance into the political discourse. The fellows here can elevate the debate beyond rhetoric. They can provide the substantive analysis that can help all Americans -- and especially members of Congress -- make informed judgments about which path we should follow.

As the saying goes, "Be there a will, and wisdom finds the way."

We have the will. With your help, I think we have the wisdom. And hopefully we will find the way to become a healthier, happier nation.

Thank you.

###

1) Weiner - alliances - resp. to crit.

- not reg'ry central agents -
- "pooling agents"
- us co - not ignorant & self-centered.
- "Stark chair" - not a pun
- collect \$, go into marketplace & qualify plans for people to choose.

2) Why no single payer? - no internal competition within system i.e. market free

3) Flexibility -

- a) benefit pkg. at 20%
- b) phase in - longer
- c) indiv'l mandate for smaller co.
- d) employees pay 50% share

{ > if you can give us to universal coverage, with contrib. benef., + cost controls, we'll look at it.

((HAC - no incentive approach))

4) Single physician - In case of reform - sacrific'g role of private practice.

HAC: more ungt. question

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- National Health Expenditures Under Current Policy and the Health Security Act: 1994 - 2000 -- Bulleted Summary
- National Health Expenditures as a Percent of GDP, Under Current Policy and Under Reform -- Line Chart
- National Health Expenditures in Dollars, Under Current Policy and Under Reform -- Line Chart

FINANCING HEALTH SECURITY TALKING POINTS

The vast majority of funding for health security will come from building on our current system and asking all employers and employees to take responsibility for paying for health coverage. But additional funding is needed to protect small businesses, provide long-term care and prescription drug coverage to older Americans, and ensure that no American ever loses their health coverage. The President's approach includes a cigarette tax and corporate assessment, and savings from slowing the growth of the cost of federal health care programs.

1. Asking people who don't have insurance and companies who don't provide it to take responsibility and contribute.

Today, nine out of ten Americans who get private health coverage get it through the employer-based system. It's a system that works for the vast majority of Americans. That's why the President rejected a broad-based tax to pay for a government-run system -- deciding instead to leave our health care system rooted in the private sector. In fact, under reform, three quarters of total health insurance premiums will continue to come from the private sector -- businesses and households.

The President's approach asks those employers and individuals who aren't paying to take responsibility and pay their fair share. This will lower costs for the vast majority of companies who currently provide insurance and who will no longer see their premiums rise to pay for free care for people without insurance.

2. Taxing tobacco and large corporations that form their own alliances.

This plan has no broad-based tax, but to try to encourage health in this country, increasing the tobacco tax is an appropriate way to help discourage smoking and therefore promote good health. And we're going to ask those large corporations that form their own alliances to contribute to the cost of health care for everyone.

3. Slowing down the growth of spending for Medicare and Medicaid.

Every serious health reform proposal -- Democratic and Republican -- recognizes that national health care reform can save money in the rate of growth in federal health programs. Medicare and Medicaid will no longer have to reimburse doctors and hospitals for the cost of caring for the uninsured, saving billions of dollars per year. With all employers contributing to health care, Medicaid and Medicare will also save on workers now covered by those programs. Upper-income people will pay a larger share of their Medicare Part B premium, and there will be a crackdown on the fraud and overcharges that drive up Medicare costs.

FINANCING HEALTH SECURITY OVERVIEW

SUMMARY: *Financing for the President's approach builds on the current system with three quarters of the total health insurance premium costs coming from the private sector -- businesses and households -- just as they do today.*

- *The President's approach is the only comprehensive health reform plan which spells out exactly what benefits will be provided and how this reform will be financed -- with the exception of plans that call for raising taxes on all Americans.*
- *The process used to arrive at the financing estimates was rigorous and has been validated by many independent sources.*
- *The federal costs for the proposal are identifiable and clear -- with significant long-term deficit reduction.*
- *The sources of federal funding are specific and scorable.*
- *Most importantly, the President's approach contains strong financial protections to ensure accountability and fiscal responsibility and guarantee that projected savings are locked in.*

I. OUR PLAN BUILDS ON TODAY'S PRIVATE SECTOR SYSTEM:

The President's approach builds on our current private health care system. According to the March 1992 Current Population Survey, nine out of ten Americans who are privately insured today get their insurance through the employer based-system -- this will continue. But now every employer will be asked to take responsibility. Firms that now cover their employees' health insurance will no longer be penalized in a system where their competitors can choose to cut costs by not providing insurance. And all individuals will now have to take responsibility for their share of insurance as well.

By providing discounts to small businesses and low-wage workers, the President's approach will enable millions of Americans to contribute toward their comprehensive, affordable insurance coverage. In fact, under the President's health reform bill, 76% of health insurance premiums come from these private sources and remain in the private sector.

II. NO OTHER PLAN PROVIDES THIS LEVEL OF FINANCIAL DETAIL:

The President has provided more specifics about the plan's financing -- exactly how much the program will cost, where the funds will come from, and how these funds will be spent -- than any other proposal. In fact, the Administration is the only sponsor of a health reform plan which has released extensive documentation detailing exactly what benefits will be provided, how premiums and discounts were estimated, exactly where we expect to get savings, the methodology behind predicting the federal revenues and the anticipated distributional effects of the proposal. No other plan out there has come anywhere close to this level of detail.

III. EXPERTS VALIDATE OUR PROCESS OF ESTIMATING COSTS:

The health care financing analysis undertaken by the administration has been rigorous, drawing on the best analytical talent from inside and outside the federal government. Our methodology and premium estimates were validated by a team of prominent, private sector actuaries from firms such as Coopers & Lybrand, Towers Perrin, and Price Waterhouse. These actuaries gave said our cost estimates are the "*best possible*" and pass a "*real world test*." Although they may disagree about specific policy choices, many independent economists and health economists agree that our process was thorough and our estimates are both credible and achievable.

An independent analysis of the Health Security Act -- conducted by the Lewin VHI health care consulting firm and co-authored by a former top Reagan administration official -- confirmed 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.*" Robert Reischauer, Director of the non-partisan Congressional Budget Office, testified that the estimating process "*as far as I can tell, really was done without any bias at all, was a first-rate professional effort to get at these costs.*" [Lewin, PR, 12/8/93; Reischauer Testimony, *Senate Finance Committee*, 2/9/94]

IV. USES OF FUNDS – Federal Costs are Identifiable and Clear:

1. Premium Discounts for Businesses and Families: \$151 Billion – over 5 years (1996-2000)

Discounts on the cost of insurance will be provided to three groups who may not be able to assume full financial responsibility for their share of their insurance premiums:

- 1) businesses within the regional alliances (with 75 percent of discounts going to small firms);
- 2) low-income individuals, families and retirees; and
- 3) people who have lost their jobs.

The cost of providing these discounts is approximately \$110 billion over five years. In addition, there is a 13% discount "cushion" -- \$41 billion over 5 years -- built into the discount structure for unpredictable behavioral changes that could result in an additional demand for discounts.

Net Discounts (\$151 B) = Gross Discounts (\$327 B) - Offsets (\$176 B)
Gross discounts -- the amount of discounts that are actually distributed to businesses and families -- are offset by money saved by the federal government (\$104 billion -- \$79 billion from Medicaid and \$25 billion from Medicare) and state/local governments (\$72 billion) when people who used to be on Medicare and Medicaid now are enrolled in the alliances. Therefore, the total net cost to the government is \$151 billion.

2. Medicare Drug Benefit:
\$69 Billion – over 5 years (1996-2000)

The savings in the Medicare program will be reinvested in improved benefits for seniors. For less than \$10 a month, Americans eligible for Medicare will automatically receive prescription drug coverage -- with standard 25% Part B premium payments and a \$250 deductible. Enrollees will benefit from a \$1,000 annual limit on out-of-pocket prescription drug costs, with all costs above this amount fully covered.

3. Long-Term Care:
\$62 Billion – over 5 years (1996-2000)

Americans of all ages who are disabled will gain access to a wider variety of home and community-based support services, making it possible for many to continue to live at home rather than in nursing homes. There are three components to the long-term care benefit:

- (i) the home and community-based program (\$57 billion);
- (ii) state option to liberalize eligibility for nursing home care under Medicaid / enhanced resource protection under Medicaid for nursing home residents (personal needs allowance) (\$2 billion);
- (iii) tax incentives to encourage the purchase of long-term care insurance and a tax credit for the working disabled (\$3 billion).

4. **Self-Employed Tax Deduction:**
\$9 billion – over 6 years (1995-2000)

Today, individuals who are self-employed are discriminated against because they can only deduct 25% of the cost of their health premiums from their taxes, rather than 100% as all other businesses do. Eliminating this bias against the self-employed -- by allowing a 100% income tax deduction for the cost of their comprehensive benefits -- will bring equity to the system and encourage the formation of small businesses.

5. **Public Health Initiatives/Veterans/WIC/New Administration:**
\$47 billion – over 6 years (1995-2000)

New public health spending on programs for children, for veterans, to train nurses, and for research and development are also included in the proposal. New funds for the Women, Infants and Children (WIC) program will enable more mothers, infants and children benefit from WIC through its health promotion and nutritional supplements (\$3 billion). This provision also includes additional funds for academic health centers to support research and development (net of offsets from current Medicare funding for this purpose) (\$24 billion), other public health initiatives -- such as school-based clinics, health research, and prevention-promotion programs (\$7 billion), additional funds for training Advanced Practice Nurses under Medicare (\$2 billion), additional funds for veterans' health programs (\$3 billion), additional funds for community hospitals serving "vulnerable populations", such as undocumented persons (\$3 billion), and new start-up and administrative costs (\$5 billion).

NEW FEDERAL SPENDING TOTALS \$338 BILLION – OVER THE 6 YEAR PERIOD FROM 1995 - 2000

V. **SIGNIFICANT DEFICIT REDUCTION:**

Over the long term, experts acknowledge that comprehensive health reform that provides the universal access needed to control health care costs is the single best hope for reducing the structural deficit. According to administration estimates, the President's approach will reduce the deficit by \$59 billion -- over the six year period from 1995 to 2000.

- The independent analysis from Lewin-VHI estimated that the President's approach would reduce the deficit by \$25 billion by the year 2000 and would continue to reduce the deficit in the long-run.
- The Congressional Budget Office also estimated that the President's approach "*should make ever-increasing contributions to deficit reduction after 2004*". While CBO and the Administration agree that the plan will begin to save money by 2000, CBO estimates that much of these initial savings will go to businesses and state/local governments. In contrast, the administration expects these savings to initially go to the federal government and therefore to immediately begin to reduce the deficit. Since CBO and the Administration are in agreement on the essential framework as well as the magnitude of the overall savings projections, the short-term deficit issue is something that can be easily worked out as the proposal proceeds through the U.S. Congress.

VI. SOURCES OF FUNDS - Specific and Scorable:

1. Medicare Savings: \$118 Billion – over 6 years (1995-2000)

The Medicare program remains intact under the President's plan, with improved benefits and slower rates of growth of spending. Every serious health reform proposal -- Democratic and Republican -- recognizes that national health care reform can save money in the rate of growth in Medicare and Medicaid. But only the President's approach reinvests these savings in new prescription drug and long-term care benefits for seniors and combines Medicare savings with reductions in the growth of private sector spending so Medicare savings are not simply shifted to the private sector. In the long run, health reform represents the most economically and politically viable way to change the nature of our entitlement system and control the skyrocketing growth of entitlement programs. Our plan will provide greater health security -- and two new benefits -- for older and disabled Americans while bringing down the cost of their health care and the cost of the health insurance system as a whole.

The plan identifies \$118 billion in specific, scorable, line-by-line savings -- described by CBO Director Reischauer as "*quite real and quite achievable*" -- which are outlined in the Medicare section of this document. For example, Medicare will no longer have to reimburse doctors and hospitals for the cost of caring for the uninsured, thereby saving the Medicare program billions of dollars each year. In addition,

upper-income participants in the program will be asked to pay a larger share of their Medicare Part B premiums. Together these reforms will slow the rate of growth of Medicare costs from three to two times the rate of inflation, and the savings will be directed into the new benefits for older Americans.

**2. Medicaid Savings:
*\$61 Billion – Over 5 Years (1996-2000)***

All credible health reform proposals currently under consideration in the Congress recognize that, with health reform, the rate of growth of Medicaid spending -- the federal health insurance program for low-income Americans -- can be reduced. The President's approach uses these savings used to provide comprehensive health coverage to Medicaid recipients under the new system.

Under reform, the Medicaid program will be restructured and savings will be achieved. There are two categories of savings:

- (i) Disproportionate Share (or DSH) Payments -- once all Americans have insurance, the federal government can reduce the special payments it makes to providers who today provide a disproportionate amount of free services to the uninsured (\$48 billion);
- (ii) Slower Rate of Growth of Medicaid Spending -- Future Medicaid spending by the federal government for those populations that receive care through the alliances that is paid by the Medicaid program (SSI, AFDC) will grow at a slower rate of increase, as will the rest of the health care system (\$22 billion);

There are also two categories of new spending relating to the Medicaid program: (a) additional spending for Medicaid "wrap-around services" - - such as transportation -- that will continue to be provided to disabled children (\$5 billion); and (b) additional expenses for administration (\$4 billion).

**3. Tobacco Tax and Corporate Assessment:
*\$92 Billion – Over 6 Years (1995-2000)***

The plan will raise taxes on tobacco products, asking people whose health costs are higher to pay more for products that increase the risk of poor health. The tobacco tax on cigarettes is increased by \$.75 per pack (to \$.99 per pack), raising \$67 billion over 6 years.

The President's approach also asks those large self-insured corporations who establish their own alliances to help pay for health care for everyone -- for example, by contributing to the cost of academic health centers which benefit all Americans. The corporate assessment is 1 percent of payroll, raising \$24 billion over 5 years.

4. **Federal Programs Savings:**
\$29 Billion – Over 5 Years (1996-2000)

The plan will lower the federal government's cost of providing health care for federal workers by integrating them into the alliance structure. By purchasing health care in the private sector, the government will be guaranteed the same low rate of cost increase as private businesses. The savings are from several sources: Veterans Department (\$19 billion); Department of Defense (\$3 billion); and Federal Employees Health Benefits program (\$8 billion).

5. **Increased Federal Revenues:**
\$93 Billion – Over 6 Years (1995-2000)

The President's approach will raise an additional \$93 billion in federal revenues without raising a broad-based tax, although there will be some changes in tax deductibility outside of the comprehensive benefits package. There are several components to these savings.

- (i) As employers' health care costs -- which are currently *tax-preferred* -- decrease, more employer funds will be channeled into *taxable* avenues such as increased wages for existing workers and new hires, increased profits, greater shareholder dividends, etc. Initially, premiums under reform will be 10.5 percent lower than they are now because, with universal coverage, firms that insure their workers will no longer be overcharged to cover the costs of those who are uninsured but still receive care. The new incentives to increase competition and encourage cost consciousness on the part of both consumers and providers will continue to lower health insurance costs over time. This re-channeling -- expected to translate primarily into an increase in taxable wages -- is estimated to raise \$28 billion over 6 years.
- (ii) increased revenue from removing health insurance from currently tax-preferred "cafeteria plans" -- mechanisms used by employers today to provide their employees a variety of benefits on which to spend their pre-tax dollars (\$31 billion);

- (iii) dedicated revenues for academic health centers (\$18 billion);
- (iv) other conforming tax changes largely affecting the self-employed (\$4 billion); and
- (v) contributions made by businesses, and upper-income retirees, for health coverage for their early retirees (\$12 billion).

**6. Reductions in Debt Service:
\$4 Billion**

Lower deficits will lead to savings in federal interest payments on the federal debt.

VII. RESPONSIBLE, CONSERVATIVE FINANCIAL PROTECTIONS:

Several mechanisms have been included in the plan to ensure accountability, fiscal prudence, and credibility.

- **13% Discount "Cushion":**

We have been careful in estimating the funds needed for discounts, basing our estimates on sophisticated models built from very specific information about factors such as worker's earnings, numbers of workers in firms at certain sizes, etc. However, there are some behavioral changes, both positive and negative, that are difficult to quantify in a program of this magnitude -- such as creative accounting by businesses to qualify for additional discounts. For these reasons, the President's approach has a built-in 13% "cushion" -- of \$41 billion over 5 years -- as a safeguard for these unknowns, giving us even greater confidence in our estimates.

- **Entitlement Caps on Discounts – Fiscal Accountability:**

The plan sets a limit on the amount of funding for discounts that is automatically appropriated. We felt an open-ended entitlement left the federal budget and the American taxpayer vulnerable to unpredictable cost increases in the future. The health reform program must pay for itself, and the costs must be clear and predictable. However, we are confident we have been conservative in estimating the needed funds for discounts so that this cap will never be reached. As just one example, we overestimated the demand for discounts for businesses, families, and retirees in order to be as conservative as possible. Then, we ran sophisticated models to test how the system would respond to extreme hypothetical situations. For example, an

unexpected 2 percentage point increase in unemployment -- with millions more suddenly qualifying for discounts -- would require an additional \$4 billion a year. In 2000, the cushion is \$12 billion -- three times the funds necessary for this extreme situation. In addition, any funds that are not used in one year can be carried over to the next year so that a contingency reserve will build over time.

If it appears that the entitlement cap might be reached, the Secretary of HHS must notify the President and the Congress immediately. Within 30 days, the President must submit to Congress a report containing specific legislative recommendations for actions which would eliminate the shortfall and this report will be considered by Congress under an expedited procedure. These provisions reflect the President's strong commitment to financial responsibility.

- **Premium Caps – Backup Cost Control Measure:**

We strongly believe that -- regardless of how quickly or how firmly competitive reforms take hold -- we need to build some discipline and certainty into the health insurance system. This is essential to assure businesses and consumers that their health insurance premiums will not continue to spiral out of control year after year, and that the federal government will not be allowed to increase spending without accountability. The President's approach reinforces the private marketplace and the competitive system with a fail-safe limit on health care premium increases. This targeted, selective limit will be used only if the average premium across all plans exceeds the alliance's premium target; it cannot be triggered by one or two extreme plans. We are confident that these limits will not be reached. If triggered, however, these limits will apply only to those plans in the Alliance that exceed the target. Plans and providers that propose excessive rate increases will be required to adjust their premiums downward or face stiff financial penalties (to automatically "rebate" the portion of the premium which exceeds the alliance's premium target).

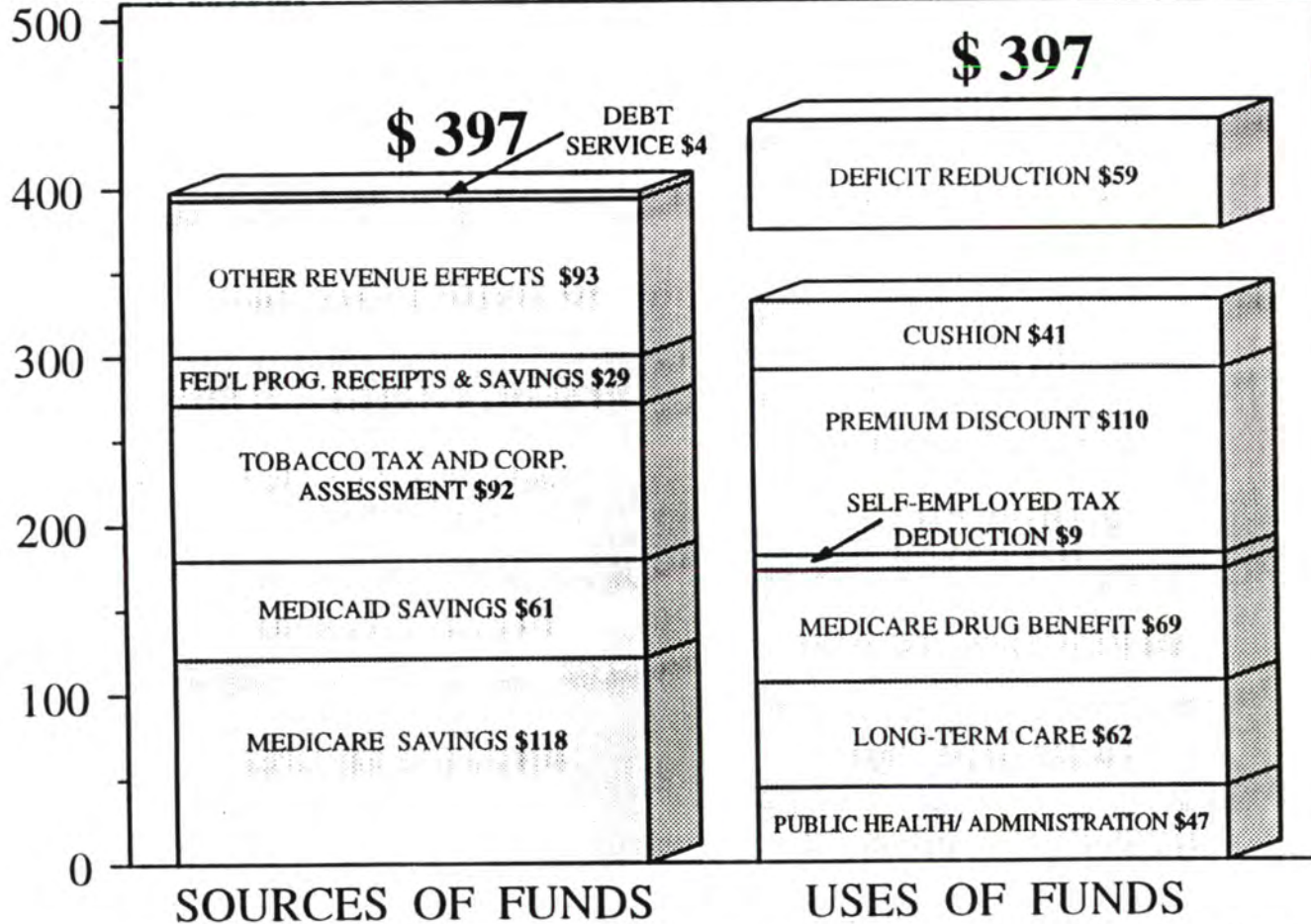
LEWIN-VHI ANALYSIS OF HEALTH SECURITY ACT Selected Excerpts

- "...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." [Lewin, PR, 12/8/93]
- "This report validates the logic of the plan's financing..." [Lewin, PR, 12/8/93]
- "There is no smoke and mirrors here." [Lewin, AP, 12/8/93]
- "The Lewin-VHI analysis also shows that American families as a group are the major beneficiaries under President Clinton's health care reform package..." [Lewin-VHI Press Release, 12/8/93]
- "The 'magic' in the administration's plan, is community rating. This is quite simply a return to the way insurance use to work before insurers competed to avoid risk." [John Sheils, author of Lewin study, PR, 12/8/93]
- "[Lewin] has concluded that the proposed funding system for President Clinton's national health plan is basically sound." [Washington Post, 12/9/93]
- "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." [Lewin, Washington Post, 12/9/93]
- "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." [AP, 12/9/93]
- "...the Lewin report concluded that older people stand to gain the most from the Clinton plan, particularly the 55-64 age group." [Knight-Ridder, 12/8/93]

Chart 4-1. FINANCING THE HEALTH SECURITY ACT

(TOTALS: 1995-2000)

DOLLARS IN BILLIONS



NOTE: These estimates were calculated using the economic assumptions in the 1995 budget. Estimates released in November 1993 were based on economic assumptions in the 1993 Midsession Review. Numbers may not add due to rounding.

Financing the Health Security Act

Uses of Funds (billions of dollars)

27-Jan-94

Fiscal Years		1995	1996	1997	1998	1999	2000	95-99	95-00
	Veterans, Public Health, New Administration, and Other	3.0	5.2	9.6	8.9	10.0	10.3	36.7	47.0
26	Veterans Health Care Investment Fund	1.0	0.6	1.7	0.0	0.0	0.0	3.3	3.3
27	New Public Health Initiatives	0.4	1.1	1.6	1.3	1.2	1.1	5.6	6.7
28	New Spending on Acad. Health Ctrs. and Grad. Med. Educ.	0.3	1.8	3.8	4.9	6.2	6.5	17.0	23.5
29	Advance Practice Nurses (Medicare)	0.0	0.2	0.4	0.5	0.6	0.7	1.6	2.3
30	New Federal Administrative and Start-Up Costs	1.3	0.9	1.2	0.9	0.6	0.6	4.8	5.4
31	Special Supplemental Food Program (WIC)	0.0	0.5	0.6	0.6	0.7	0.7	2.4	3.1
32	Vulnerable Population Adjustment	0.0	0.1	0.3	0.7	0.8	0.8	1.9	2.7
	Long-Term Care	0.0	5.1	8.8	12.2	16.0	20.1	42.1	62.2
33	Home Based Care for the Disabled	0.0	6.0	10.2	13.9	18.2	22.8	48.3	71.1
34	Medicaid Offset	0.0	-1.5	-2.4	-2.9	-3.5	-4.1	-10.3	-14.4
35	Liberalized Medicaid Eligibility & Personal Needs Allowance	0.0	0.4	0.5	0.5	0.5	0.5	1.9	2.4
36	Tax Incentives for Long-term Care	0.0	0.2	0.5	0.7	0.8	0.9	2.2	3.1
37	Medicare Drug Benefit	0.0	6.9	14.0	15.0	16.0	17.2	51.9	69.1
38	100% Tax Deduction for Self-Employed Health Insurance	0.5	0.6	0.9	1.7	2.5	2.8	6.2	8.9
	Discounts	0.0	5.8	17.5	41.8	44.3	41.8	109.3	151.1
	Discounts -- Net of Cushion	0.0	4.5	13.6	31.4	31.7	28.8	81.1	109.9
	Total Discounts	0.0	10.2	31.6	82.7	100.0	103.0	224.4	327.4
39	Employers (net of cushion)	0.0	3.0	9.2	23.7	28.4	28.7	64.4	93.1
40	Non-retired Households (net of cushion)	0.0	4.4	14.0	36.8	45.0	46.7	100.2	146.9
41	Retirees -- low income discounts (net of cushion)	0.0	0.7	2.1	5.5	6.7	7.0	15.0	21.9
42	Retirees -- added discounts (net of cushion)	0.0	0.4	1.4	3.7	4.5	4.8	10.1	14.8
43	Out-of-Pocket	0.0	0.3	1.0	2.6	2.7	2.8	6.6	9.4
44	Cushion	0.0	1.3	4.0	10.4	12.6	13.0	28.2	41.2
	Offsets Made Possible by Health Reform:	0.0	-4.4	-14.1	-40.9	-55.7	-61.2	-115.1	-176.3
	Medicaid	0.0	-3.4	-12.1	-34.9	-47.7	-53.2	-98.1	-151.3
45	States' Required Maintenance of Effort	0.0	-2.0	-6.4	-18.1	-22.4	-23.4	-48.9	-72.3
	Discontinued Medicaid Coverage	0.0	-1.4	-5.7	-16.8	-25.3	-29.8	-49.2	-79.0
46	Basic Benefits	0.0	-1.3	-5.2	-15.2	-22.9	-26.9	-44.6	-71.5
47	Wrap-around Benefits	0.0	-0.1	-0.5	-1.6	-2.4	-2.9	-4.6	-7.5
46	Medicare Offset for Employed Beneficiaries	0.0	-1.0	-2.0	-6.0	-8.0	-8.0	-17.0	-25.0
	Total Spending	3.5	23.5	50.9	79.4	88.8	92.2	246.1	338.3
47	Deficit Reduction	11.0	3.2	-6.9	-4.8	18.2	37.7	20.8	58.5
	TOTAL	14.5	26.7	44.0	74.7	107.0	129.8	266.9	396.8

Financing the Health Security Act

Sources of Funds (billions of dollars)

27-Jan-94

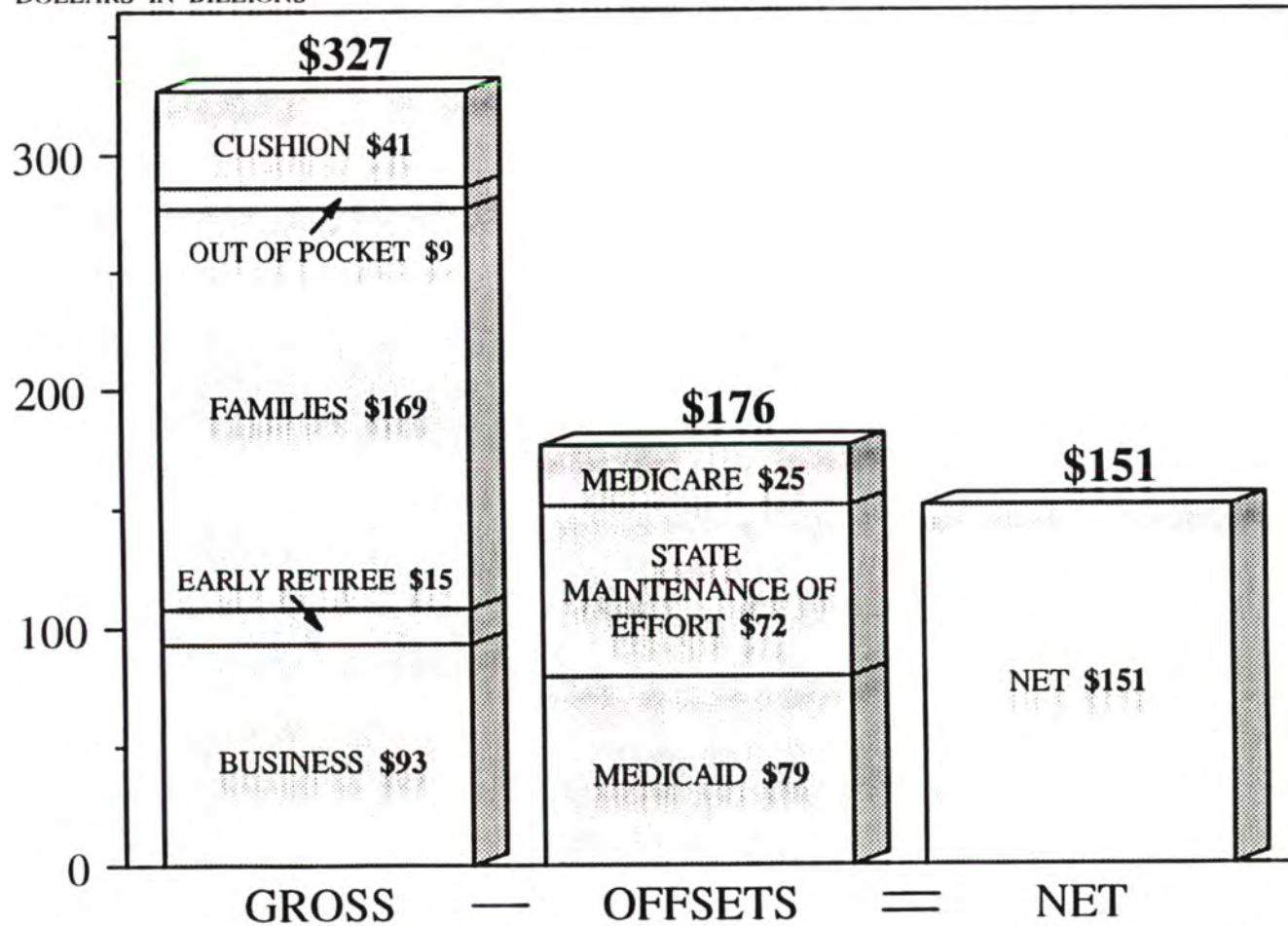
Fiscal Years		1995	1996	1997	1998	1999	2000	95-99	95-00
	Medicare	2.1	9.0	14.3	22.1	31.6	39.2	79.1	118.3
1	Part A Savings	0.0	3.3	7.0	12.0	16.4	20.4	38.7	59.1
2	Part B Savings (including interactions with premiums)	1.9	2.4	2.6	5.2	8.6	11.4	20.7	32.1
3	Parts A and B Savings	0.2	1.5	2.2	2.6	4.2	5.0	10.8	15.8
4	HI Tax Extended to all State & Local Government Employees	0.0	1.6	1.6	1.5	1.5	1.5	6.1	7.6
5	Income Related SMI Premium -- gross receipts	0.0	0.2	0.9	0.8	0.9	1.0	2.8	3.8
	Medicaid	0.0	0.8	3.5	9.2	20.1	27.1	33.7	60.8
6	Cash-Eligible Beneficiaries in Alliances	0.0	0.3	1.2	3.7	6.6	9.7	11.8	21.5
7	Reduced Disproportionate Share Hospital Payments	0.0	1.0	3.7	10.4	15.2	17.4	30.3	47.7
8	Less Supplemental Services for Children	0.0	-0.1	-0.4	-1.1	-1.6	-1.6	-3.2	-4.8
9	Payment Lag, Administrative Savings, and Other Changes	0.0	-0.4	-1.0	-3.8	-0.1	1.6	-5.2	-3.6
	Other Federal Programs	0.0	0.4	1.2	6.9	9.8	10.9	18.3	29.2
10	Veterans Affairs: Third Party Payments	0.0	0.6	1.7	4.4	5.8	6.1	12.4	18.5
11	Defense Department Health (a)	0.0	0.1	0.2	0.7	0.8	0.8	1.8	2.6
12	Federal Employees Health Benefits	0.0	-0.2	-0.7	1.8	3.2	4.0	4.1	8.2
	Tobacco Tax/ Corporate Assessment	12.0	15.0	16.2	16.2	16.1	16.1	75.5	91.6
13	Tobacco Tax	12.0	11.3	11.2	11.1	11.0	10.9	56.5	67.4
14	Corporate Assessment	0.0	3.8	5.0	5.1	5.1	5.2	19.0	24.2
	Other Revenue Effects	0.1	0.8	8.4	20.0	28.8	34.5	58.1	92.6
15	Exclusion of Health Insurance from Cafeteria Plans	0.0	0.0	5.3	8.1	8.7	9.3	22.1	31.4
16	Effects of Mandate, Cost Containment, and Discounts	0.0	0.1	0.9	4.4	9.3	13.7	14.7	28.4
17	Dedicated Revenues for Academic Health Centers	0.0	0.5	1.6	4.3	5.5	5.8	11.9	17.7
18	Assessment on Employers for Retiree Discounts	0.0	0.0	0.0	2.4	4.3	4.7	6.7	11.4
19	Anti-Abuse Rule -- Certain S Corp. Shareholders	0.0	0.2	0.5	0.5	0.5	0.5	1.6	2.2
20	Modify Tax Treatment of Certain Health Care Organizations	0.0	0.0	0.1	0.2	0.2	0.2	0.5	0.7
21	Reporting Penalties -- Non-corp. Ind. Contractors	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.5
22	Modify Tax Treatment Retirement Funding Accounts	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.3
23	Recapture Retiree Discounts High-Income Recipients	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2
24	Incentives for Health Providers in Shortage Areas	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1
25	Debt Service	0.3	0.6	0.5	0.2	0.6	2.0	2.2	4.2
	TOTAL	14.5	26.7	44.0	74.7	107.0	129.8	266.9	396.8

(a) Under the proposed legislation, the Secretary of Defense is to decide when the military system will be coordinated with national health reform. This table shows the estimated budgetary effects on the Department of Defense if the military system were to be fully coordinated with national health reform by FY 1998.

Chart 4-2. COST OF PREMIUM DISCOUNTS

(TOTALS: 1995-2000)

DOLLARS IN BILLIONS



NOTE: These estimates were calculated using the economic assumptions in the 1995 budget. Estimates released in November 1993 were based on economic assumptions in the 1993 Midsession Review.

NATIONAL HEALTH EXPENDITURES UNDER CURRENT POLICY AND THE HEALTH SECURITY ACT: 1994 - 2000

- **Absent comprehensive reform, health care would consume 17.5 percent of GDP, or \$1.653 trillion, in the year 2000. [Charts I-A and I-B]**
- **Under the Health Security Act, health care will consume 16.9 percent of GDP, or \$1.597 trillion, in the year 2000. This is \$56 billion lower than if there were no comprehensive reform. [Charts I-A and I-B]**
- **Under the Health Security Act, there will be a short-term increase in national health expenditures. Between 1995 and 1998 national health expenditures will consume 0.1 percent to 0.2 percent more of GDP than they would have without comprehensive reform. By 1999, health care will consume a lower percentage of GDP under the Health Security Act than if there were no comprehensive reform. [Charts I-A and I-B]**
- **Over the entire period from 1994 to 2000, savings will exceed additional expenditures by \$37 billion. [Chart I-B]**

NATIONAL HEALTH EXPENDITURES AS A PERCENT OF GDP

Under Current Policy and the Health Security Act: 1994 - 2000

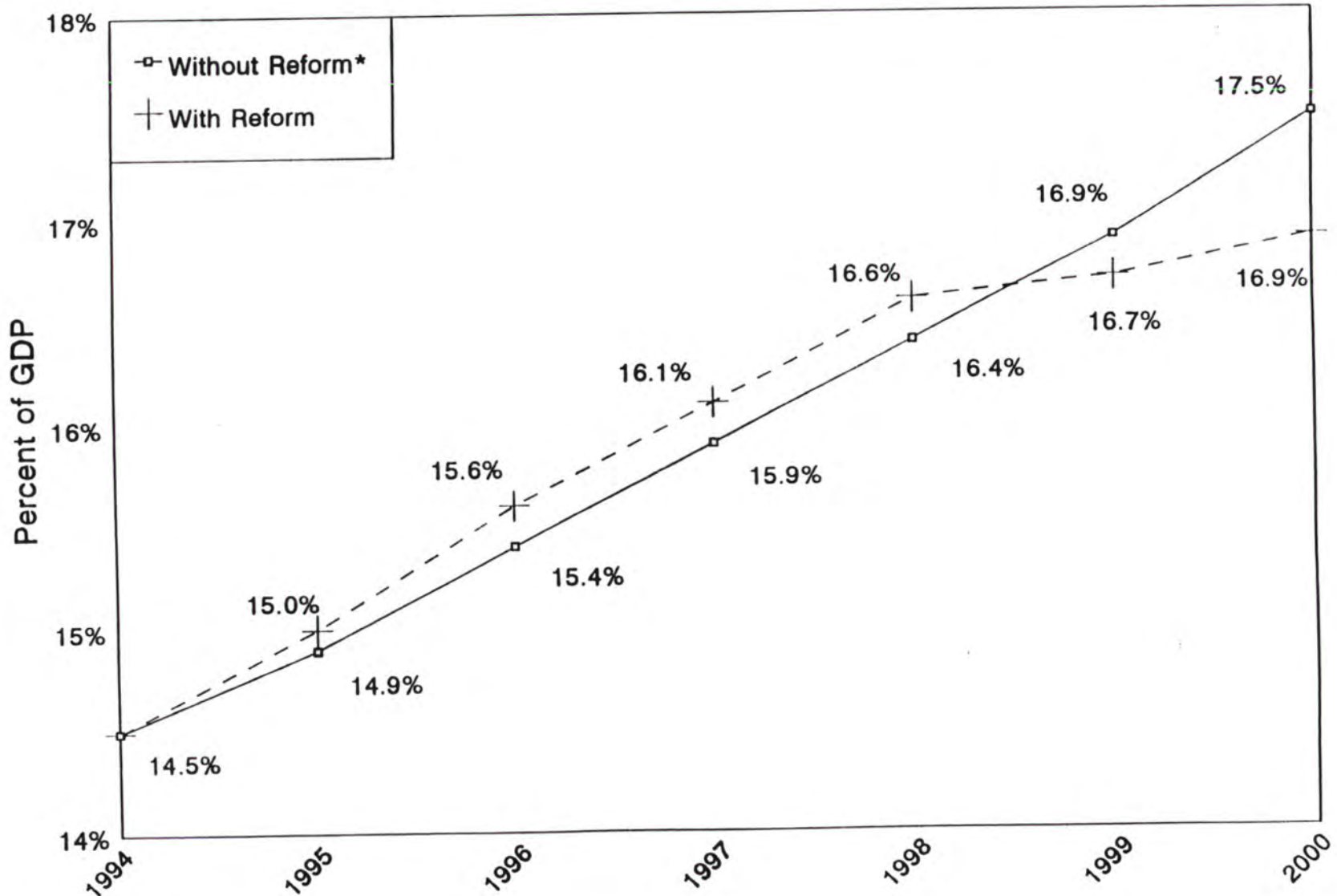


Chart I-A

SOURCE: Administration Estimates.
 * CBO baseline with Administration's economic assumptions.

NATIONAL HEALTH EXPENDITURES IN DOLLARS

Under Current Policy and the Health Security Act: 1994 - 2000

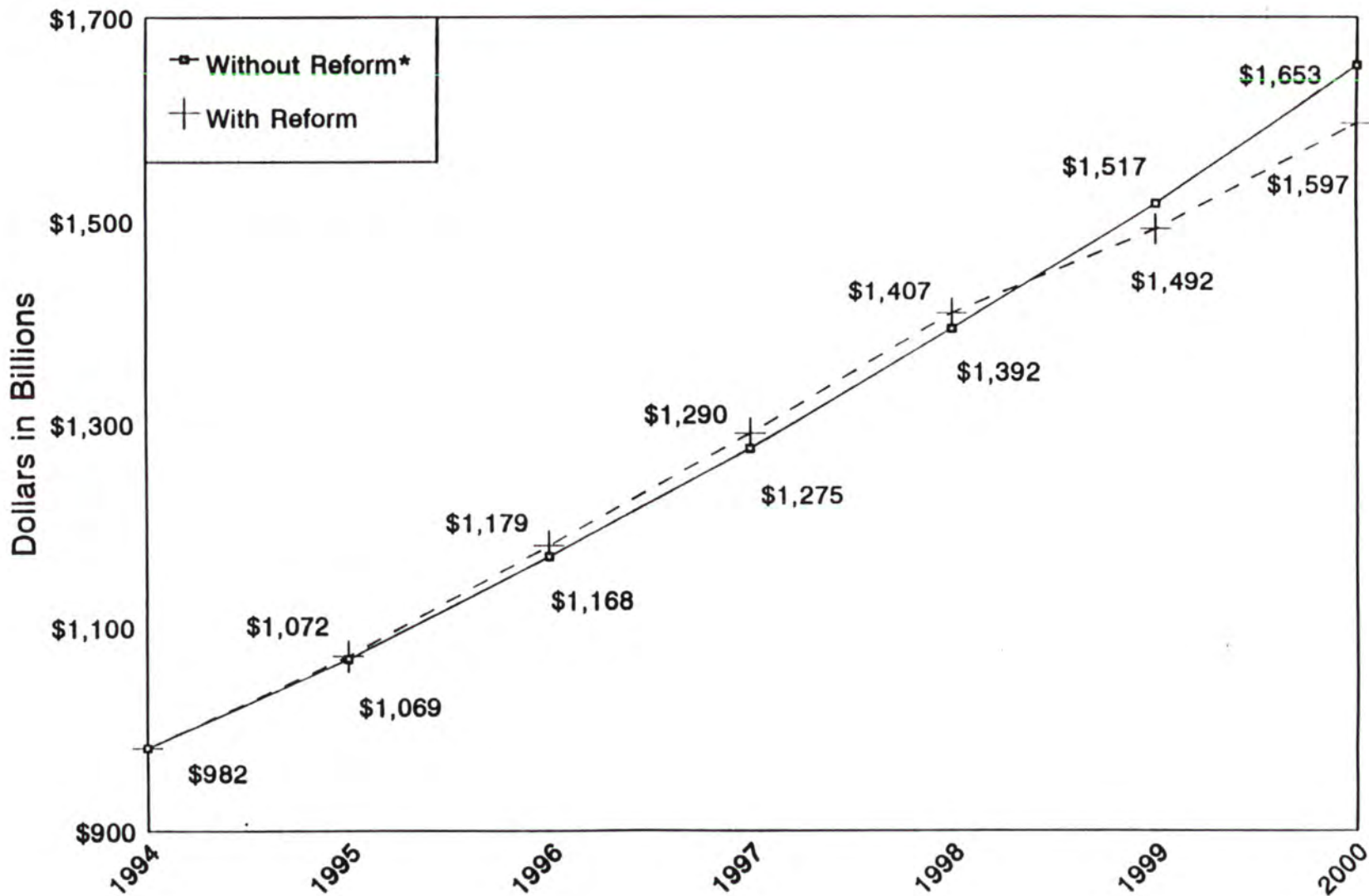


Chart I-B

SOURCE: Administration Estimates.

* CBO baseline with Administration's economic assumptions.

BROOKINGS INSTITUTION

Questions and Answers

February 28, 1994

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BROOKINGS INSTITUTION

Questions and Answers

February 28, 1994

I. FINANCING / MANDATES

Q: *Why do you need an employer mandate?*

A: Let's start with the President's bottom line: guaranteed private insurance for all Americans.

While there is more than one approach to universal coverage, building on the existing employer-based system makes the most sense. 9 out of 10 people who have private insurance get coverage through their job. Except for the very smallest firms -- those with 5 or fewer employees -- the vast majority of firms in the U.S. offer their workers health benefits. And many of these smallest firms say that they would provide if they could afford it. Our goal is to bring those now getting a free ride into the system -- to lighten the load of those now providing insurance -- and to aggressively control costs to make insurance affordable for even the smallest firms.

Requiring all employers to contribute builds on what works, and is a proven means of reaching universal coverage through the private sector. The state of Hawaii has had a universal system based on an employer mandate for nearly 20 years, and the results are impressive: the unemployment rate is one of the lowest in the nation, small business creation rates have remained high (the number of employers grew almost 200% from 1970 to 1991), and the rate of business failures in Hawaii remained less than half the national business failure rate.

Every other state that has passed legislation or looked seriously at this issue universally agrees that an employer mandate is the best and most expedient route to full coverage. Two of the three states that passed comprehensive reform legislation last year -- Oregon and Washington state -- passed legislation based on an employer mandate. The third state, Florida, passed a managed competition plan that set up alliances and health plans, and Florida's governor Lawton Chiles has said that the missing piece that will bring universal coverage to Floridians is a national system based on the President's plan.

Combining the goal of universal coverage with the firm belief that health care can and should remain in the private sector means employers have to be involved in providing their workers' insurance.

Q: *Aren't the government discounts in your proposal just another uncapped entitlement?*

A: No. The Health Security Act provides discounts on the price of insurance for small businesses and low-income people. And the amount of discounts provided was said to be sufficient by an independent study done by Lewin-VHI. But the plan also sets a limit on the amount of these discounts that can be spent automatically. We felt an open-ended entitlement left the federal budget vulnerable to unpredictable costs in the future, and that was not an option. This program must pay for itself, and costs must be clear and predictable. If the amount specified for discounts -- plus a 15% cushion -- is spent, Congress has to review the discounts and take action. This trigger represents the President's strong commitment to fiscal responsibility.

That said, we are confident we have been conservative in estimating the needed funds for discounts. These estimates are based on sophisticated models built from very specific information about factors like family income data, numbers of firms at certain sizes and wage-rates, etc. Some behavioral changes -- both positive and negative -- are difficult to quantify in a program of this magnitude. This is why we have also specifically built in a cushion for these unknowns, giving us even greater confidence in these estimates.

Q: *What will happen when the cap is hit and there's no money left?*

A: That's very unlikely. We believe that there are enough protections within the system to prevent us from ever reaching that point, including early warning mechanisms that allow alliances to take action before problems even arise.

Our plan is based on the most responsible financing possible and on very conservative assumptions. As just one example, we overestimated the demand for discounts for small businesses and low-income families in order to be as conservative as possible. In addition, we have a 13 percent "cushion" -- about \$41 billion -- to cover unexpected costs. We ran sophisticated models to test how the system would respond to extreme hypothetical situations. For example, an unexpected increase of two percentage points in unemployment - with millions more suddenly qualifying for discounts -- would require an additional \$4 billion a year. In 2000, the cushion is \$12 billion -- three times the funds necessary for this extreme situation, and any funds that are not used in one year can be carried over to the next year so that a contingency reserve will build over time.

So, the system is designed to prevent the kind of situation you're talking about. We believe the financing is solid and the early warning system will be effective. But, if Congressional action is needed, it will be taken. It could mean limiting the amount of money spent on discounts or it could mean raising additional revenue. The important thing is that Congress and the President will have to re-examine the system, identify the problems, and decide what to do. They cannot just let federal health spending increase automatically -- as it has in the cases of Social Security, Medicare and Medicaid. This mechanism ensures that type of accountability and fiscal responsibility that the American people demand from their government.

II. ALLIANCES

Q: Why do you need these big, regulatory alliances?

A: The issue really isn't how many alliances there are or how big they should be, the issue is how to best bring about the changes to the insurance market that almost everyone agrees are necessary. And all the major plans -- Cooper, Clinton, Chafee-- think some type of group purchasing is the best way to do that.

Today's insurance market is fragmented and overly bureaucratic, filled with different companies, agents, marketers and underwriters selling different plans with different benefits, exclusions, co-pays and deductibles. Insurance companies are in the driver's seat today -- and they compete by selecting only the healthiest people possible to insure. Small groups and individuals have no bargaining clout, and as a result are often charged the highest prices, get the worst benefits, or can't buy insurance at any price.

Under reform we want to consolidate the buying power of small and mid-sized employers, increase choices for consumers, and limit health cost increases for consumers and small and large employers. That's the idea behind the alliance.

Alliances allow you to have one set of rules all private insurance plans follow, not several hundred insurers each setting their own rules. They allows businesses and families the broadest range of choices possible regardless of how much money they make, what company they work for, or whether they've ever been sick. And it returns insurance to what it was meant to be -- spreading risk over a whole community of people and charging everyone the same price for insurance, regardless of their age or their job or their health.

Alliances also enforce consumer protections -- making sure every person is provided with a choice of plans and good information about each plan to help them decide; making sure anyone unhappy with their insurance can switch to a different plan each year without penalty; making sure all health plans meet tough quality standards and provide all covered services; and guaranteeing that insurance premiums only go up by a certain amount each year.

An increasing number of employers in both the public and private sectors have used similar approaches with positive results. The state employee health programs in Minnesota, California, and Wisconsin have done this, as have large companies such as Xerox, Digital, and GTE.

Q: *Why are these alliances so bureaucratic? The last thing we need is a big government bureaucracy.*

A: The last thing we want is big government bureaucracies, and that is exactly why we rejected a government-run plan. What we designed instead is a plan that calls for the minimal amount of new government needed to ensure that the market is providing real choice, real quality and real competition that serves the consumers -- and not the health care industry at the expense of the rest of us. We expect most alliances will be run by groups of local businesses and consumers. They will not be run by the government. Alliances are purchasers, not government regulators. We expect the alliance will function on a budget of about 2% of premiums -- reflecting savings that will result from the consolidation of administration, marketing, and purchasing for all companies within the system.

Alliances replace thousands of small inefficient purchasers of insurance (small and mid-size employers) with one larger, stronger, more sophisticated buyer that's able to wield bargaining power to get better value and offer much more choice to individuals. People will continue to get their care through private health care plans.

Q: *If alliances are so wonderful, why are they not voluntary?*

A: One of the fundamental ways that we are going to fix our system so that we get both savings and quality is to create a health care system where competition takes place on the basis of the price and the quality of the product and services provided and not on which insurer is best at risk selection. Our plan creates a competitive, private market system where the incentives encourage competition on cost and quality and not on becoming the best at excluding those who are sick, or who might become sick.

If the alliances were voluntary, or if there were several competing alliances in one area, we would just be recreating another system where there would be incentives for competing on the basis of risk selection instead of quality. If alliances were voluntary, employers with younger, healthier populations might all be enticed by the "risk-selecting" insurers offering attractive prices to go outside the alliances (at least until their employees got older or sicker) to purchase insurance -- leading to a new form of competition on risk selection. This would leave older and sicker people vulnerable to high prices and limited choices within the voluntary alliance. One alliance can offer consumers a full choice of plans at a range of prices. It guarantees security, maximizes choice and competition, and minimized the incentives for risk selection.

Follow-up: Why not competing alliances?

One alliance can offer all individuals the full range of choices of health plans. That's what people are buying -- a health plan, not an alliance. The only real difference between alliances could be the price of plans -- which would be based largely on risk-selection, the very thing we are trying to get away from. Then we would need to have another agency risk-adjusting between alliances.

Q: *Why are all companies with fewer than 5000 employees required to join alliances? The Cooper plan has a 100 employee cutoff? Isn't there a compromise?*

A: Most of the innovative strategies to control costs in the business world have come from firms with over 5000 employees because they have enough participants to get reasonable rates. As the alliance becomes smaller, it becomes harder and harder to offer a wide variety of choices and to keep prices down through competition. There's no question: the larger the alliance, the better their bargaining power. And it's tough to think about enforcing the insurance reforms everyone thinks are necessary without a central way of doing it. Without that, there is almost nothing that can be done to prevent insurance companies from continuing to pick and choose whom to cover, offering the best prices to the healthiest people and refusing to cover sick or old people all together.

Still, there are legitimate issues to be worked out on the size of the alliance, and we expect this will be a significant point of discussion in the committees. What is important is that all businesses have the clout to bargain for good prices, and that insurance reforms are real and enforceable.

III. SAVINGS / PREMIUM CAPS

Q: What makes you think that you can squeeze so much savings from the system?

A: I realize we may be more optimistic about the amount of savings that we can get from the current system than many people in this room. I respect that. I can only tell you about the hundreds of people that my husband and I have spoken to over the past few years. Every doctor, every nurse, every patient -- everyone who comes into contact with today's health care system -- will tell you that there is an incredible amount of waste and excess and inefficiency. Dr. C. Everett Koop, who was Surgeon General under President Reagan, thinks that there is over \$200 billion in waste that we can eliminate by reforming the system. This explains why our international competitors spend so much less than we do on health care -- while insuring all of their people with richer benefits than the average American currently has.

For an example in the United States, look at the Mayo Clinic in Minnesota. It provides some of the highest-quality care in the country and has kept the growth in its costs down to 3.9% a year. Look at the California Public Employees Retirement System -- a working health alliance -- which had costs increases of 3.1% last year compared to 13.2% for California as a whole.

Study after study shows inexplicable cost differences -- between two hospitals in the same state, between two bordering regions, from one city to the next -- that have nothing to do with the quality of care or with the results. If we have more and better information about the cost and results of different kinds of treatments, as the President's plan calls for, then we can examine more of these discrepancies, and figure out how we can save money and provide better quality care.

So I say: instead of going to the American people and imposing broad middle class taxes, as some suggest, let's try and save some money from the current system. Other countries have done it, individual states have done it, and we can do it as well.

Q: How can you control rising health care costs when one of the main reasons costs increase is due to technological change that saves people's lives?

- A: History has shown that technological change responds to market incentives. Our current system encourages producers of new technologies to charge whatever the market will bear, in an environment that lacks cost-sensitivity on the part of both providers and consumers. No wonder costs are skyrocketing out of control.

Better technology can lead to either higher or lower spending depending on whether the new technology is more expensive than the therapies that it replaces. For example, if a drug that cures Alzheimer's is cheaper than the cost of caring for a person in a nursing home, the new technology actually reduces health care costs. If the drug costs more than a nursing home -- which often happens in our current system because manufacturers know people are willing to pay a high premium for these products -- costs will increase. Our plan increases the incentives in the system for cost-effective technologies that increase the quality of care while decreasing costs.

Our plan encourages competition on quality and price, and increases the cost-sensitivity of both providers and consumers. We provide better information and give individuals the opportunity to choose plans that provide the best care at the lowest price. In this newly-created competitive environment, I would expect that there would be a race to provide the best therapies at the lowest cost -- and technological change would reflect the presence of these new incentives.

- Q: *There have been many reports that states with a high percentage of the population in managed care have had the same increases in health costs as states with very few of their citizens in managed care. So why do you think that managed care can really lower costs?***

- A: We believe that managed care can significantly lower costs, but not in a fragmented insurance market operating on a blank check.

Today, managed care entities can take advantage of the greater efficiencies brought about by more integrated delivery of care and better attention to primary care, and can operate at costs far lower than traditional insurance plans. However, in a market with little or no price sensitivity and no cost discipline, managed care entities "shadow price" -- pricing their insurance premiums at just below those offered by traditional insurance plans.

In other words, even if an HMO can deliver health care and make a good profit by charging \$200 for a monthly premium, if their only competition is a fee-for-service plan charging \$400, the HMO might charge \$375 and still attract many enrollees.

When managed care is combined with incentives to committee on both quality and price, costs can decrease dramatically. The experience of groups like CalPers and the Minnesota Public Employees system shows that managed care entities bidding for business against aggressive competitors price significantly lower than they do for the rest of the market. Florida is now seeing that same phenomena at work as they begin to take bids for their health alliances.

Q: *What do you say to the charge that your premium caps in the Clinton bill are so tight that no nation on earth has achieved them?*

A: The critics who claim that the rate of growth needed to reach the administration's premium caps has not been attained in other industrialized countries, and is therefore not realistic, are missing the point. As the U.S. phases-in universal coverage, the administration predicts a major expansion in health expenditures -- rising *above* where they would have been without reform. Under the administration's proposal, health expenditures as a percent of GDP are projected to increase from 14.5% of GDP in 1994 to 16.9% in 2000. Far from being unattainable, this is a more rapid increase in the share of resources devoted to health care than has occurred in any other country in a comparable time period. It is only after this substantial increase that we predict the rate of growth to slow and come into line with our GDP -- an essential goal if we are ever to control long-term deficits and maintain our international competitiveness.

Other industrialized countries -- such as Germany and Japan -- have been successful at keeping their rate of growth in national health expenditures in line with their rate of growth in their nation's GDP. At the same time that their costs have been kept under control, the quality of their health care has remained high. Both countries guarantee comprehensive insurance to all their citizens with health outcomes that are in many cases better than the U.S. For example, from 1981 to 1991, Japan's GDP grew at an average of 5.5% while its national health expenditures grew at an average of 5.4%. Even with our premium caps, we predict that in the first five years of reform, our national health expenditures will expected to rise by 8.5% while GDP will rise by 4.4%.

Q: *It seems like health care inflation is coming down by itself, so do we really need to do so much?*

A: Although recent reports have indicated that medical inflation did not rise as quickly last year as it has in the past -- this is, by itself, no reason to let our guard down. First of all, historically, every time comprehensive health reform has loomed on the horizons, those who profit from the waste and excess in the health care system have curbed their excessive prices for a time. The most graphic example came during the Carter administration, when the White House was pushing a hospital cost containment bill and crafting a proposal to extend health coverage to all Americans. The annual increase in inflation-adjusted national health spending slowed from 5% in 1978 to 1% in both 1979 and 1980. When President Carter's proposals died, health inflation skyrocketed back up to 5% in 1981 and by 1983, inflation-adjusted health spending was growing at 7% a year.

You should also note that medical costs are still rising two to three times as high as other prices. The average employers' cost for health care benefits rose by 8% last year -- exceeding by far the 2.5% to 3% overall rate of inflation. And more than two thirds of companies with over 200 employees reported that their health care costs rose last year. And, this does not even include small companies, whose annual costs rise significantly more than those of large companies.

IV. CBO

Q: *What is your response to the CBO analysis? Wasn't there a huge discrepancy between your estimates and CBO's on the deficit?*

A: The fundamental premise of the President's approach to health reform is that we can guarantee private insurance to every American and still reduce the amount the nation spends on health care. The Congressional Budget Office completely validated that premise.

In fact, the CBO determined that, **between the years 2000 and 2004, we will be able to guarantee private insurance to all Americans while spending \$413 billion less on health care.** That's \$413 billion that can go to higher wages for American workers, money that businesses can invest and use to create jobs, and increased savings.

The CBO and the Administration agree that the President's approach will save money. In fact, the two estimates of savings in national health expenditures are very close. The difference between the Administration and the CBO analyses is that CBO predicts that these savings will initially go to businesses and state/local governments. [con't]

In contrast, the administration expects these savings to initially go to the federal government and therefore to immediately begin to reduce the deficit. The \$133 billion "difference" in the CBO and the Administration deficit estimates -- which is described as "*small potatoes*" by the CBO Director itself -- is a result of these differing assumptions. **Nonetheless, the CBO too projects long-term deficit reduction.**

This issue clearly can be resolved. Since we are in agreement on the essential framework, the deficit issue is something that can be easily worked out as the proposal proceeds through what will be a very substantive process in the U.S. Congress. **We stress that the President's health reform proposal will pay for itself and reduce the deficit.**

Q: What is your response to the CBO decision to put the health premiums on the budget?

A: We agree with CBO that the full operations of the reformed health system should be prominently displayed in one place in the budget. It is important that the public be able to see not only the federal contributions to the health system, but also corporate, private, and state contributions displayed together. We disagree with CBO, however, regarding the treatment of premiums for private health insurance as government receipts. Government receipts are received by the government. Premium payments for private health insurance under the Health Security Act should not be government receipts any more than payments currently made by employers to private insurance companies on behalf of tens of millions of Americans are government receipts. Thirty-nine states today have requirements that their residents purchase auto insurance. The resulting payments -- between these people and their insurance companies -- are *not* counted as part of state budgets, nor would anyone expect them to be.

V. MISCELLANEOUS

Q: I am worried that there is so much uncertainty that it will freeze companies from hiring more people just when the economy might be picking up.

A: I think that uncertainty has hurt job growth in this country for some time -- in large part because this nation had no economic plan and employers did not know how fast health care costs would continue to rise or how much the deficit was going to increase. Now this administration has already passed the largest deficit reduction plan in history, and long-term interest rates are at historic lows -- reflecting more certainty about a stable economy in the future. The economy has created more private sector jobs under the first 8 months of this Administration as it did during the last four years. And our health care plan will ensure that health care spending will be under control and predictable as well.

Controlling health care spending is probably the best thing that could happen to the American economy and to American workers. Right now skyrocketing health care costs are bankrupting American businesses and weakening our ability to compete in the global marketplace. How are U.S. car companies expected to outsell Japanese competitors who spend \$550 less per car to cover their workers? How are American workers supposed to boost their productivity when they show up to work sick because they can't afford to see a doctor? Reforming health care and reining in costs will be a real plus for American business. And it will produce a more productive, more flexible American workforce and encourage -- not discourage -- employment.

We know that as we take this next step in regaining control of our economic destiny and create more certainty in the market through health care reform, there will always be naysayers who make wild accusations and misunderstandings. But -- with the vigilant help of the people in this room -- people will come to see that what we are doing is reasonable, just as they did with our economic plan.

Q: *My company self-insures and this gives us a great economic incentive to take good care of our employees and bring down our costs. Why are you taking these incentives?*

A: We compliment the companies that have recognized that it makes good economic sense to keep workers healthy rather than just pay for their care once they're sick. The incentives to keep workers healthy will not change under our plan. Healthy workers are, in most cases, productive workers. If employers to be competitive in today's marketplace, they have incentives to increase productivity and minimize employee's sick leave. Regardless of any new system put in place, employers who feel that they save money for their companies by taking extra steps to ensure that they have healthier, more productive workers and less absenteeism will still have that incentive.

In addition, we're adding these incentives to the whole system by guaranteeing that all plans will cover a broad range of primary and preventive services that few insurance plans companies cover today. Companies will no longer be forced to pick up the slack for benefits package shortfalls, because every one of their workers, no matter which plan they choose, will have full coverage of screenings, physicals and other preventive services to help keep them healthy.

Q: *I'm uncomfortable with the idea of a National Health Care Board.*

A: Well if we were creating a board like some opponents of reform have described, I would be uncomfortable with it too.

People who have opposed reform have seized on the National Board recently, exaggerating both its size and staff to mis-characterize it as a huge bureaucracy. The Board will set broad national guidelines for quality and then get out of the way and let states craft health care solutions that respond to their individual situations.

Limited to a small permanent staff, the National Health Board will oversee the state health plans and guarantee that they meet federal standards, update the standard benefits package, ensure that the quality of medical care doesn't suffer, and assure that the nation's health care needs are being addressed.

The Board will consist of only seven individuals, appointed by the President for staggered four-year terms. Recent reports have exaggerated the National Board's "enormous new federal bureaucracy" with "thousands of Washington bureaucrats." It has always been the position of the administration that if the Board has 100 employees, it will be many too many.

Q: *How do you respond to those who seek to cast doubt on your long-range cost estimates – claiming that when the Medicare program was enacted, it was estimated to cost about \$9 billion in 1990 but ended up costing \$66 billion – 7.5 times that amount?*

A: First of all, we have built the potential of unexpected costs into our models. Our plan is based on the most responsible financing possible and on very conservative assumptions. As just one example, we overestimated the demand for discounts for small businesses and low-income families in order to be as conservative as possible. In addition, we have a 13 percent "cushion" -- about \$41 billion -- to cover unexpected costs.

Secondly, we ran sophisticated models to test how the system would respond to extreme hypothetical situations. For example, an unexpected 2% increase in unemployment -- with millions more suddenly qualifying for discounts -- would require an additional \$4 billion a year. In 2000, the cushion is \$12 billion -- three times the funds necessary for this extreme situation, and any funds that are not used in one year can be carried over to the next year so that a contingency reserve will build over time.

Another example is our use of a very conservative inflation estimate -- even more conservative than CBO's assumption. CBO's mid-session inflation figure was 3.1%, while we used an estimate of 3.5%.

Q: *On early retirees, why do you provide this huge subsidy to employers and then take back all the money with an "assessment"? Isn't that just a new tax?*

A: Not at all. Here's how the policy works. Right now, more and more companies are being forced to drop benefits for early retirees. We thought it was important to protect working Americans from losing the benefits they've worked hard for all their lives. So when reform is fully implemented at the end of this decade, early retirees will become eligible for discounts requiring them to pay only the portion of their insurance premium that they paid as employees. We added two provisions to protect the federal budget and be as fiscally prudent as possible. This policy will generate substantial savings for many employers who now cover the health care costs of early retirees. In order to recover some of this windfall to employers, employers who benefit from this policy will be required to pay a portion of the savings -- the amount they would have otherwise paid -- for a three year period. In addition, these discounts phase out for retirees with an annual income higher than \$100,000 for an individual, or \$125,000 for a couple.

Q: *Didn't the CBO study say that there was a large incentives for firms to out-source or spin off their low wage workers to qualify for additional discounts?*

A: We realize that this is a possibility, and have put provisions in the legislation specifically to prevent firms from "gaming" the system to maximize the discounts that they receive. In the event that some firms find ways to reorganize and increase their discounts in spite of our efforts to prohibit them from doing so, our discount "cushion" should sufficiently cover these additional discounts -- ensuring that our financing estimates will hold over time.

Q: *What does it mean that the BRT rejected you and threw their support behind the Cooper plan?*

Obviously we are disappointed that the BRT didn't include guaranteed private insurance for every American as part of their starting point for health care reform, particularly since businesses now insuring have so much to gain through universal coverage.

We are certainly heartened that many prominent members of the BRT policy group, including American Airlines, (check with Marylin) and others have said they squarely support the President's direction for health care reform -- universal coverage, real cost control, reduced bureaucracy and increased choice.

On background: *It's also important to note that the BRT and the Chamber both oppose central elements of the Cooper / Grandy plan, most notably capping the deductibility of employer-paid health benefits. Saying you support Cooper except for the tax cap is like saying you support single-payer except for the government's role.*

COMPARISON OF ALTERNATIVE APPROACHES*

Crisis vs. No Crisis

Our approach is based on the fact that American families and businesses are facing a health care crisis.

Others have adopted the insurance company/Republican line that a crisis does not exist. They don't understand how Americans live.

Guaranteed Private Insurance vs. Continued Insecurity

Our approach guarantees private insurance for every American that can never be taken away.

Other approaches don't protect families from the threat of losing their insurance or solve the problem of rising costs.

People In Charge vs. Insurance Companies In Charge

Our approach puts individuals and small businesses in control of their health care choices.

Other approaches allow insurance companies to continue picking and choosing whom to cover, how much to raise your rates, and when to drop you.

Comprehensive Benefits vs. Bare Bones Benefits

Our approach guarantees a comprehensive benefit package, including preventive care and prescription drugs, with low deductibles.

Other approaches provide for a bare bones package with high deductibles.

Benefits Spelled Out in Law vs. Benefits To Be Determined Later

Our approach sets down in law the comprehensive health benefits that must be provided to every American.

Other approaches leave it to a government board to decide what benefits people should get; they want you to buy a pig in a poke.

Good For Seniors vs. Threatening To Seniors

Our approach preserves Medicare, adding new coverage for prescription drugs and more long-term care options.

Alternatives threaten Medicare, cutting its growth but providing no new benefits; they see Medicare as a bank to pay other bills.

* This does not apply to the single-payer proposal.