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**THE HEALTH SECURITY ACT:
A FINANCIAL AND DISTRIBUTIONAL ANALYSIS**

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A FINANCIAL AND DISTRIBUTIONAL ANALYSIS**

- I. NATIONAL HEALTH EXPENDITURES**
- II. IMPACT ON FEDERAL GOVERNMENT**
- III. IMPACT ON BUSINESS**
- IV. IMPACT ON FAMILIES**

**THE HEALTH SECURITY ACT:
A FINANCIAL AND DISTRIBUTIONAL ANALYSIS**

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NATIONAL HEALTH EXPENDITURES

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]

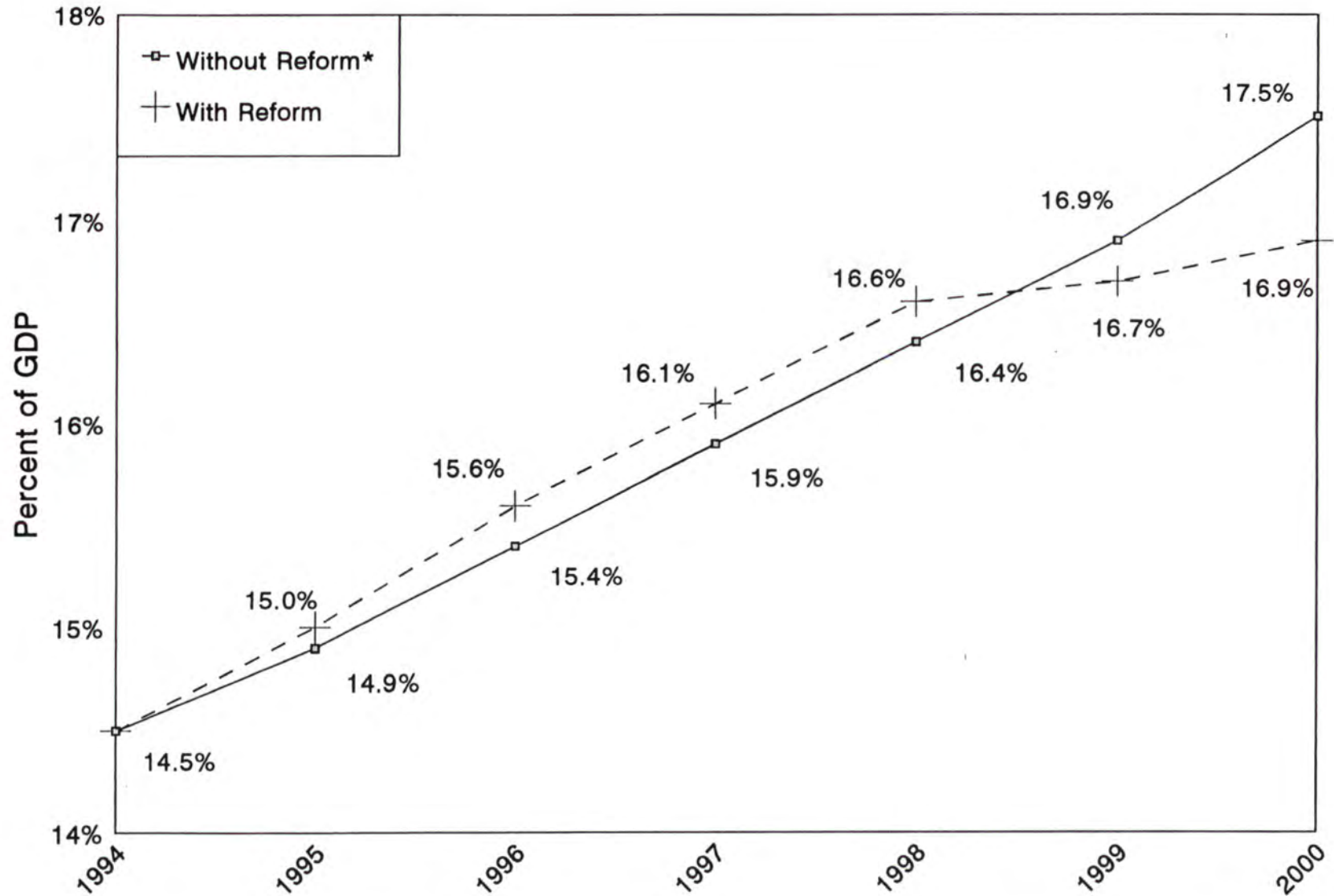
Under the Health Security Act, health care will consume 16.9 percent of GDP, or \$1.597 trillion, in the year 2000. This is \$56 billion lower than if there were no comprehensive reform. [Charts I-A and I-B]

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



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

Chart I-A

NATIONAL HEALTH EXPENDITURES IN DOLLARS

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

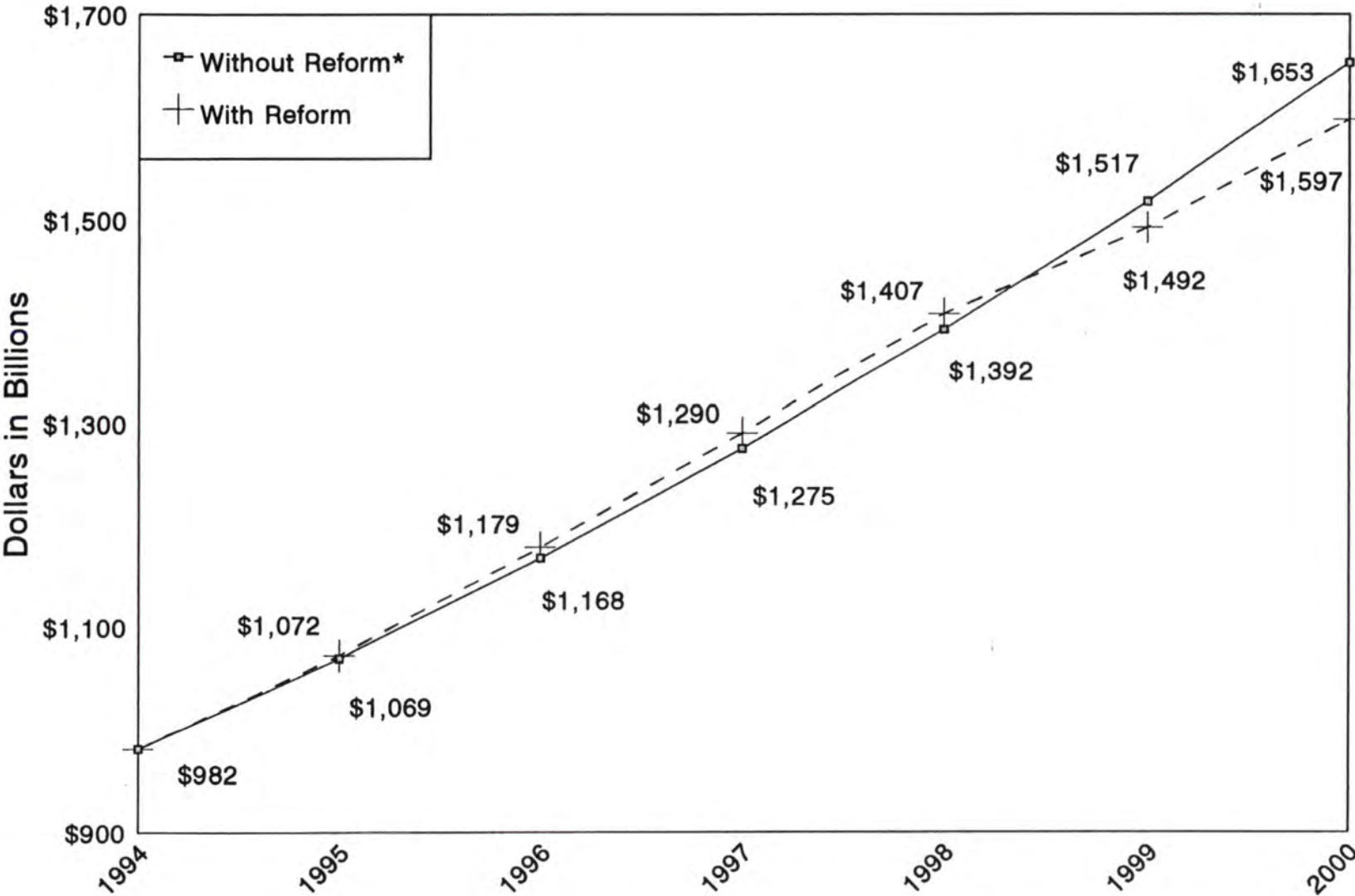


Chart I-B

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

IMPACT ON FEDERAL GOVERNMENT

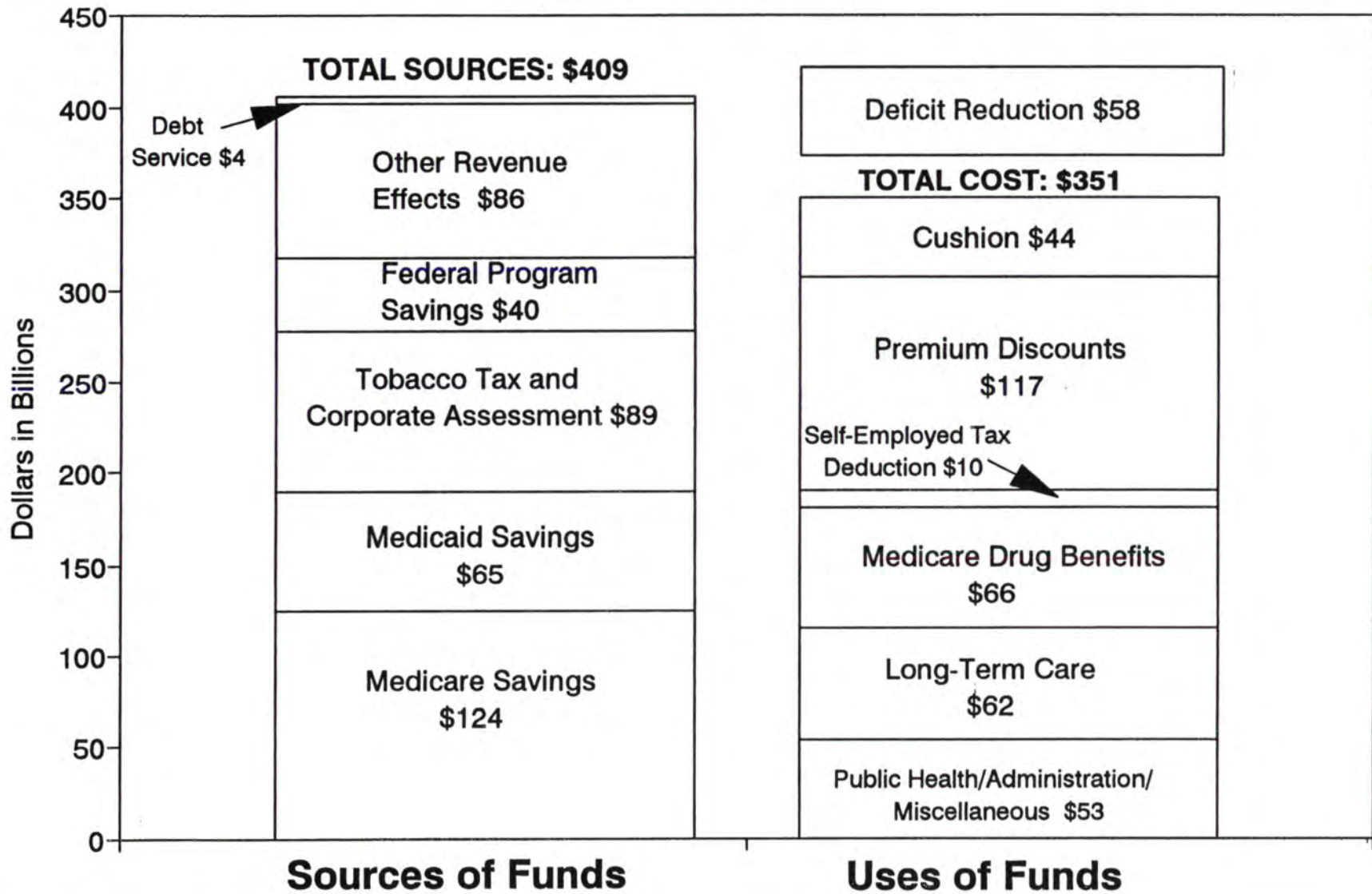
FINANCING HEALTH CARE REFORM

Totals: 1995 - 2000

- Under the Health Security Act, federal sources of funds (savings and resources) will total \$409 billion for the period 1995 to 2000. The total federal cost (expenditures) of health reform will be \$351 billion over that period. Thus, health reform will contribute \$58 billion toward deficit reduction in the first five years alone. [Chart II-A]
- The total estimated cost includes a \$44 billion discount "cushion", designed to ensure that there is adequate funding in the event of unanticipated economic or behavioral changes. [Chart II-A]

FINANCING HEALTH CARE REFORM

Totals: 1995 - 2000



SOURCE: Office of Management and Budget
Totals may not add due to rounding.

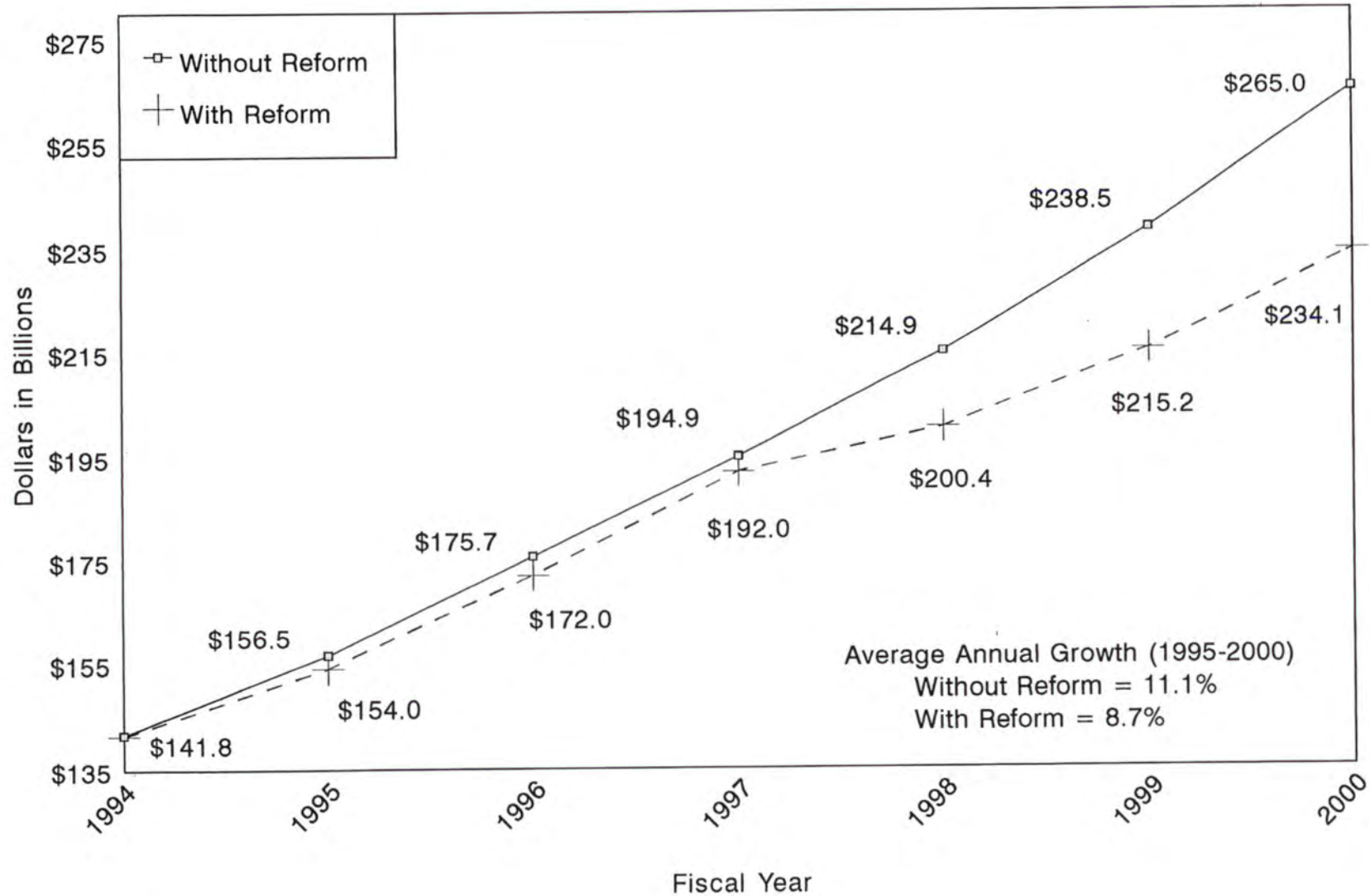
MEDICARE PROGRAM UNDER CURRENT POLICY AND THE HEALTH SECURITY ACT: 1994-2000

- Absent comprehensive reform, Medicare spending would grow at an average annual rate of 11.1 percent from 1995 to 2000. [Charts II-B and II-C]
- Including spending for the new prescription drug benefit, Medicare expenditures under the Health Security Act will increase at an average annual rate of 8.7 percent from 1995 to 2000. This is an average decrease of 2.4 percentage points due to the Health Security Act. [Chart II-B]
- Without spending for the new prescription drug benefit, Medicare expenditures under the Health Security Act will increase at an average annual rate of 7.2 percent for the same years. This is an average decrease of 3.9 percentage points due to the Health Security Act. [Chart II-C]
- Not including spending for prescription drugs, the Health Security Act will reduce Medicare spending by \$47.1 billion in the year 2000 alone. If spending for prescription drugs is included, Medicare spending will drop by \$30.9 billion in that year. [Charts II-B and II-C]

- Only 13 percent of all Medicare savings will be financed by beneficiaries. These savings will result from provisions such as coinsurance for home health care and laboratory services. [Chart II-D]
- Beneficiaries with annual incomes over \$90,000 for individuals and \$115,000 for couples will pay higher Part B premiums.
- Older Americans will pay an additional \$11.00 a month for the prescription drug benefit.

THE MEDICARE PROGRAM* UNDER THE HEALTH SECURITY ACT

Growth With and Without the Health Security Act
(With the Prescription Drug Benefit): 1994 - 2000



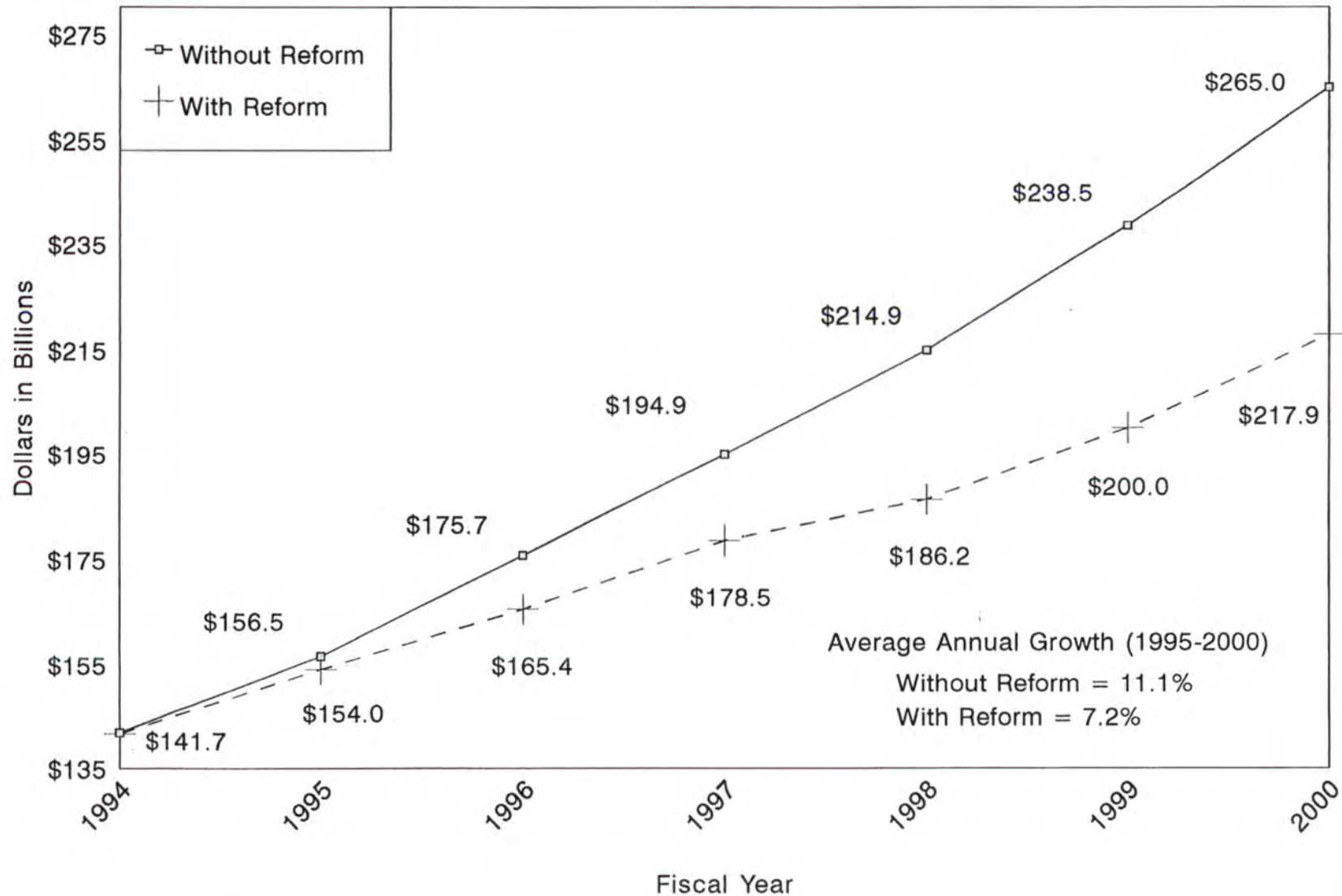
SOURCE: Office of the Actuary, HCFA.

* Net of Offsetting Receipts

The proposed Medicare drug benefit becomes effective in 1996.

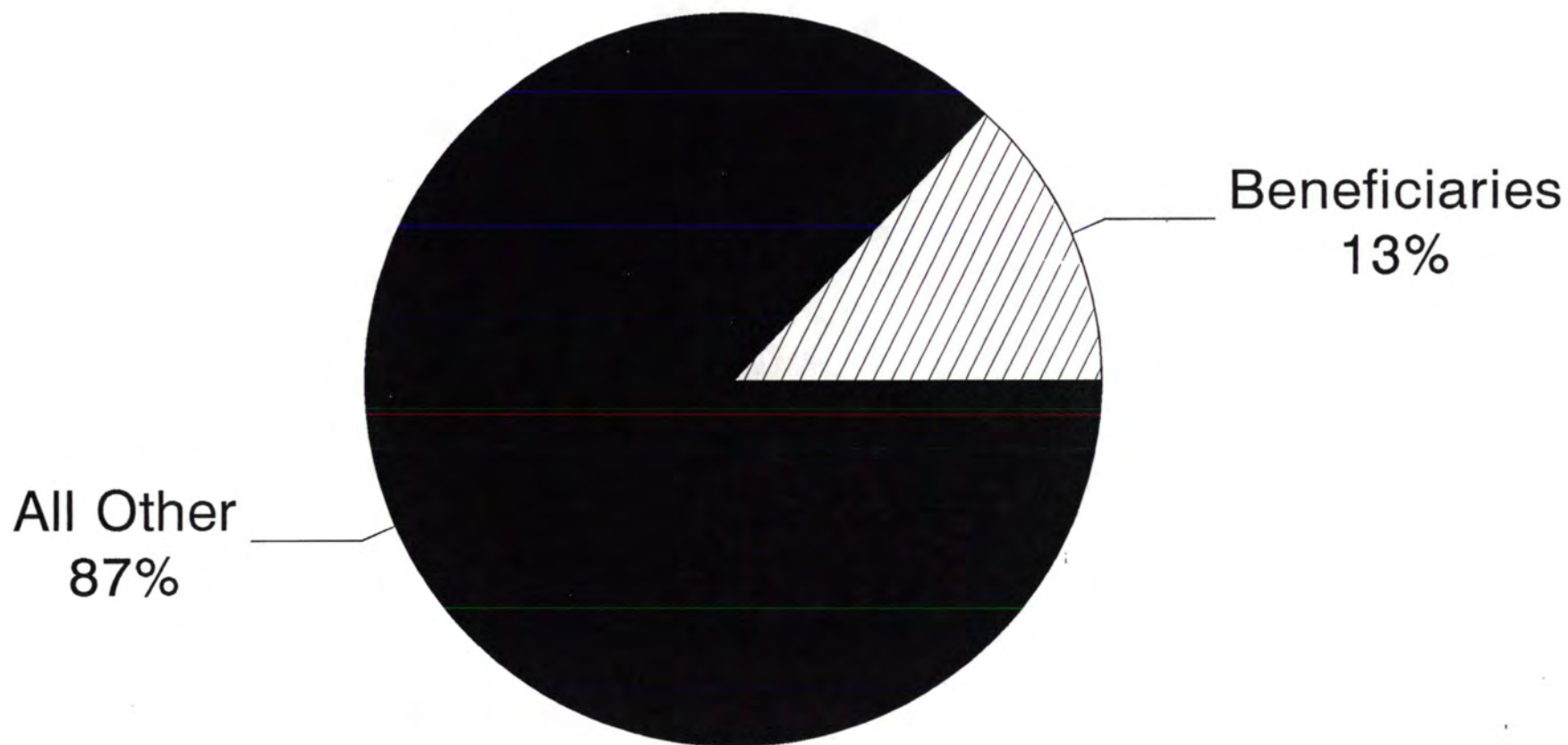
THE MEDICARE PROGRAM* UNDER THE HEALTH SECURITY ACT

Growth With and Without the Health Security Act
(Without the Prescription Drug Benefit): 1994 - 2000



SOURCES OF MEDICARE SAVINGS

Beneficiaries v. All Other: 1995 - 2000



MEDICAID PROGRAM UNDER CURRENT POLICY AND THE HEALTH SECURITY ACT: 1994-2000

Without comprehensive reform, federal spending for Medicaid would grow at an annual rate of 12.2 percent from 1995 to 2000. [Chart II-E]

Under the Health Security Act, federal Medicaid spending will increase at an annual rate of 8.5 percent for the same years. This is an average decrease of 3.7 percentage points due to the Health Security Act. [Chart II-E]

The Health Security Act will save \$27.8 billion in federal Medicaid spending in the year 2000 alone. [Chart II-E]

THE MEDICAID PROGRAM UNDER THE HEALTH SECURITY ACT

Growth With and Without the Health Security Act*

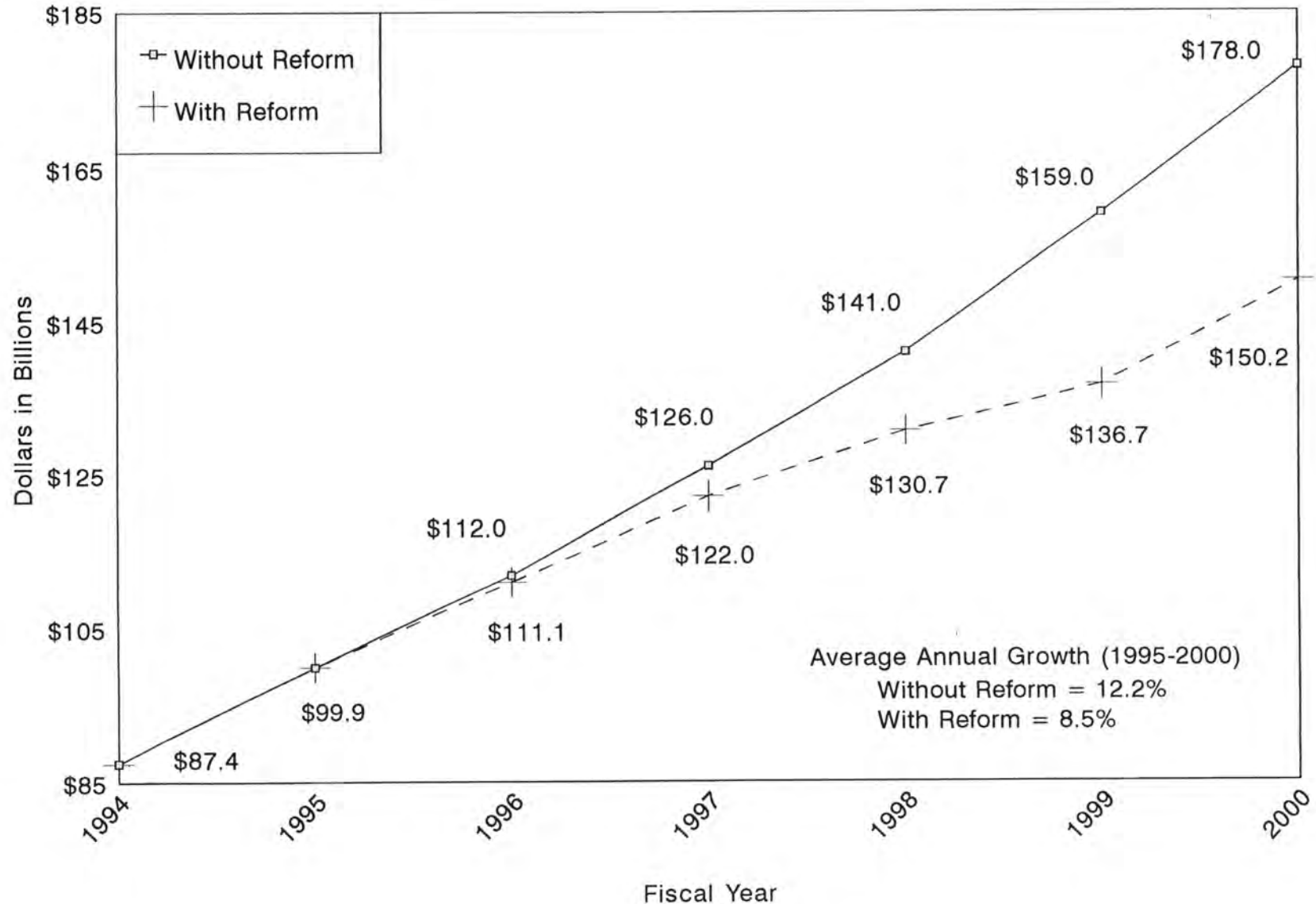


Chart II-E

SOURCE: Office of the Actuary, HCFA.
 * Federal expenditures only.

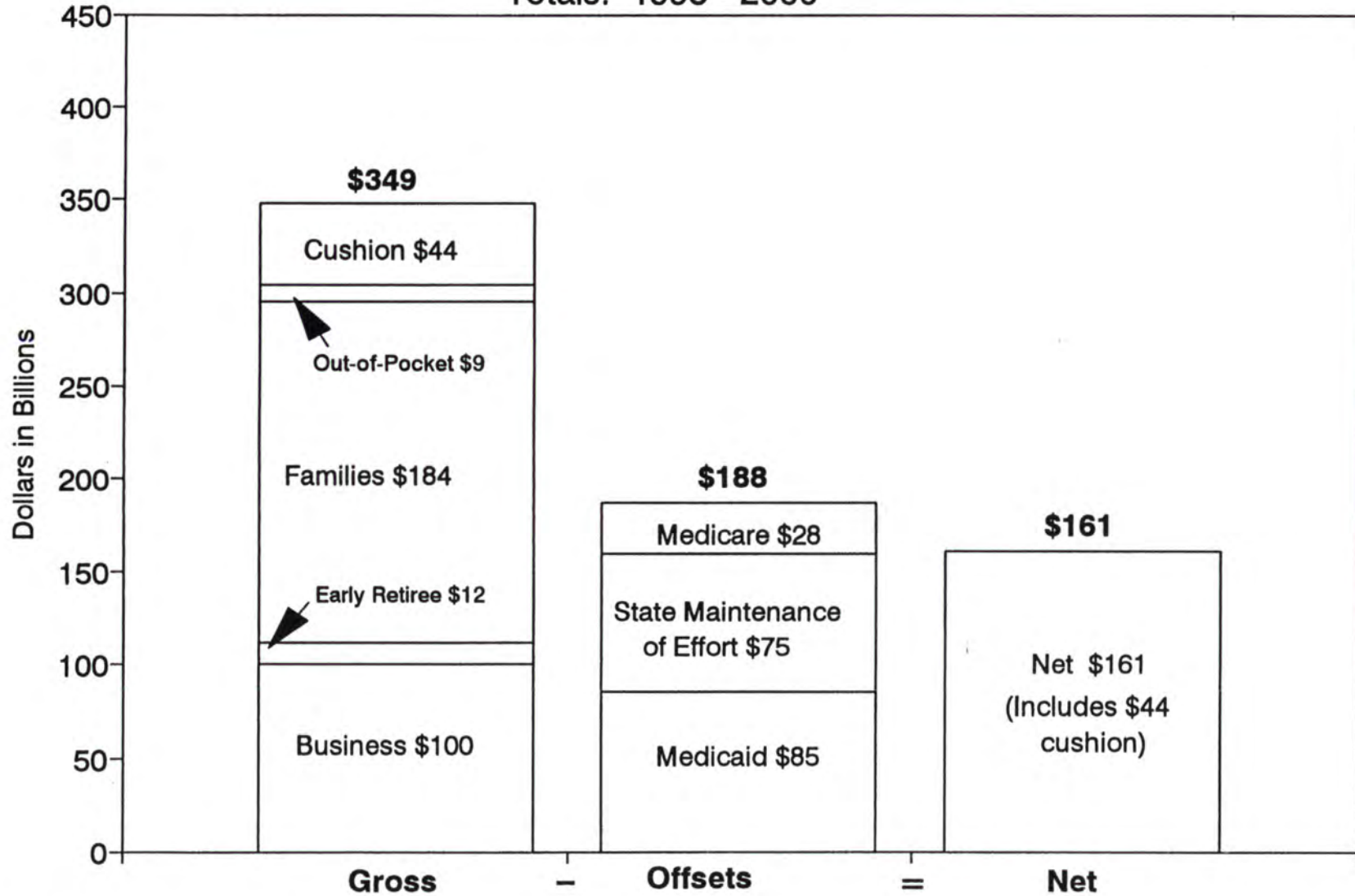
COST OF DISCOUNTS
For Families, Businesses, and Early Retirees
Totals: 1995 - 2000

- The federal government will provide discounts totalling \$349 billion for the period from 1995 to 2000. This cost will be partially offset by \$188 billion which will be saved because some persons who used to be in public programs will move into alliances. Thus, the net cost of the discounts will be \$161 billion for the period from 1995 to 2000. [Chart II-F]
- The net cost includes a \$44 billion "cushion", designed to ensure that there is adequate funding in the event of unanticipated economic or behavioral changes. [Chart II-F]
- Excluding the cushion, about \$184 billion (60 percent of the total cost) will be used for premium discounts for families. About \$100 billion (33 percent) will be for discounts to businesses. Approximately \$12 billion (4 percent) will be for discounts for early retirees, and \$9 billion (3 percent) will be for individuals' out-of-pocket expenses. [Chart II-F]

COST OF DISCOUNTS

(For Families, Businesses, and Early Retirees)

Totals: 1995 - 2000



SOURCE: Office of Management and Budget

Chart II-F

IMPACT ON BUSINESSES

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT: 1994 - 2000

Absent comprehensive reform:

- Employer premium payments will increase from \$180 billion in 1994 to \$303 billion in 2000. [Chart III-A]
- This correlates to an increase in percent of payroll spent on health insurance from 5.8 percent of total payroll to 7.0 percent of total payroll, and an increase in per worker premium expenditures from \$1,540 in 1994 to \$2,473 in 2000. [Charts III-B and III-C]
- This represents an overall increase in premium payments of nearly 70 percent.

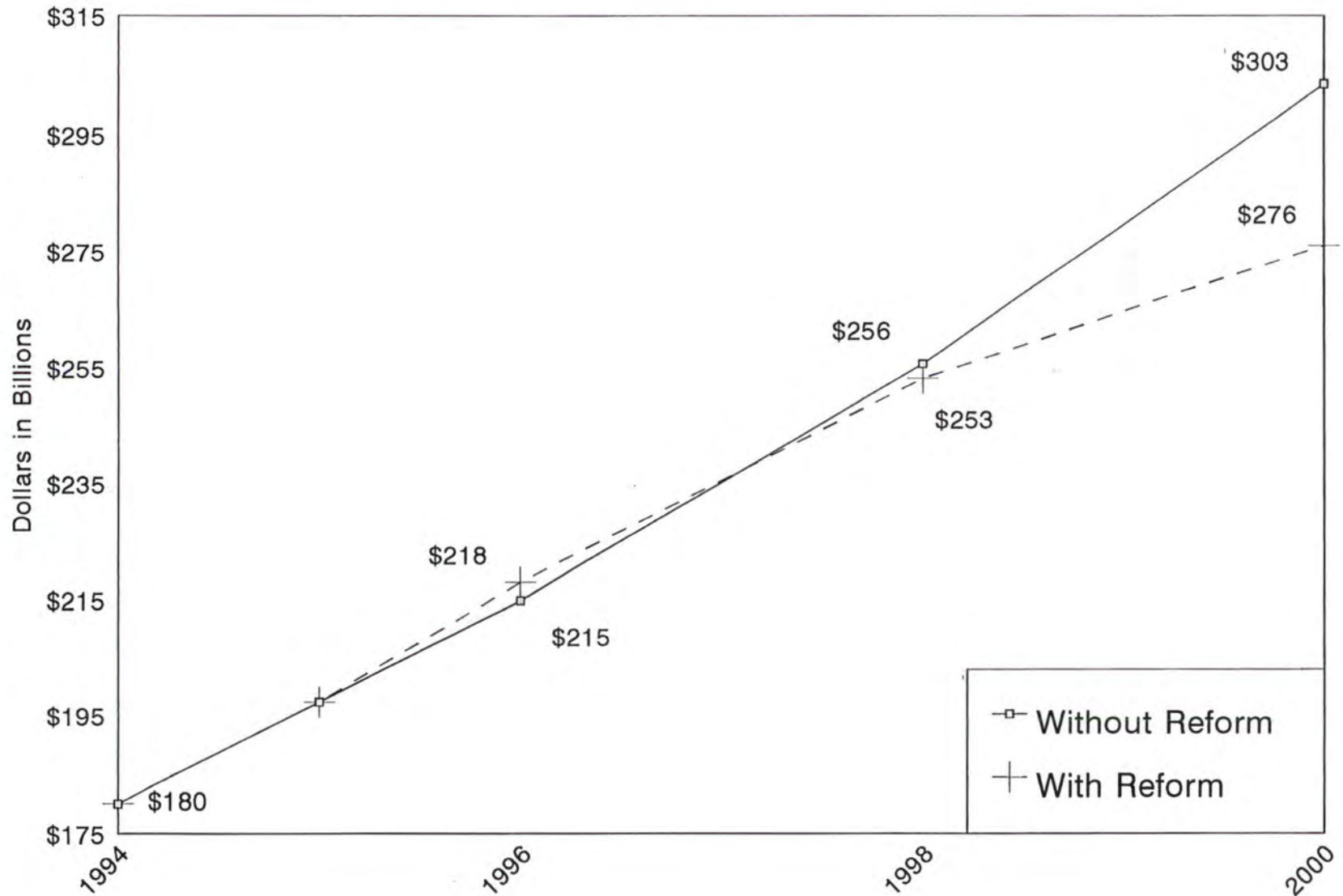
Under the Health Security Act:

- Employer premium payments will only rise from \$180 billion in 1994 to \$276 billion in 2000 -- **\$27 billion less** than would have been the case without reform. [Chart III-A]
- This correlates to a smaller increase in percent of payroll spent on health insurance -- only 6.4 percent with reform. [Chart III-B]

- Per worker premium expenditures increase at a slower rate, from \$1,540 in 1994 to \$2,245 in 2000. [Chart III-C]

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Annual Employer-Paid Premiums: 1994 - 2000

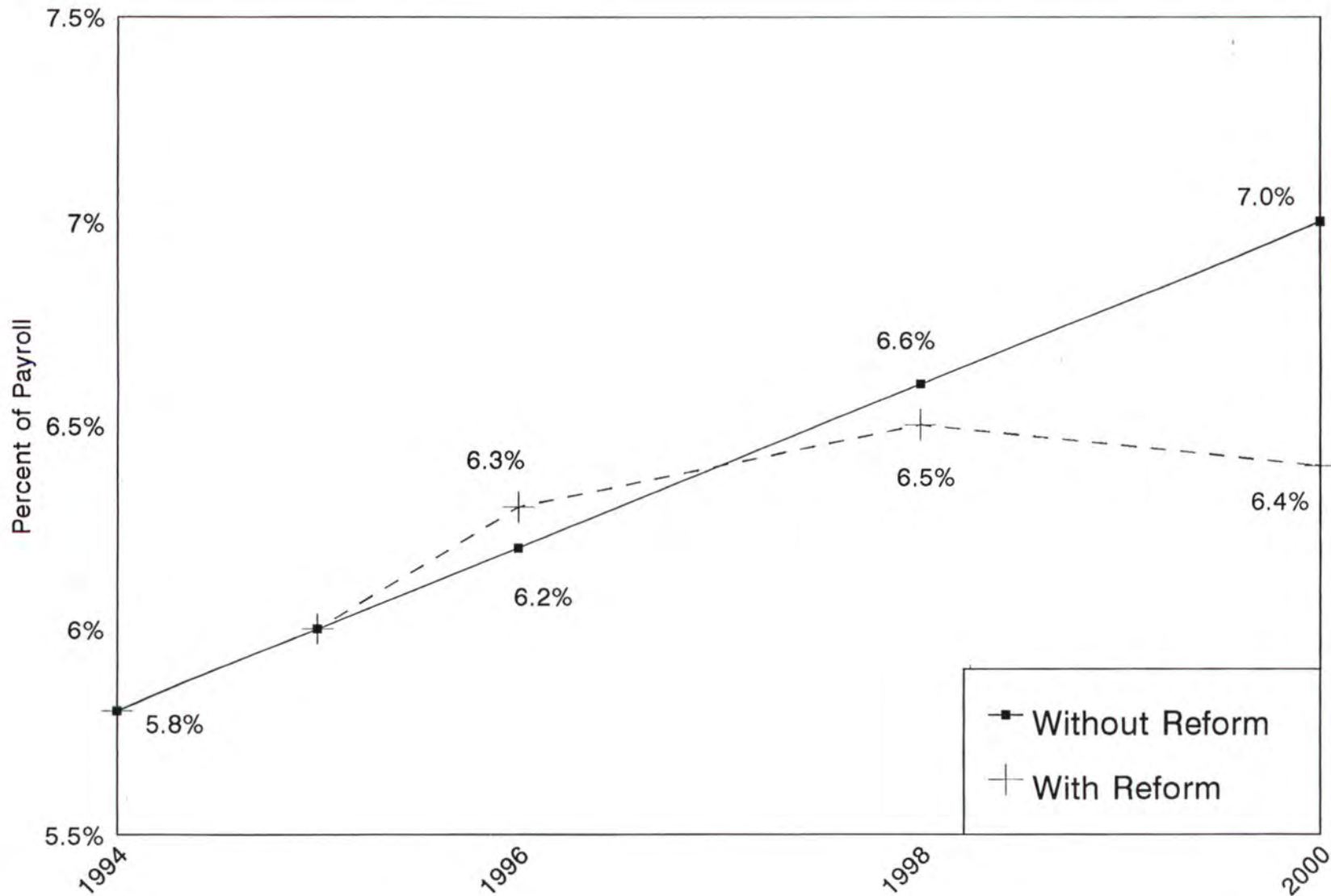


SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

Chart III-A

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

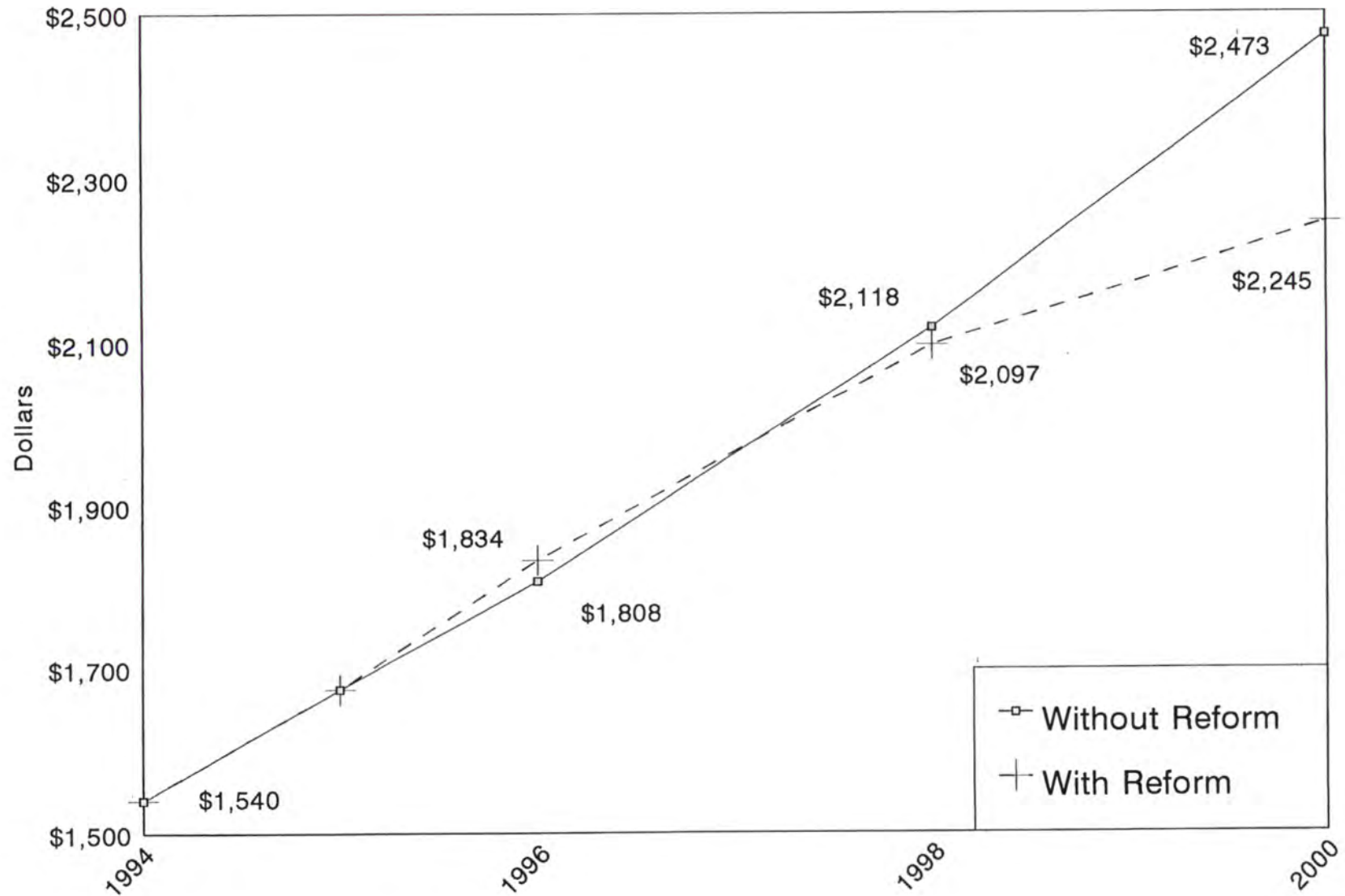
Average Annual Percent of Payroll: 1994 - 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker: 1994 - 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT For Firms Currently Offering Insurance: 1994 - 2000

Absent comprehensive reform:

Employer-paid premiums for firms that currently offer insurance would rise at a rate of approximately 70 percent, from \$180 billion to \$303 billion between 1994 and the year 2000. [Chart III-D]

This results in an increase in percent of payroll spent on health insurance from 6.8 percent of total payroll to 8.2 percent of total payroll, and an increase in per worker premium expenditures from \$1,923 in 1994 to \$3,086 in 2000. [Charts III-E and III-F]

Under the Health Security Act:

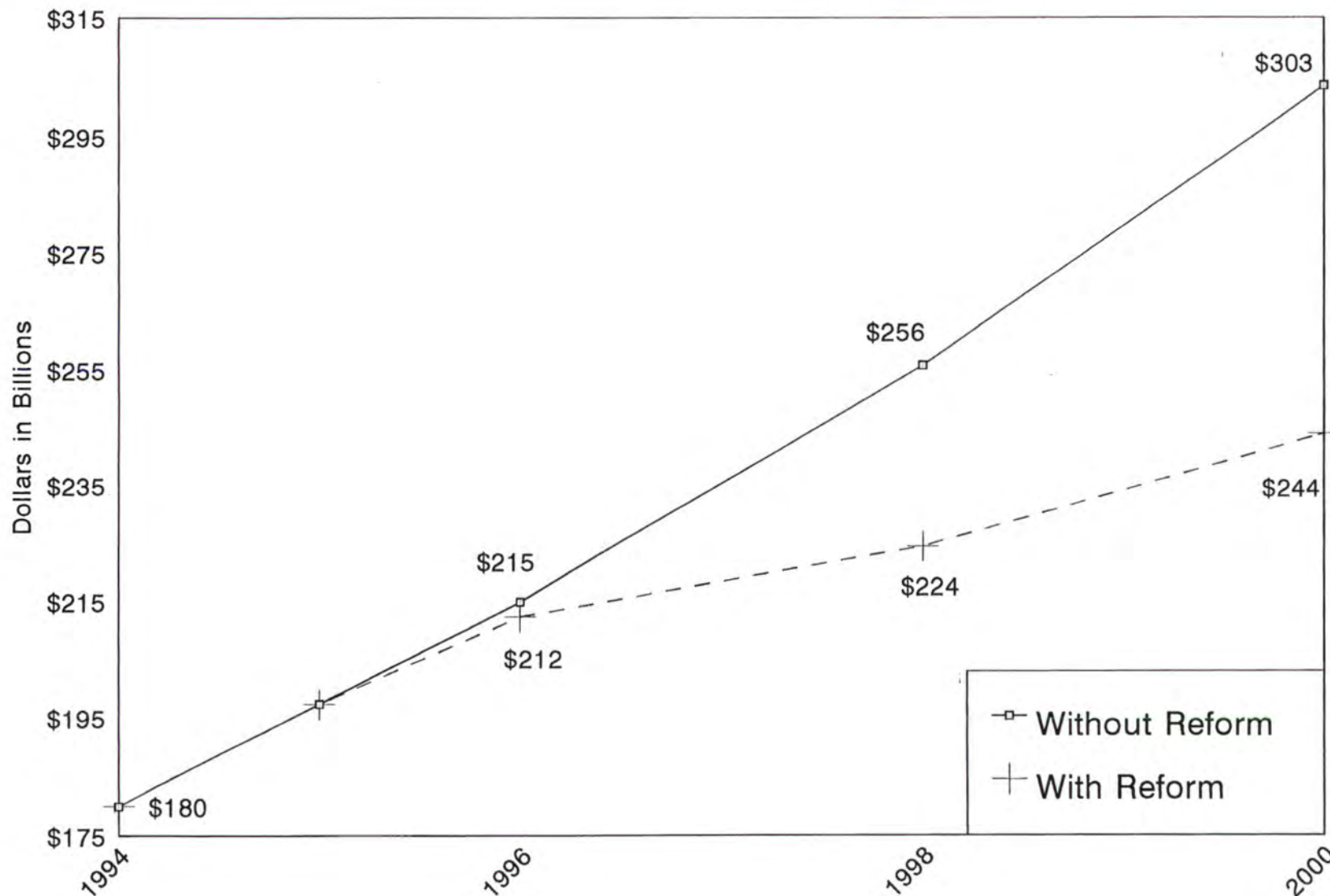
Employer premium payments will rise from \$180 billion in 1994 to only \$244 billion in 2000 -- **\$59 billion less** than would have been the case without reform. [Chart III-D]

- This results in a smaller increase in percent of payroll spent on health insurance -- only 6.6 percent with reform, versus 8.2 percent without reform. [Chart III-E]

- Per worker premium expenditures increase at a slower rate, from \$1,923 in 1994 to \$2,481 in 2000, an overall increase of only 29 percent. This equates to savings of \$605 per worker in the year 2000. [Chart III-F]
- Under the Health Security Act, employers who now offer insurance will experience immediate savings.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Annual Employer-Paid Premiums for Firms Currently Offering Insurance: 1994 - 2000

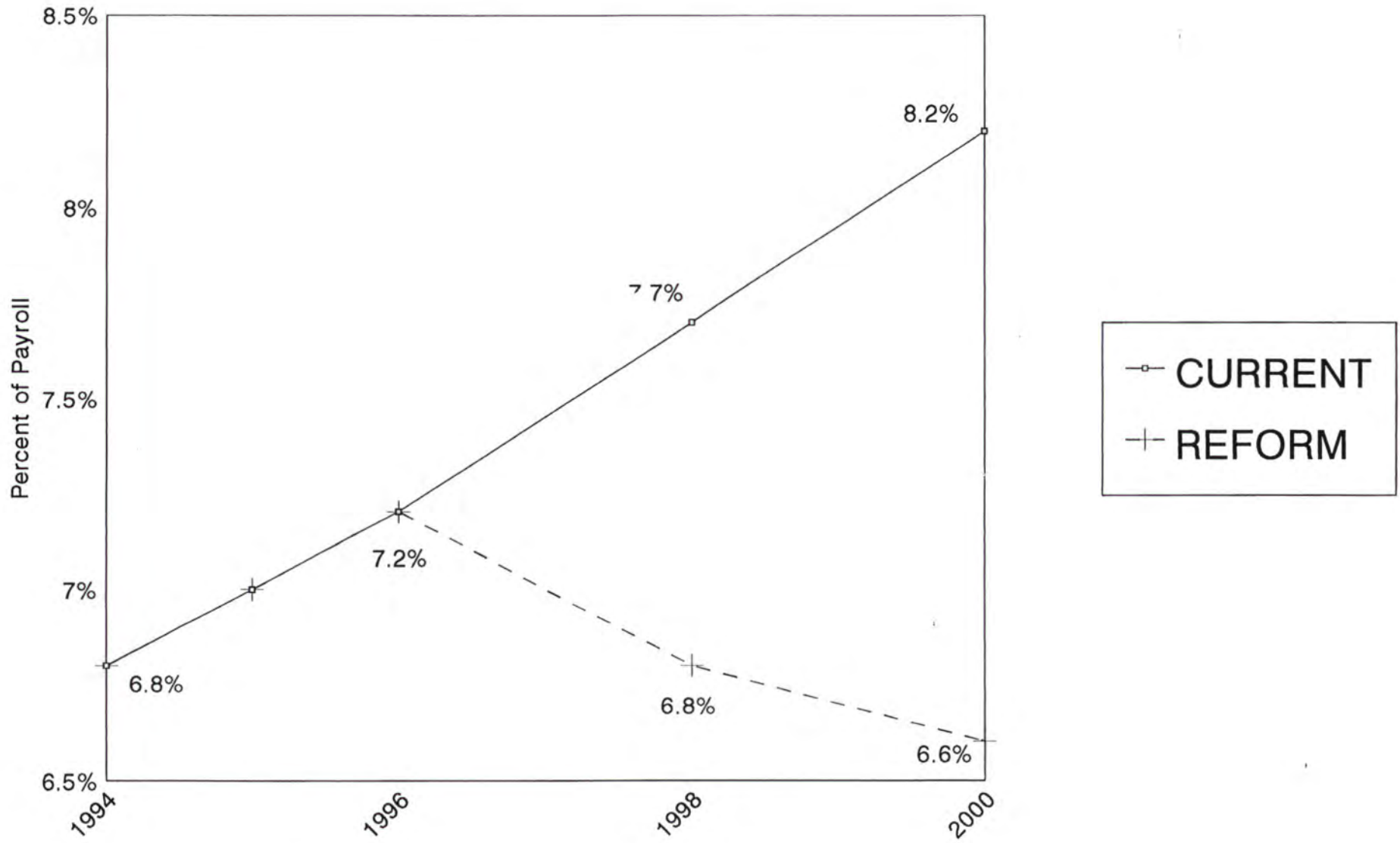


SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

Chart III-D

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Percent of Payroll for Firms Currently Offering Insurance: 1994 - 2000

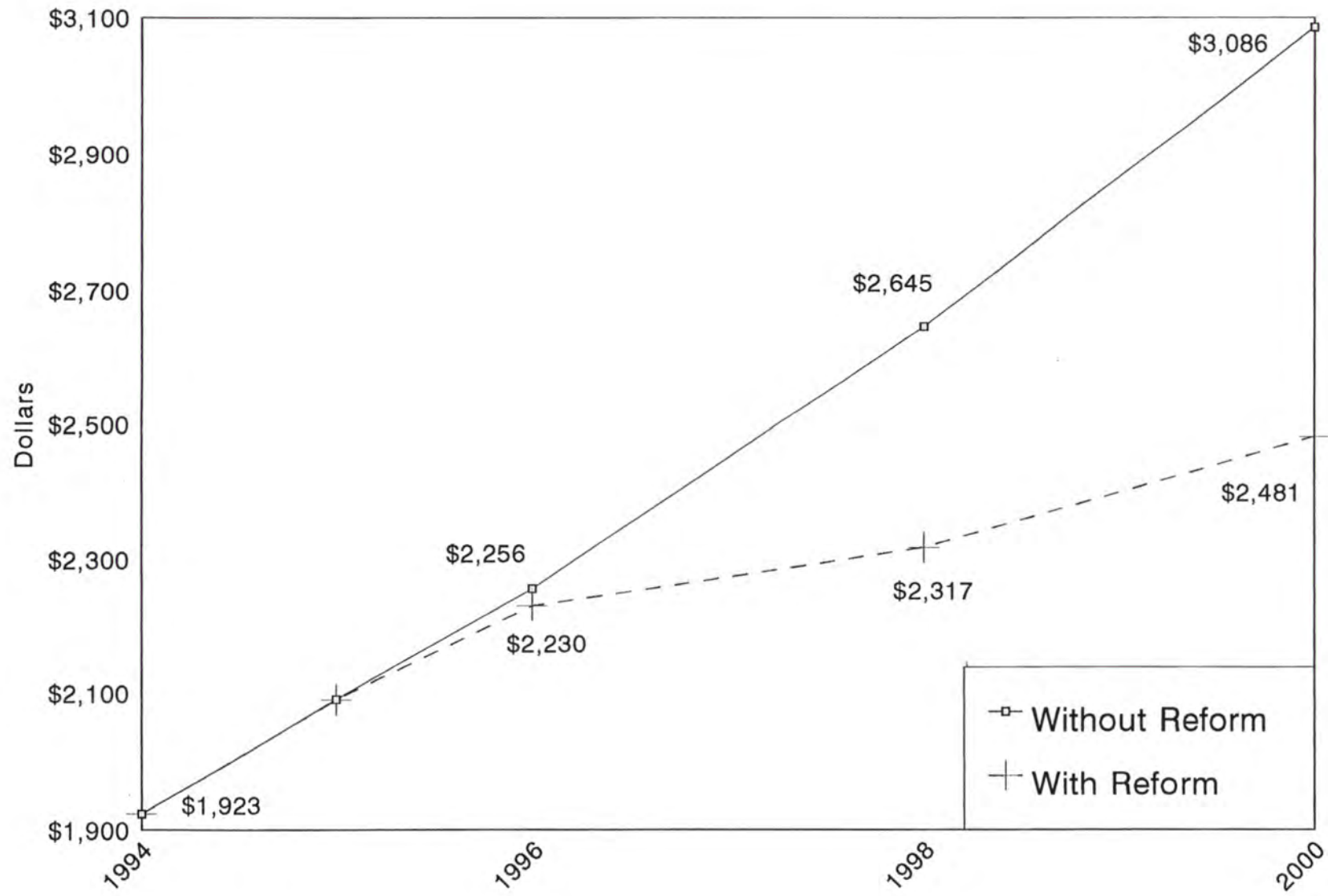


SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

Chart III-E

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker for Firms Currently Offering Insurance: 1994 - 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT
For Firms Currently Offering Insurance
For Firms with Greater or Less Than 5000 Employees: Year 2000

Firms with more than 5000 employees are eligible to form corporate alliances. Employees of firms with less than 5000 employees will enroll in regional alliances.

Under the Health Security Act, the average employer that currently offer insurance will pay less, per worker and as a percent of payroll, on health insurance premiums for their employees than would be the case without reform.

Firms with less than 5000 employees that currently offer insurance will save \$621 per worker in the year 2000 alone. They will spend only 6.5 percent of total payroll on employees' health insurance premiums.

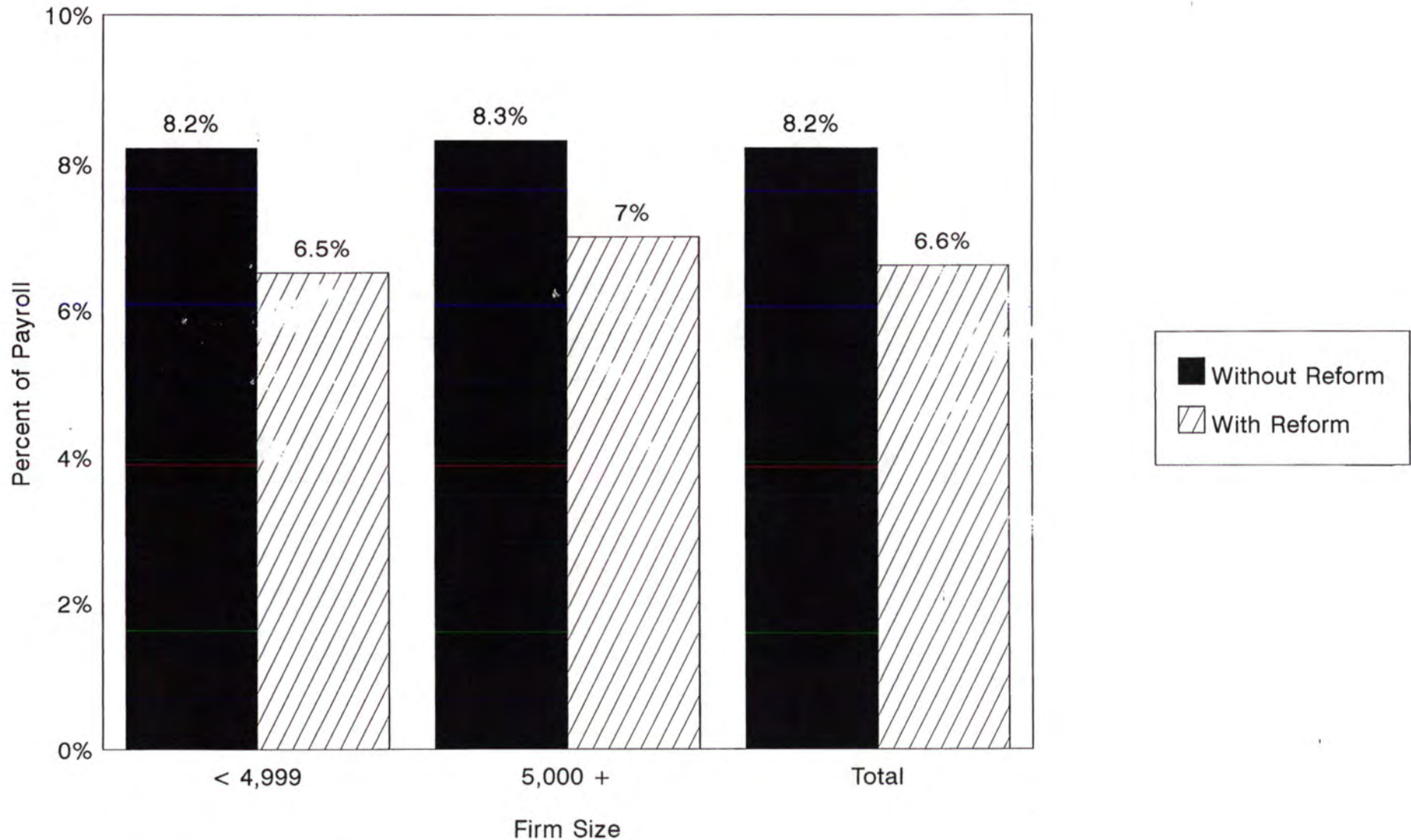
[Charts III-G and III-H]

Firms with more than 5000 employees that currently offer insurance will save \$551 per worker in the year 2000 alone. They will spend only 7.0 percent of total payroll on employees' health insurance premiums.

[Charts III-G and III-H]

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

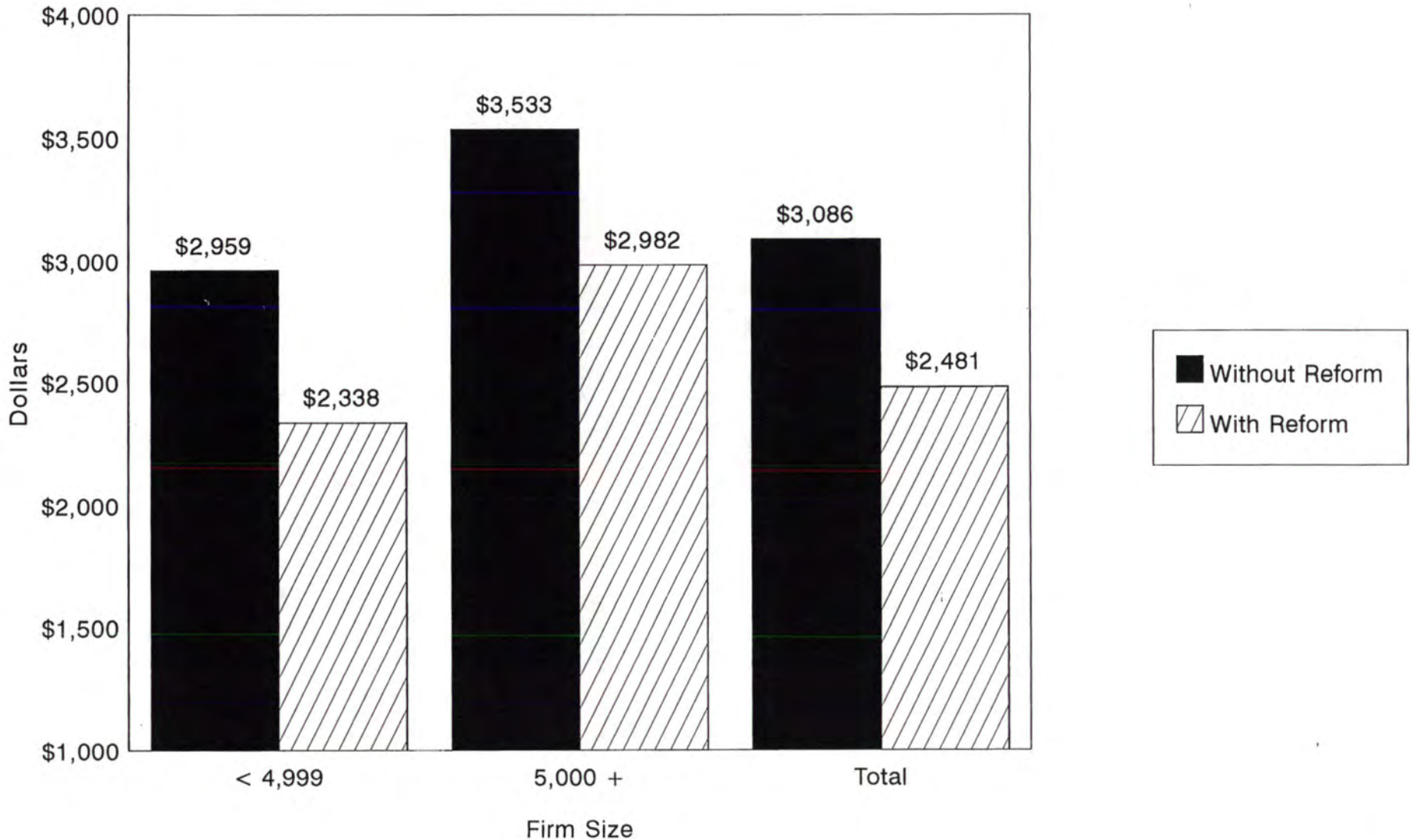
Average Annual Percent of Payroll for Firms Currently Offering Insurance
For Firms with Greater or Less Than 5,000 Employees: Year 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker for Firms Currently Offering Insurance
For Firms with Greater or Less Than 5,000 Employees: Year 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

Chart III-H

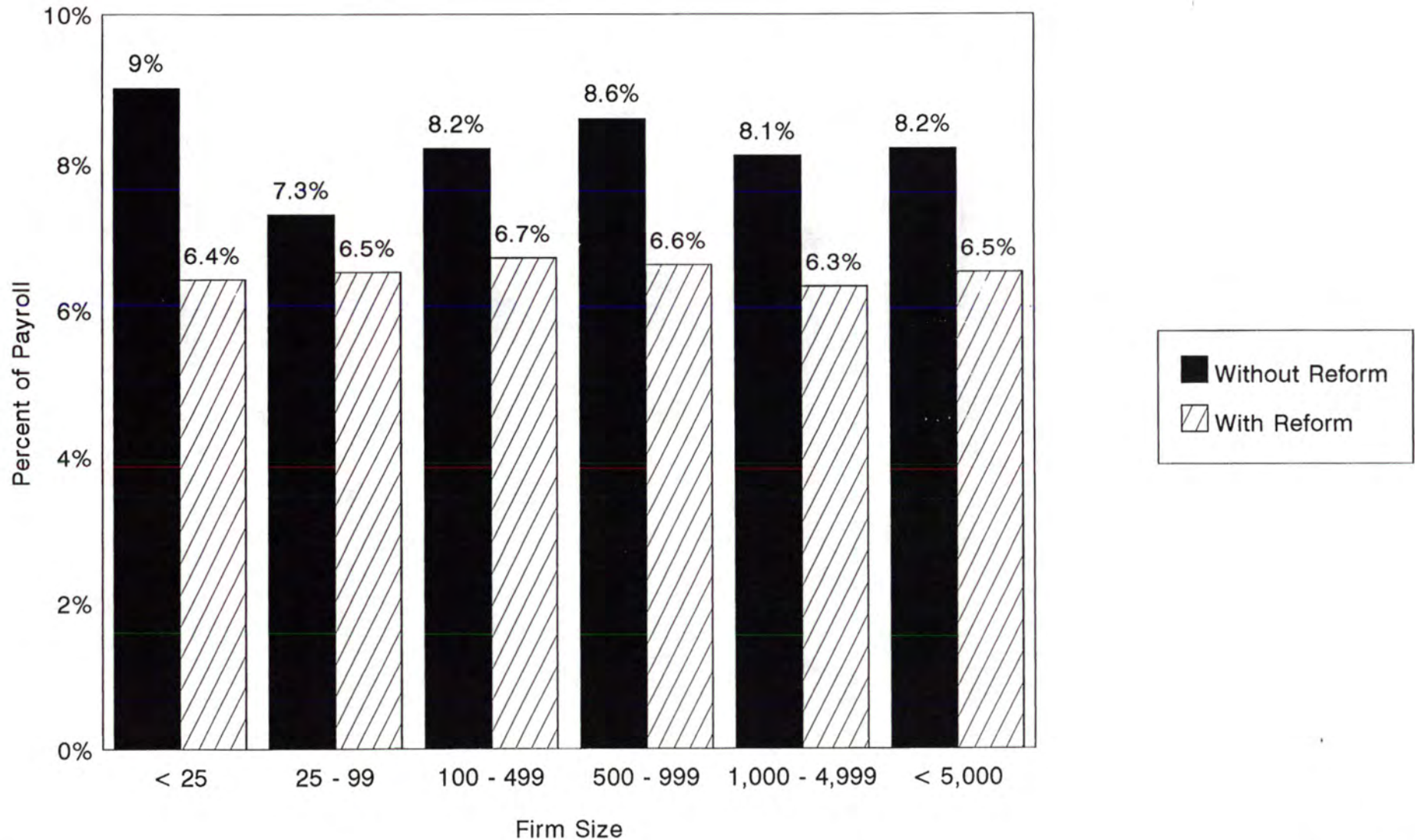
EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT
For Firms Currently Offering Insurance
By Firm Size: Year 2000

- On average, firms with fewer than 5000 employees that currently offer insurance will save, both as a percent of payroll and per worker, under the Health Security Act. [Charts III-I and III-J]
- **Small firms with fewer than 25 workers will experience the largest savings as a percent of payroll under the Health Security Act. They will pay a full 2.6 percentage points less of their payroll - \$771 per worker - on premiums after reform. [Charts III-I and III-J]**

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Percent of Payroll for Firms Currently Offering Insurance

By Firm Size: Year 2000

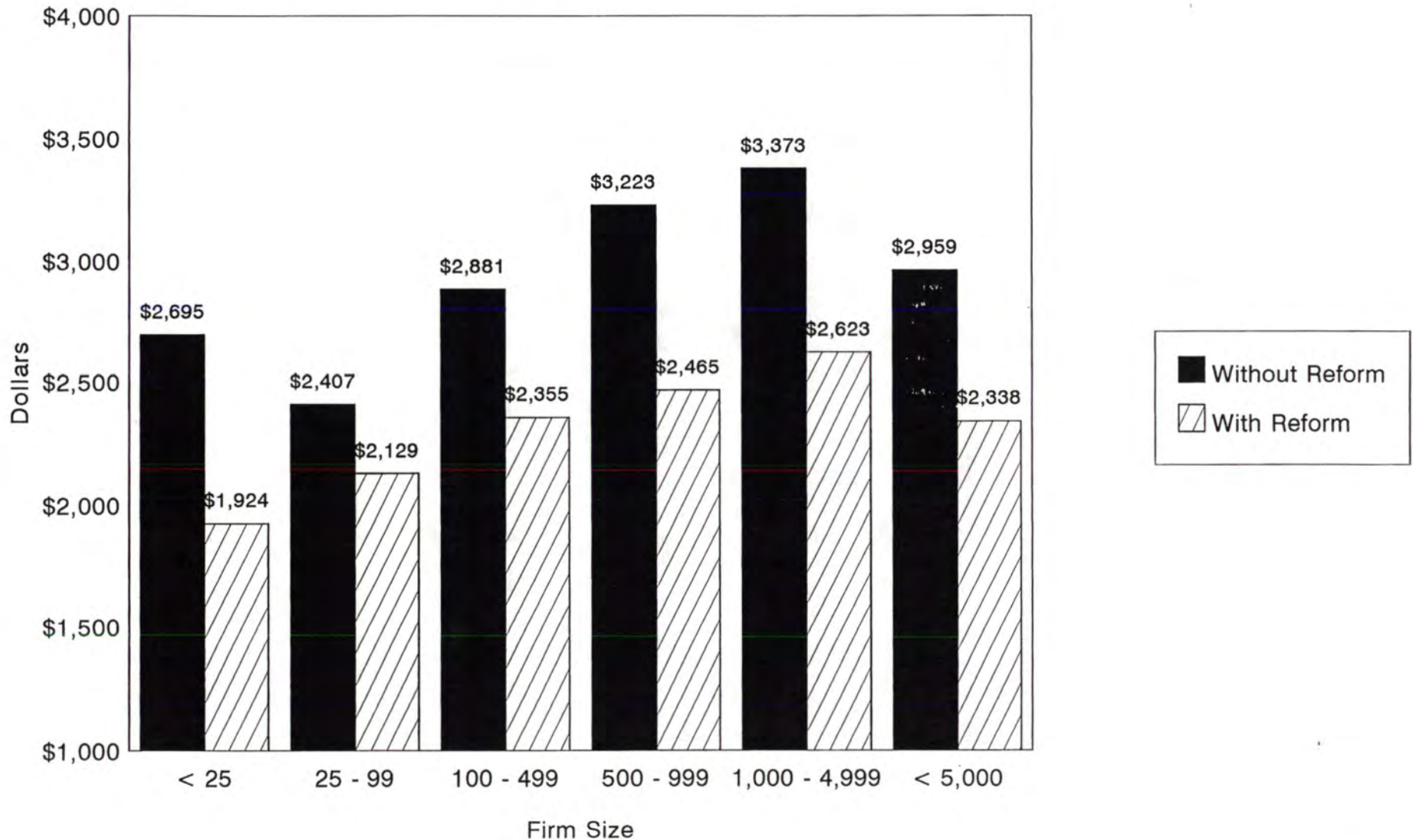


SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

Chart III-1

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker for Firms Currently Offering Insurance
By Firm Size: Year 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

IMPACT ON WORKERS AND FAMILIES

WORKERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT: 1994 - 2000

- Absent comprehensive reform, workers' premium payments would rise, on average, from 1.4 percent of payroll in 1994 to 1.7 percent in 2000. [Chart IV-A] By the year 2000, workers would contribute an average of \$600 each year for their share of their premiums. [Chart IV-B]
- As states phase in universal coverage under the Health Security Act, workers' premium payments will fall from 1.5 percent of payroll in 1996 to 1.2 percent in the year 2000. [Chart IV-A] By the year 2000, workers will contribute an average of \$437 per year for their share of their premiums -- 27 percent less than if there were no comprehensive reform. [Chart IV-B]
- Thus, under the Health Security Act, workers's premium payments will be 0.5 percentage points less of total payroll costs in the year 2000. [Chart IV-A]

WORKERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Percent of Payroll: 1994 - 2000

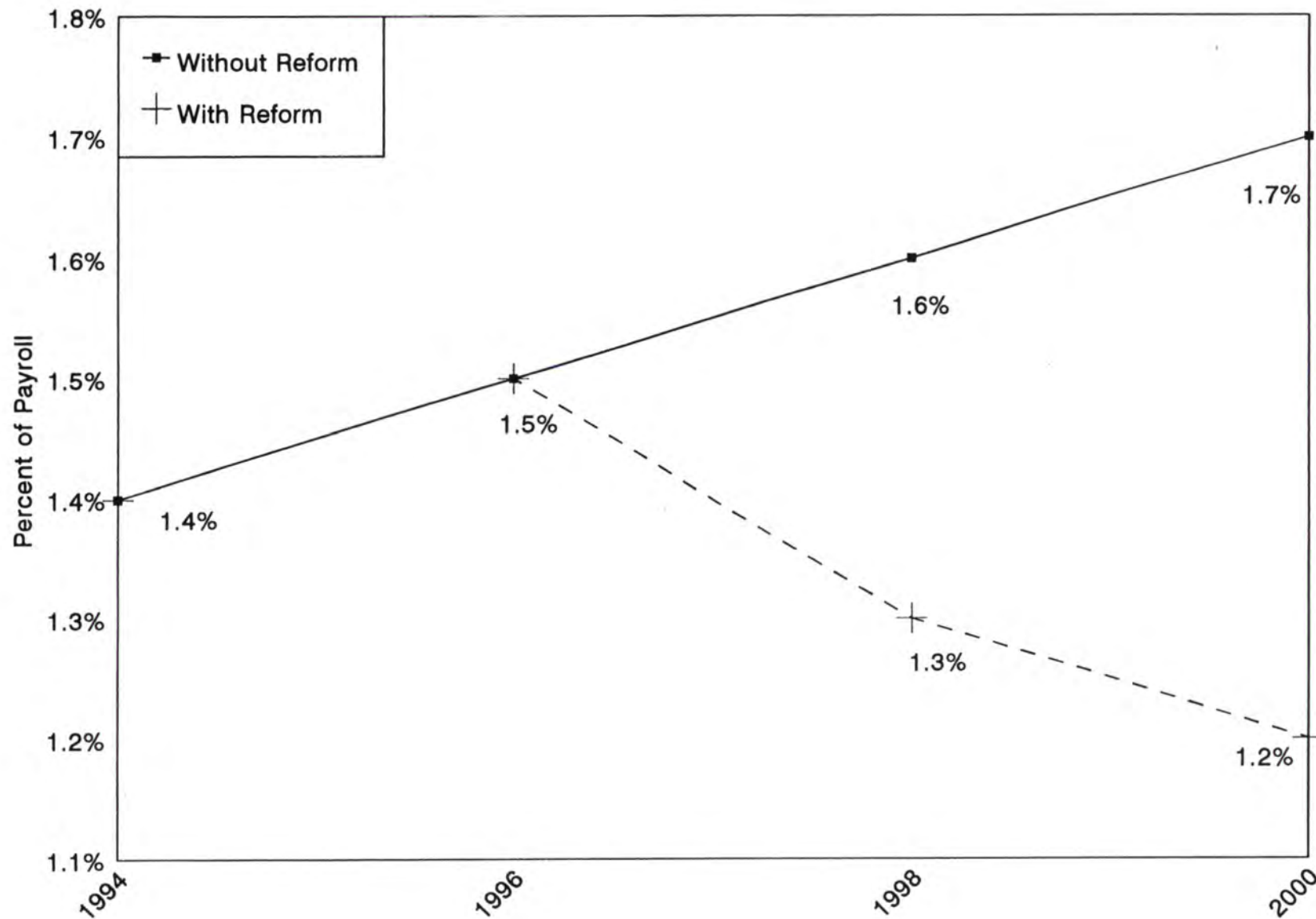


Chart IV-A

WORKERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker: Year 2000

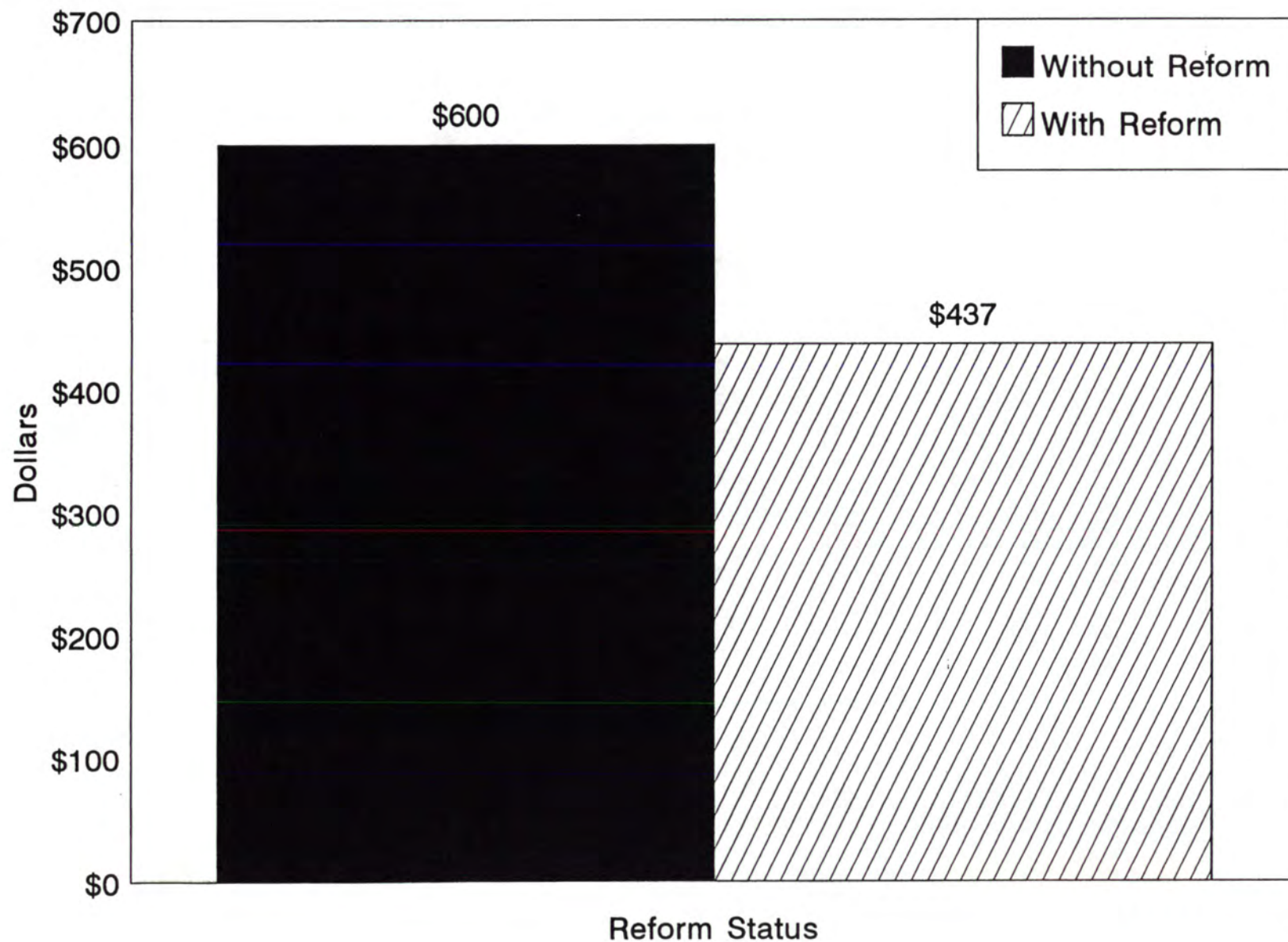


Chart IV-B

FAMILIES' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT: Year 2000

- Absent comprehensive reform, families' average annual spending in the year 2000 on health insurance premiums would be \$373 higher than under the Health Security Act (\$1062 versus \$689, respectively). [Chart IV-C] This translates to their spending 2.3 percent of income on premiums without comprehensive reform, as opposed to 1.5 percent under the Health Security Act. [Chart IV-D]
- Families with annual incomes between \$30,000 and \$50,000 would spend an average of \$377 more for premiums in the year 2000 if there is no comprehensive reform than they would under the Health Security Act (\$1171 versus \$794, respectively). [Chart IV-C] This translates to their spending 3.1 percent of income on premiums without comprehensive reform, as opposed to 2.1 percent under the Health Security Act. [Chart IV-D]

- All families, regardless of income, will save money on premium payments in the year 2000 under the Health Security Act. [Chart IV-E]
- On average, families with annual incomes between \$30,000 and \$50,000 will spend 1.0 percent of income less on health care in 2000 under the Health Security Act. [Chart IV-E, Chart IV-C]
- On average, the Health Security Act will save families 35 percent of their premium costs in the year 2000. Families with annual incomes between \$30,000 and \$50,000 will save 32 percent. [Chart IV-C]

FAMILIES' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premium Spending: Year 2000

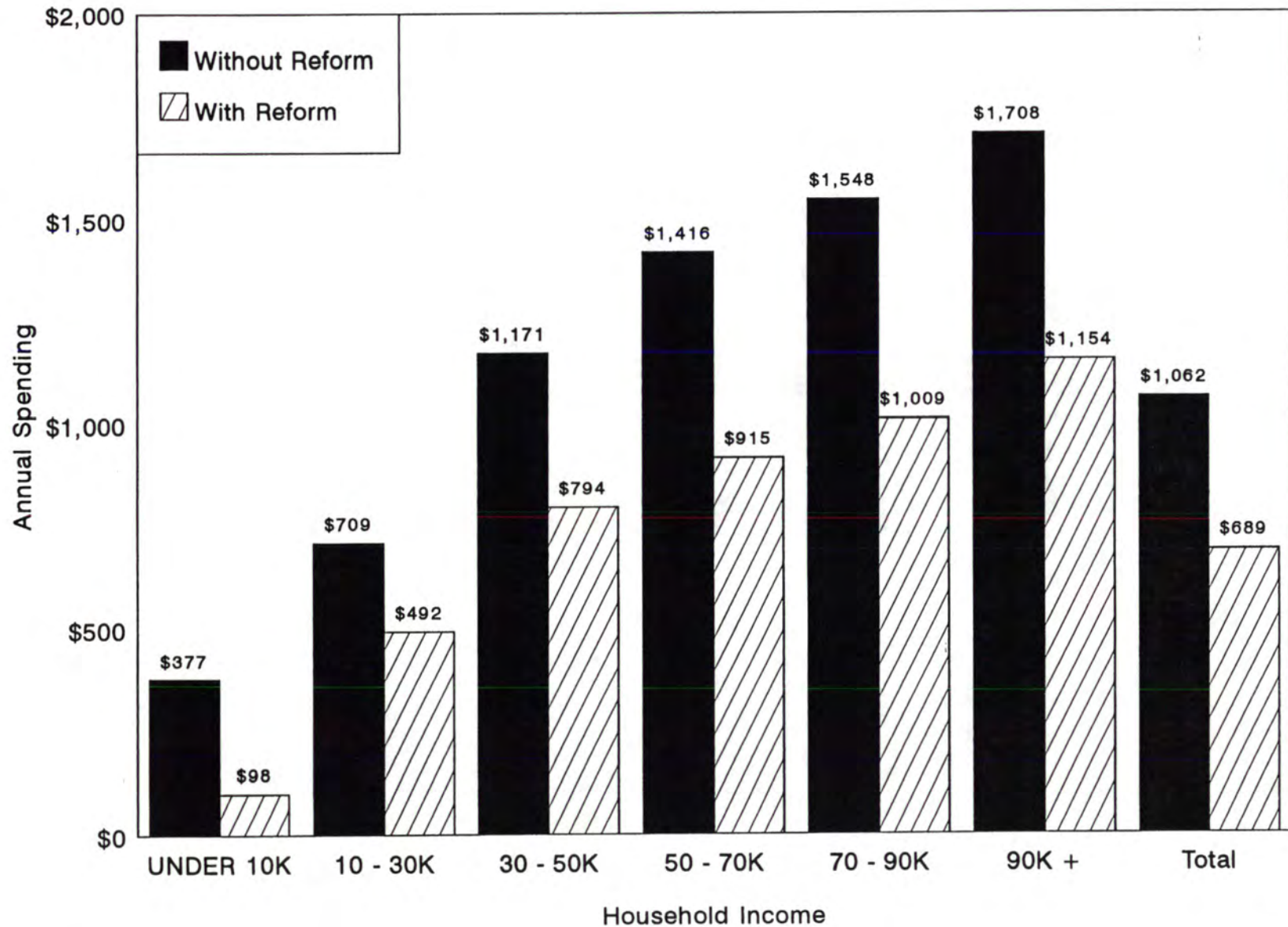


Chart IV-C

FAMILIES' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premium Spending as a Percent of Income: Year 2000

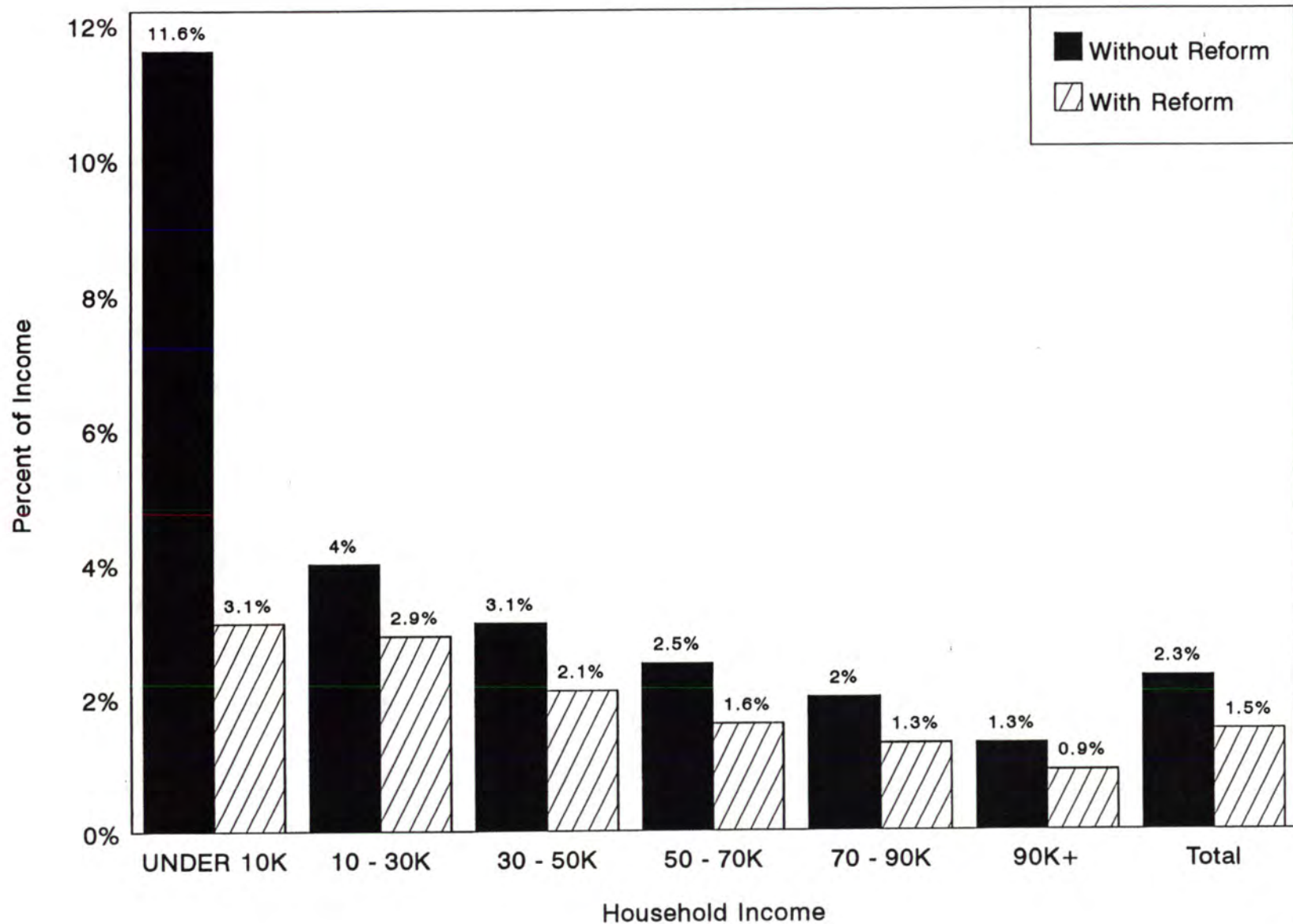


Chart IV-D

FAMILIES' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Savings on Premium Spending as a Percent of Income

By Income Category: Year 2000

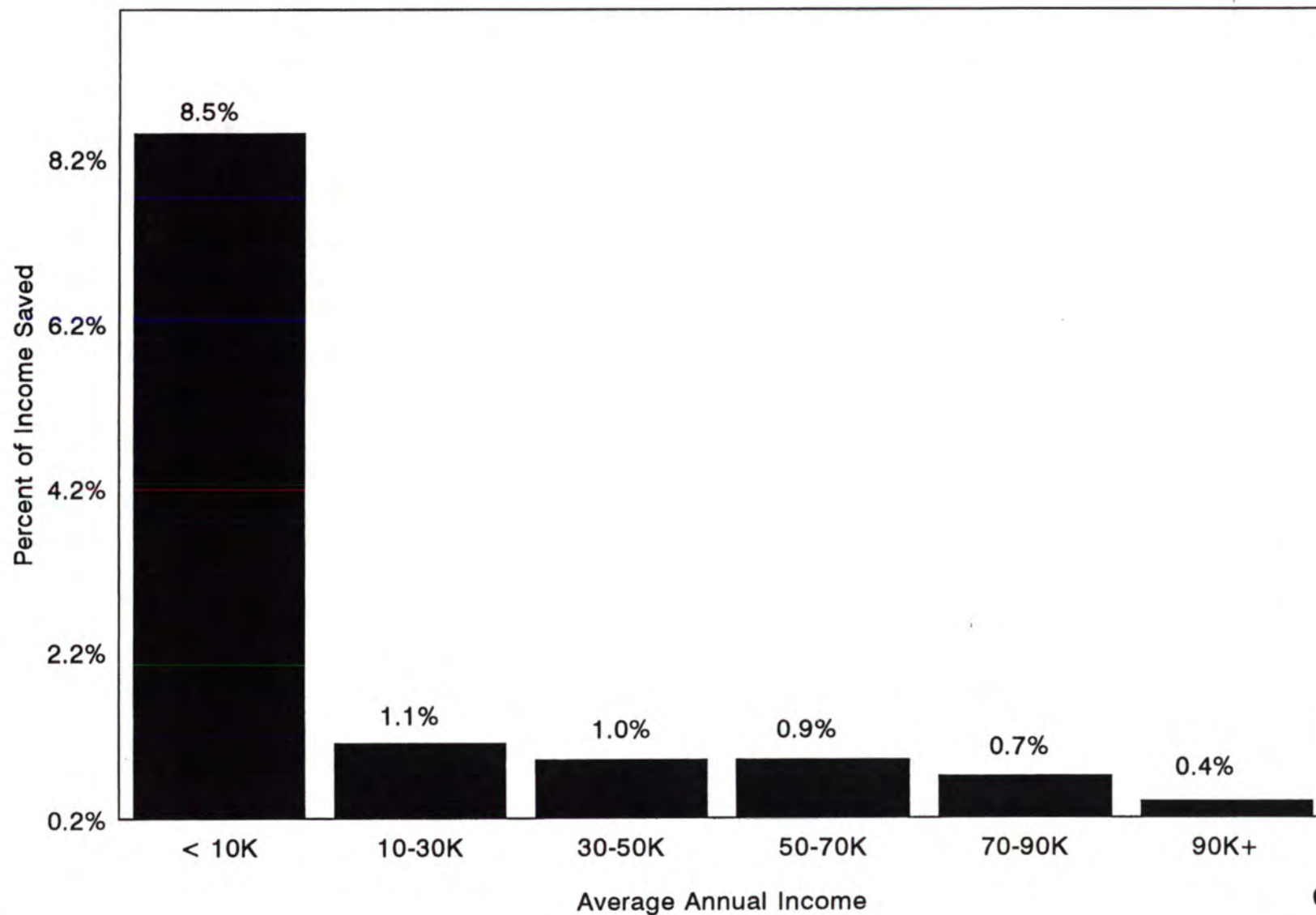


Chart IV-E

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT Year 2000

In the year 2000, under the Health Security Act:

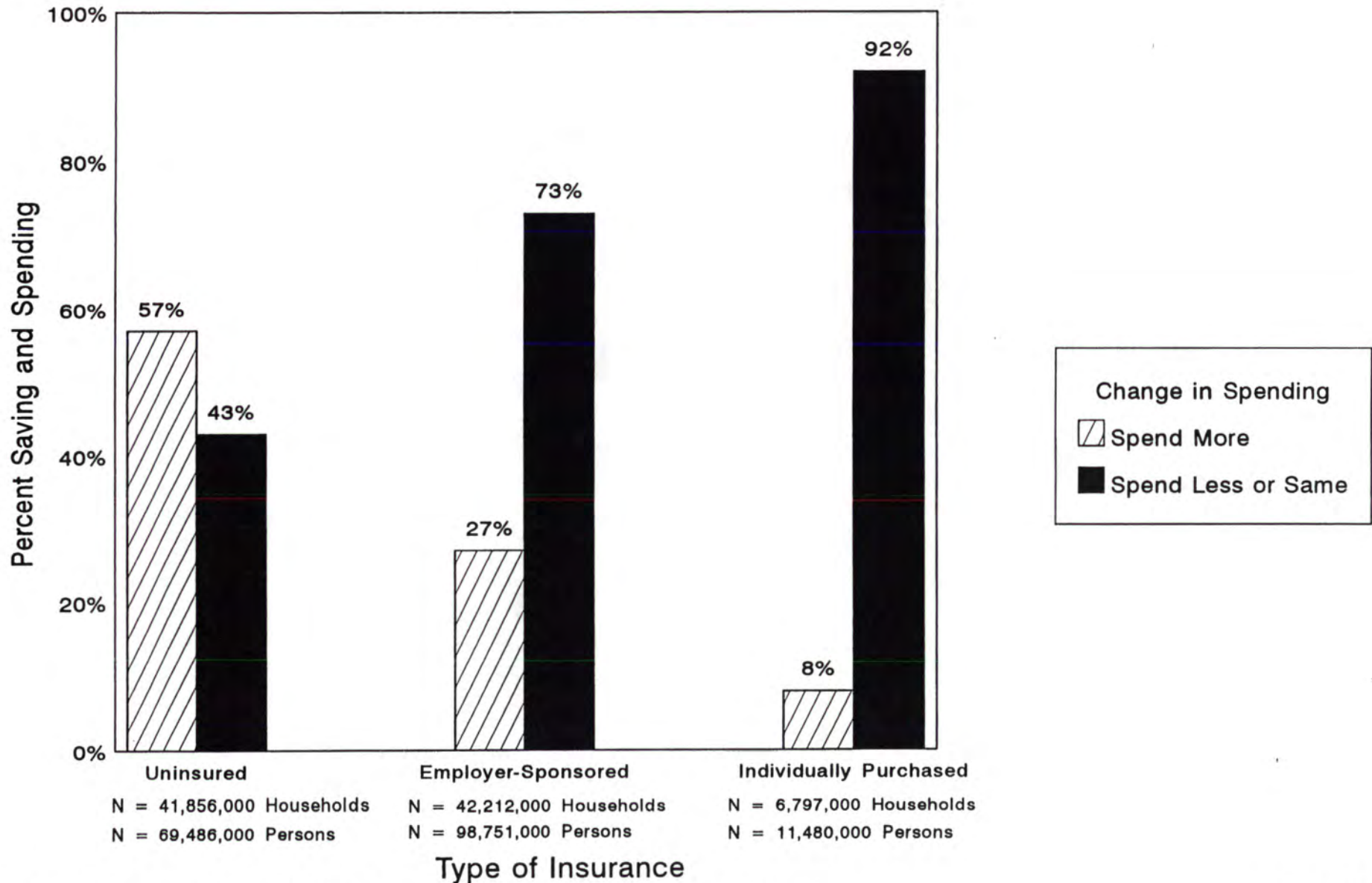
Of those families which are currently uninsured at least part of the year, 43 percent will spend the same or less for health care than they would if there were no comprehensive reform. [Chart IV-F]

Of those families which currently have employer-sponsored insurance, 73 percent will spend the same or less for health care than they would if there were no comprehensive reform. [Chart IV-F]

Of those families which currently purchase their insurance individually, 92 percent will spend the same or less for health care than they would if there were no comprehensive reform. [Chart IV-F]

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Change in Health Care Spending: Year 2000



SOURCE: HHS and Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premium and out-of-pocket spending in regional alliances. Uninsured includes 31.8 million persons uninsured part-year.

Chart IV-F

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

By Current Insurance Type: Year 2000

Under the Health Security Act:

Employer-Sponsored Insurance

- 38 percent of all families which currently have employer-sponsored insurance will experience savings of up to \$1,000 in overall health care spending (premiums and out-of-pocket expenditures) in the year 2000. [Chart IV-H]
- 30 percent of all families which currently have employer-sponsored insurance will experience savings of more than \$1,000 in overall health care spending in the year 2000. [Chart IV-H]
- On **average**, families which experience savings in overall health care spending will enjoy a **decrease of \$109 per month** (\$1,309 for the year) in the year 2000. [Chart IV-G]
- 5 percent of all families which currently have employer-sponsored insurance will experience no change in overall health care spending (premiums and out-of-pocket expenditures) in 2000. [Chart IV-H]

- Families which will be spending more on overall health care expenditures will spend on average an additional \$31 per month (\$367 for the year) in the year 2000. [Chart IV-G]

Individually Purchased Insurance

- The vast majority (85.9 percent) of families which currently purchase health insurance individually will experience savings of more than \$1,000 on overall health care spending (premiums and out-of-pocket expenditures) in 2000. [Chart IV-I]
- On **average**, families which experience savings in overall health care spending will enjoy a **decrease of \$375 per month** (\$4,501 for the year) in the year 2000. [Chart IV-G]
- Families which will be spending more on overall health care expenditures will be spending an average of an additional \$75 per month (\$903 for the year) in 2000. [Chart IV-G]

Currently Uninsured

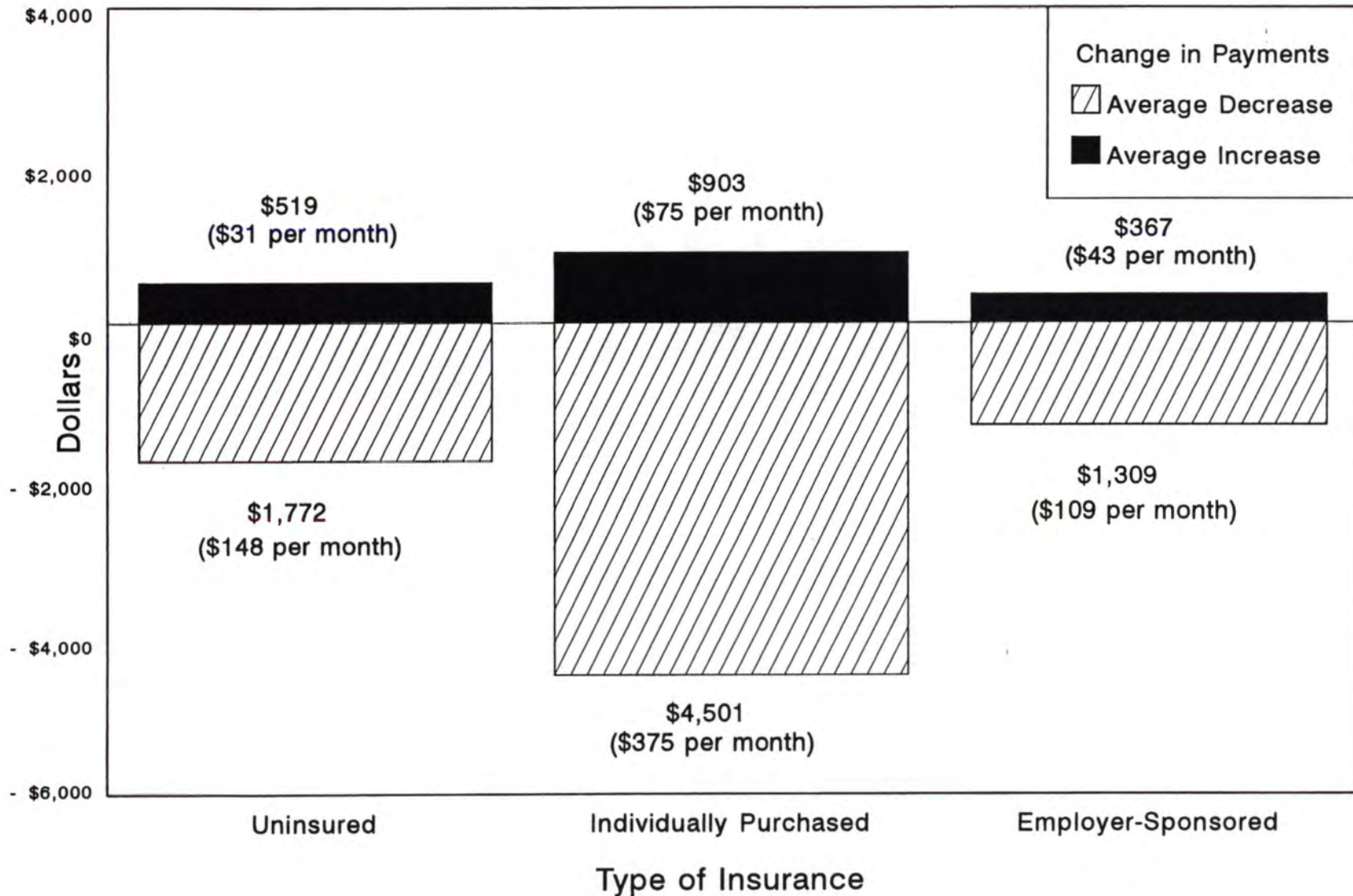
- 28 percent of all families which are currently uninsured at least part of the year will experience some savings in overall health care

spending in the year 2000, due largely to reductions in high out-of-pocket expenditures. The **average decrease** will be **\$148 per month** (\$1,772 for the year) in 2000. [Charts IV-G and IV-J]

- 15 percent of all families which are currently uninsured at least part of the year will experience no change in overall health care spending in 2000. [Chart IV-J]
- Families which will be spending more on overall health care expenditures will be spending an average of an additional \$43 per month (\$519 for the year) in 2000. [Chart IV-G]

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Average Annual Saving and Spending by Current Insurance Type: Year 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premium and out-of-pocket spending in regional alliances. Uninsured includes 31.8 million persons uninsured part-year.

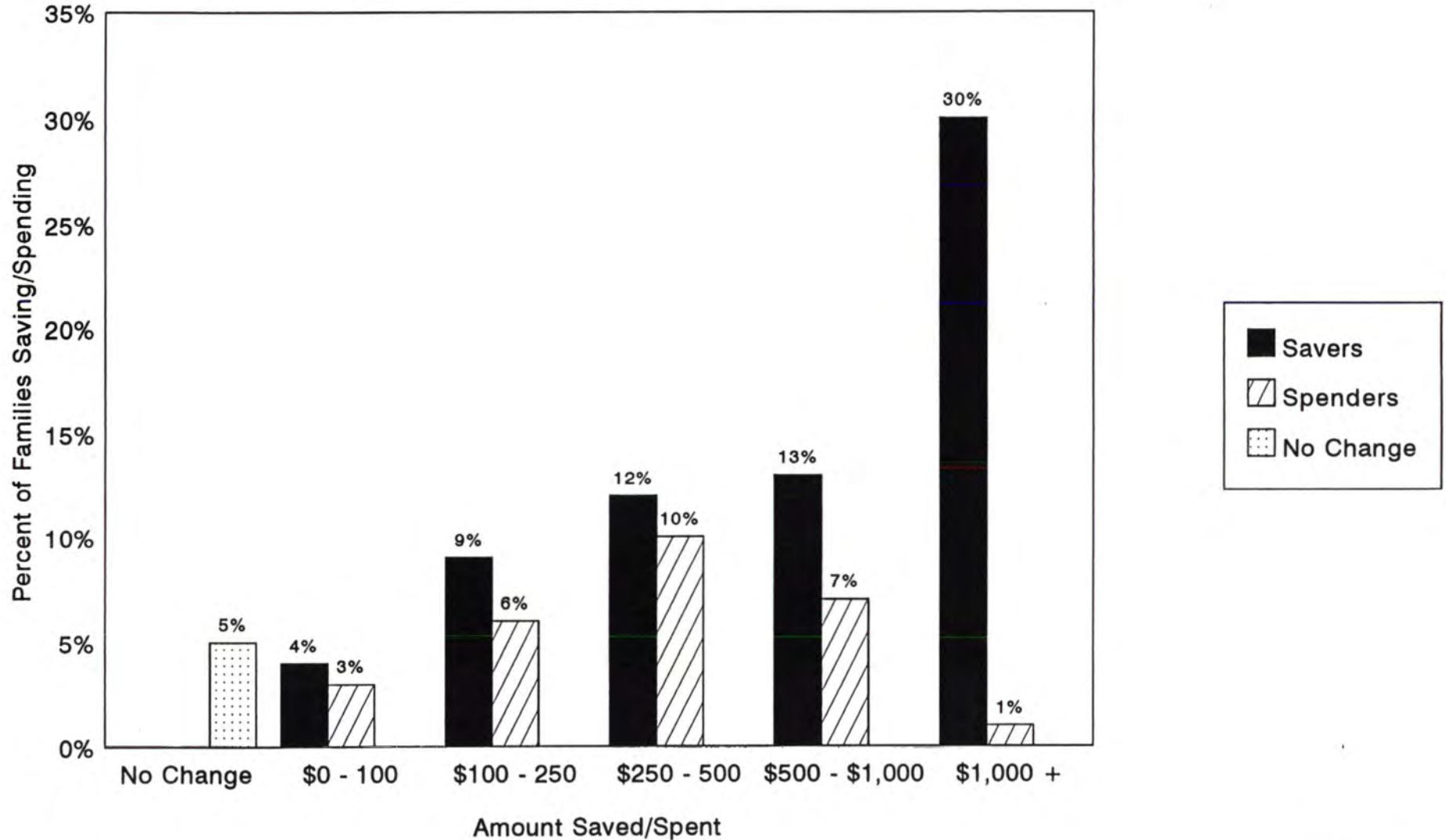
Chart IV-G

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Average Annual Percent Change in Spending

Families which Currently have Employer-Sponsored Insurance: Year 2000

N = 42,212,000 Families



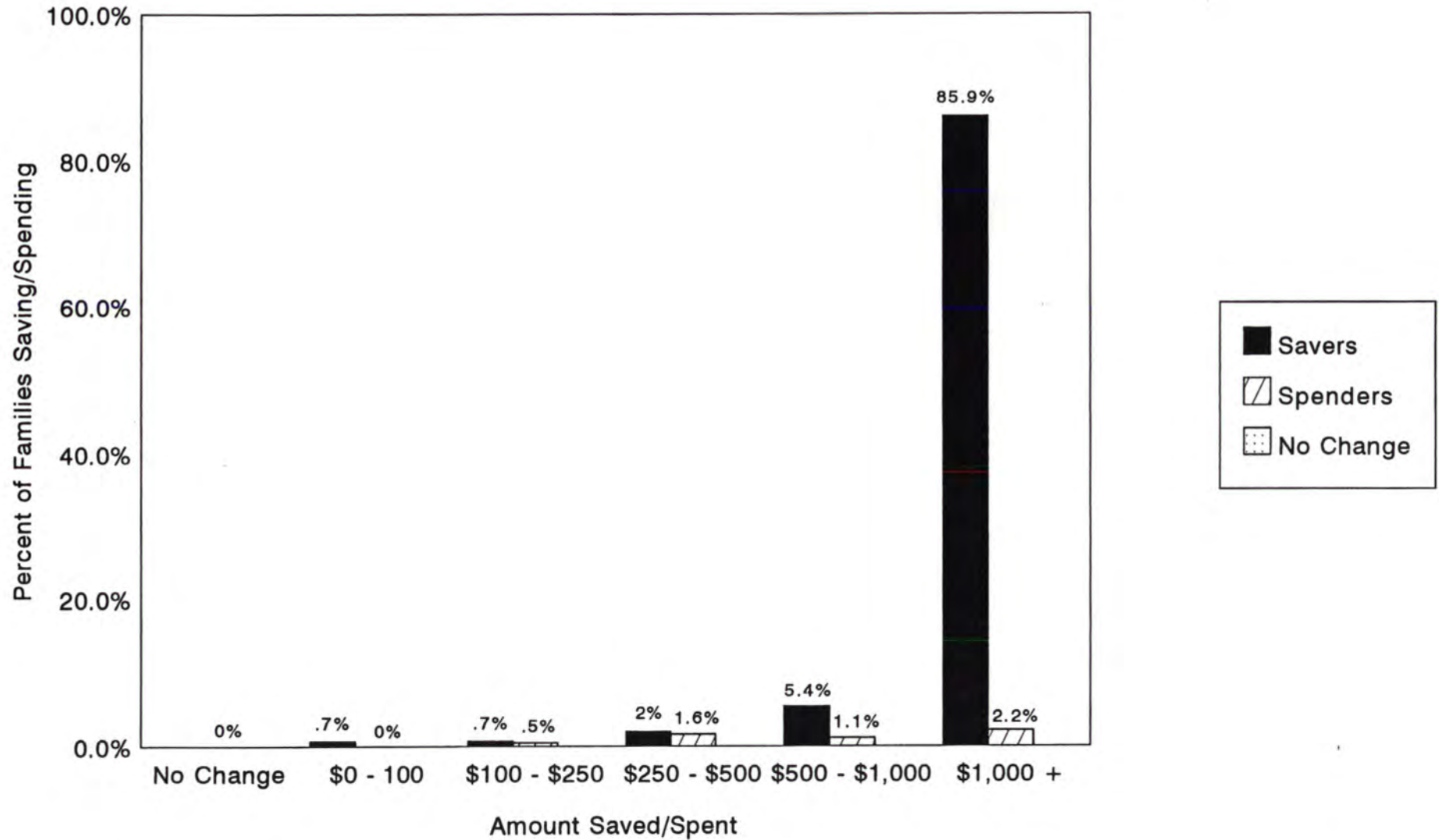
SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premium and out-of-pocket expenditures for those in regional alliances. Totals may not add to 100% due to rounding.

Chart IV-H

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Average Annual Percent Change in Spending
Families which Currently Purchase Insurance Individually: Year 2000

N = 6,797,000 Families



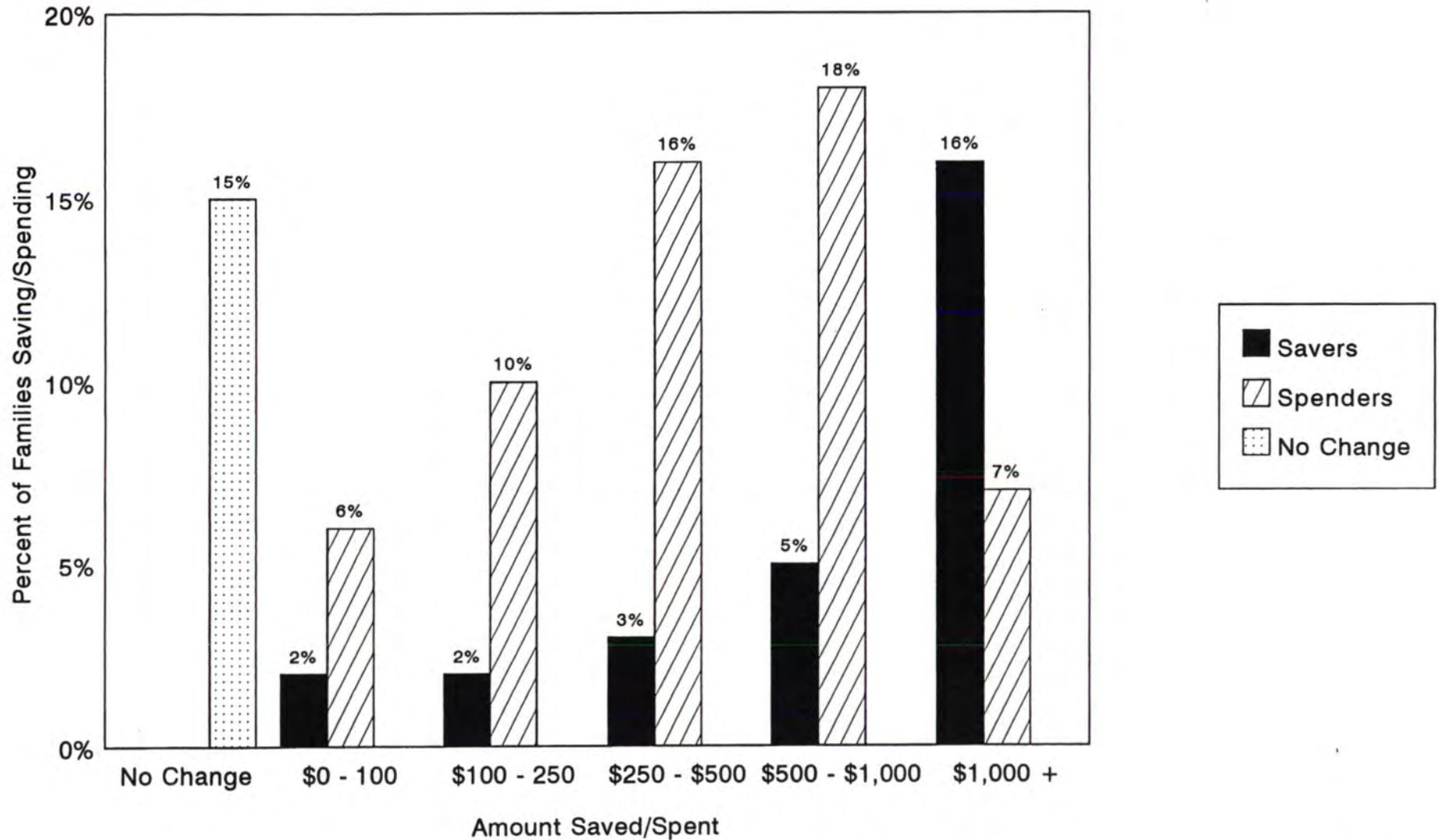
SOURCE: Center for Intramural Research, AHCPH.
Includes premium and out-of-pocket expenditures for those in regional alliances.
Totals may not add to 100% due to rounding.

Chart IV-I

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Average Annual Percent Change in Spending
Families which are Currently Uninsured: Year 2000

N = 41,856,000 Families



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premium and out-of-pocket expenditures for those in regional alliances. Totals may not = 100% due to rounding. Uninsured includes 31.8 million persons uninsured part-year.

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GROWTH RATE OF HEALTH CARE SPENDING (GROWTH RATES IN PERCENT)

Calendar Years	1994	1995	1996	1997	1998	1999	2000
GDP Growth Rate	5.4	5.3	5.0	4.6	4.3	4.1	4.2
CPI Inflation Rate	2.7	2.7	2.7	2.7	2.7	2.7	2.7
Population Growth	1.0	0.9	0.9	0.9	0.8	0.8	0.8
Private Sector Medicare and Medicaid*	baseline baseline	baseline baseline	cpi+pop+1.5 cpi+pop+2.4	cpi+pop+1 cpi+pop+1.9	cpi+pop+0.5 cpi+pop+1.4	cpi+pop cpi+pop+0.9	cpi+pop cpi+pop+0.4
Private Sector Baseline	7.4	7.6	7.7	7.6	7.2	6.8	6.4
Reform	7.4	7.6	5.2	4.7	4.1	3.6	3.5
Medicare (Fiscal Years) Baseline	11.6	11.2	11.1	9.5	9.1	9.0	9.0
Reform**	11.6	11.2	7.4	5.7	5.1	4.6	4.1
Medicaid (Fiscal Years) Baseline	16.5	14.3	11.7	11.6	11.2	11.0	11.0
Reform**	16.5	14.3	7.5	5.7	5.1	4.6	4.1

* Assumes differential growth of 0.9 percent in the public sector.

** Reform estimates are on a fiscal year basis for public programs.

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BUDGETARY EFFECTS OF HEALTH CARE REFORM
(billions of dollars)

Fiscal Years	1994	1995	1996	1997	1998	1999	2000	1994-00
Total New Spending	1	7	45	64	71	79	83	350
Subsidies Net of Offsets	0	5	25	33	34	33	30	160
Self-Employed Tax Deduction (100%)	0	0	1	2	2	2	2	9
Long-Term Care	0	0	5	10	15	22	28	80
Medicare Drug Benefit	0	0	10	14	15	16	17	72
New Public Health Spending	0	1	3	3	3	4	4	18
Administration	1	1	1	2	2	2	2	11
Total Savings	-12	-15	-36	-59	-81	-104	-134	-441
Medicare Savings	0	0	-7	-15	-23	-33	-46	-124
Medicaid Savings	0	0	-7	-15	-22	-30	-40	-114
Other Federal Program Savings	0	0	-5	-8	-10	-11	-13	-47
Revenue Effects of Mandate	0	0	-2	-6	-10	-14	-19	-51
Sin Taxes and/or Corporate Assessment	-12	-15	-15	-15	-16	-16	-16	-105
Change in Deficit	-11	-8	9	5	-10	-25	-51	-91

* Estimates are preliminary and do not incorporate interactive effects.

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DETAIL OF SUBSIDY COSTS
(billions of dollars)

Fiscal Years	1994	1995	1996	1997	1998	1999	2000	1994-00
Subsidies Net of Offset	0	5	25	33	34	33	30	160
Gross Subsidies	0	14	58	80	86	89	92	419
Total Offsets	0	-9	-33	-47	-52	-56	-62	-259
State Offset for Medicaid in Alliance	0	-3	-10	-14	-15	-15	-16	-73
Federal Offset for Medicaid in Alliance	0	-4	-15	-22	-25	-28	-31	-125
Federal Offset for Medicare in Alliance	0	-2	-8	-11	-12	-13	-15	-61

* Estimates are preliminary and do not incorporate interactive effects.

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BUDGETARY EFFECTS OF HEALTH REFORM

(billions of dollars)

Fiscal Years	1994	1995	1996	1997	1998	1999	2000	1994-98	1996-00
Changes in Outlays for Existing Programs	0	-5	-28	-53	-73	-94	-123	-159	-371
Medicaid	0	-4	-21	-36	-46	-57	-70	-107	-230
Liberalized Long-term Care Eligibility	0	0	1	1	1	1	1	3	5
Offset for Medicaid-eligibles in Alliances	0	-4	-15	-22	-25	-28	-31	-66	-121
Savings Due to Cap	0	0	-7	-15	-22	-30	-40	-44	-114
Medicare	0	-2	-5	-12	-20	-30	-44	-39	-111
Cost of Drug Benefit (with Rebate)	0	0	10	14	15	16	17	39	72
Offset for Employed Beneficiaries	0	-2	-8	-11	-12	-13	-15	-33	-59
Savings Due to Cap	0	0	-7	-15	-23	-33	-46	-45	-124
Veterans	0	0	-1	-2	-2	-2	-2	-5	-9
Defense Department Health	0	0	0	0	0	0	-1	0	-1
Federal Employees Health Benefits	0	0	-2	-4	-5	-6	-7	-11	-24
New Public Health Initiatives	0	1	3	3	3	4	4	10	17
Public Health Savings	0	0	-2	-2	-3	-3	-3	-7	-13
Added Outlays for New Programs	1	12	52	76	86	95	103	227	412
Long-Term Care (Net of Premium)	0	0	3	8	13	19	25	24	68
Subsidies (a)	0	14	58	80	86	89	92	238	405
less State Offset for Medicaid in Alliance	0	-3	-10	-14	-15	-15	-16	-42	-70
New Administrative Costs	0	0	1	2	2	2	2	5	9
Start Up Costs	1	1	0	0	0	0	0	2	0
Total Outlay Changes	1	7	24	23	13	1	-20	68	41
Receipts Changes	12	15	15	18	23	26	31	83	113
Sin Taxes/Corporate Assessment	12	15	15	15	16	16	16	73	78
Tax Incentives for Long-term Care	0	0	-1	-1	-1	-2	-2	-3	-7
Expanded Deduction for Self-Employed	0	0	-1	-2	-2	-2	-2	-5	-9
Effects on Other Taxes of the Mandate (b)	0	0	2	6	10	14	19	18	51
Deficit	-11	-8	9	5	-10	-25	-51	-15	-72

(a) From Urban Institute using HCFA premiums.

(b) Unofficial estimate.

* Estimates are preliminary and do not incorporate interactive effects.

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NATIONAL HEALTH EXPENDITURES

(billions of dollars)

Calendar Years	1994	1995	1996	1997	1998	1999	2000
CBO Baseline	998	1,089	1,185	1,288	1,395	1,510	1,631
% GDP	15.1	15.7	16.3	16.9	17.5	18.2	18.9
% change	9.4	9.1	8.8	8.6	8.4	8.2	8.0
Reform	999	1,112	1,237	1,314	1,376	1,438	1,495
% GDP	15.1	16.0	17.0	17.2	17.3	17.4	17.3
% change	9.4	11.3	11.2	6.2	4.7	4.5	4.0
Change in Spending:							
New Alliance	0	19	71	83	86	90	93
Other New Spending	1	4	13	20	25	33	38
Savings	0	0	-32	-77	-130	-195	-267

* Estimates are preliminary.

19

Financing

Description of Financing

Financing of health care under the health security plan builds on the financing of health care today.

- Regardless of how the Administration and Congress agree to fund discounts for small businesses and low income participants, 80 percent of the cost of covering Americans who are not on Medicare or cash assistance recipients (AFDC and SSI) is funded the way it is today, through employer and individual premiums.

Premiums will finance most costs

The cost of providing coverage for all Americans who are not on Medicare or cash assistance (AFDC and SSI) will cost \$325 billion. Except for individuals and small businesses who qualify for discounts, the financing will be provided the same way it is today -- through employer and individual premiums.

- Employers will pay approximately \$205 billion a year through required 80 percent employer contributions.
- Individuals will pay approximately \$55 billion through the 20 percent share for of individual or family coverage.
- 80 percent of the system is financed the way health care insurance is presently financed -- through employer and individual premiums.

Discounts are fully financed

Funding for discounts for low income individuals and small businesses -- \$65 billion -- is fully accounted for:

- The tobacco tax and corporate assessment will produce \$15 billion.
- \$10 billion in State payments for the current non-cash assistance Medicaid population who will be brought into the new system.
- The federal government will provide \$15 billion from funds currently spent on this population through Medicaid.
- Since universal coverage will eliminate the problem of widespread uncompensated care, spending on the current disproportionate share payments will be phased out, providing approximately \$10 billion a year of funding.
- The federal government will save \$10 billion a year

because Medicare recipients who continue to work will be covered by the alliance system.

- The cap on Medicaid spending will provide the final \$5 billion annually.

Medicare and Medicaid for AFDC and SSI Recipients

Spending for Medicare recipients will continue to be funded as it is today -- through the Medicare trust fund and Part B premiums.

Funding for the cash assistance Medicaid population -- people on AFDC and SSI -- will continue to be paid for by the federal and state governments as payments into the regional alliances.

PAYING FOR REFORM
BUILDING UPON AN EMPLOYER-BASED SYSTEM
WHAT'S RIGHT WITH THE CURRENT SYSTEM

THE MAIN WAY WE PAY FOR HEALTH REFORM IS BY BUILDING UPON AN EMPLOYER-BASED SYSTEM:

- IT'S THE WAY MOST PEOPLE GET THEIR INSURANCE TODAY

ROUGHLY 90% OF ALL INSURED PEOPLE RECEIVE THEIR INSURANCE THROUGH THEIR EMPLOYERS. EMPLOYERS PAY THE LION'S SHARE OF THE PREMIUM; EMPLOYEES PAY A SMALLER AMOUNT OF THE PREMIUM AND PICK UP OUT-OF-POCKET SPENDING.
- EMPLOYERS AND HOUSEHOLDS PAY \$271 BILLION FOR HEALTH INSURANCE. (CHART 1)

THIS SYSTEM WORKS FOR THE VAST MAJORITY OF AMERICANS. IT'S WHAT'S RIGHT ABOUT OUR SYSTEM. UNDER REFORM, WE WILL PRESERVE THIS BASE OF FUNDING.

PAYING FOR REFORM
BUILDING UPON AN EMPLOYER-BASED SYSTEM
WHAT'S WRONG WITH THE CURRENT SYSTEM
A LACK OF SECURITY

I

THE CURRENT EMPLOYER-BASED SYSTEM PROVIDES SOME OF THE HIGHEST-QUALITY CARE IN THE WORLD FOR THOSE WHO ARE COVERED.

YET, 37 MILLION PEOPLE DON'T RECEIVE HEALTH INSURANCE. AND, 22 MILLION PEOPLE RECEIVE INADEQUATE INSURANCE.

FOR THE MILLIONS OF AMERICAN FAMILIES WITHOUT INSURANCE, A HEALTH CARE CRISIS CAN MEAN ECONOMIC RUIN. FOR THE REST OF US, IT MEANS WE GET HIT WITH AN EXTRA COST ON THE PREMIUMS WE'RE ALREADY PAYING. HOSPITAL EMERGENCY ROOMS DON'T TURN AWAY THE UNINSURED. THEY GET THE CARE. THE REST OF US PAY THE BILL.

PAYING FOR REFORM
BUILDING UPON AN EMPLOYER-BASED SYSTEM
WHAT'S WRONG WITH THE CURRENT SYSTEM
A LACK OF SECURITY
II

WHO ARE THE UNINSURED?

- 2/3 OF THE UNINSURED ARE EMPLOYED. MOST OF THEM WORK IN SMALL COMPANIES THAT CANNOT AFFORD THE HIGH COST OF HEALTH CARE PREMIUMS.

EVEN THOSE OF US WHO CURRENTLY HAVE INSURANCE ARE AT RISK OF LOSING IT AT ANY POINT - - IF WE CHANGE JOBS, MOVE, OR LOSE OUR JOB.

REFORM NEEDS TO PRESERVE WHAT'S RIGHT ABOUT OUR SYSTEM - - A STABLE SOURCE OF FUNDING. THAT'S THE EMPLOYER-BASED SYSTEM OF FINANCING.

IT ALSO SEEKS TO FIX WHAT'S WRONG - - PROVIDING SECURITY FOR ALL AMERICANS.

PAYING FOR REFORM
BUILDING UPON AN EMPLOYER-BASED SYSTEM
PROVIDING SECURITY
EMPLOYER RESPONSIBILITY

TO PAY FOR SECURITY, OUR PLAN REQUIRES ALL EMPLOYERS TO PAY FOR HEALTH INSURANCE FOR THEIR WORKERS.

THIS IS WHERE THE MOST SUBSTANTIAL PART OF THE PROGRAM COMES FROM...NOT FROM GOVERNMENT MONEY OR NEW TAXPAYER DOLLARS, BUT FROM MAKING EMPLOYEES AND EMPLOYERS PAY THEIR SHARE.

SOME CALL THIS AN EMPLOYER MANDATE, BUT WE THINK OF IT AS RESPONSIBILITY -- ENDING THE PENALIZATION OF FIRMS THAT DO PROVIDE INSURANCE FOR THEIR EMPLOYEES.

THE MAJOR PIECE OF FINANCING FOR THOSE UNDER 65 IS THE REQUIREMENT THAT ALL EMPLOYERS AND EMPLOYEES WILL BE RESPONSIBLE FOR THEIR HEALTH CARE. THEY PAY \$ BILLION. (CHART 2)

PAYING FOR REFORM
NEW GOVERNMENT SPENDING

GOVERNMENT IS NEEDED TO PROVIDE PROTECT JOBS AND PROVIDE SECURITY WHEN AMERICANS LOSE THEIR JOBS:

IF THIS WERE ALL WE WERE DOING WE COULD RELY SOLELY ON PRIVATE SECTOR FINANCING, AND OUR PLAN WOULD AFFECT ONLY THOSE WHO DO NOT PROVIDE OR GET HEALTH COVERAGE.

THIS SYSTEM LEAVES THREE HOLES THAT ARE STILL LEFT BY EVEN MAKING THIS SYSTEM.

FIRST, WE DO NOT WANT TO MAKE THIS NEW COSTS ON EMPLOYERS BE TOO DIFFICULT AND HURT THESE PLACES. SO WE PROVIDE SIGNIFICANT SUBSIDIES TO ANY BUSINESS, BUT MOST GENEROUSLY TO BUSINESSES WITH UNDER 50 EMPLOYEES. THE PRIVATE SECTOR IS STILL CARRYING MOST OF THE BURDEN, BUT THE SUBSIDIES ARE KEY FOR HELPING SMALL BUSINESSES AND INDIVIDUALS WHO ARE TOO POOR TO PAY THEIR FULL PREMIUM. AS YOU CAN SEE THE YEARLY AMOUNT OF GOVERNMENT SUBSIDY IN THIS PICTURE IS NOT GIANT. OF THE ____ ADDITIONAL COSTS THAT WOULD BE ON EMPLOYERS AND EMPLOYEES IF THEY HAD TO BEAR THE ENTIRE BURDEN, YOU CAN SEE THAT GOVERNMENT SUBSIDIZES ONLY ____%. THUS, THE YEARLY COSTS IS ____, AND OVER FIVE YEARS IT IS _____. WE ALSO INCREASE COSTS TO SELF-EMPLOYED SO THAT THEY CAN DEDUCTION 100% OF THEIR HEALTH COVERAGE.

SECOND, THE PRIVATE SYSTEM ALONE, DOES NOT PROVIDE EVERY AMERICAN WITH TRUE SECURITY BECAUSE IT DOES NOT ANSWER THE QUESTION OF WHAT WE DO FOR AMERICANS WHO LOSE THEIR JOBS, THEIR HEALTH INSURANCE AND POTENTIALLY ALL OF THEIR SAVINGS IF THEY WERE TO FALL ILL WHEN THEY ARE UNEMPLOYED. SO WE NEED PUBLIC SECTOR FUNDING IF WE ARE TO SAY TO EVERY AMERICAN THAT THEY WILL ALWAYS BE COVERED EVEN WHEN THEY ARE UNEMPLOYED. THE SUBSIDIES FOR UNEMPLOYED WORKERS IS _____. TOGETHER WITH SMALL AND OTHER BUSINESSES AND AMERICANS WHO LOSE THEIR JOBS, THE TOTAL SUBSIDY IS \$160 BILLION. WE PAY FOR THIS WITH A SIN TAX AND THROUGH MEDICAID SAVINGS

[AT THIS POINT, WE HAVE FINISHED THE UNDER 65 GOVERNMENT BENEFITS, AND COULD GIVE THE UNDER 65 GOVERNMENT FINANCING,

WHICH WOULD BE SIN TAXES, CORPORATE ASSESSMENT, AND PART OF THE MEDICAID SAVINGS]

THIRD, WHILE MEDICARE WORKS WELL OVERALL, ITS COSTS RISE TOO HIGH AND THEREFORE MEANS WE SPEND SUCH HIGH RATES ON PROVIDER PAYMENTS THAT WE DO NOT HAVE ENOUGH FUNDS TO PAY FOR BENEFITS SENIORS VERY MUCH NEED -- DRUG BENEFITS AND LONG-TERM CARE. THEREFORE, WE TRY TO CUT PROVIDER PAYMENTS ON MEDICARE SO THAT WE CAN SHIFT THOSE FUNDS TO PAY FOR THE LONG-TERM CARE AND DRUG BENEFITS.

HOW DO WE PAY FOR THE PUBLIC COSTS?

HERE I WOULD DIVIDE UP 65 AND UNDER AND 65 AND OLDER AND SAY HOW WE WILL PAY FOR IT. WE PAY FOR THE \$169 BILLION IN SUBSIDIES FOR SMALL BUSINESS AND THE UNEMPLOYED THROUGH \$105 BILLION IN SIN TAXES AND \$68 BILLION IN MEDICAID SAVINGS THROUGH CUTTING DISPROPORTIONATE MEDICAID SAVINGS THAT ARE NO LONGER NEEDED NOW THAT EVERYONE WHO WALKS THROUGH THE DOOR WILL BE COVERED.

WE RAISE AN ADDITIONAL \$46 BILLION FROM MEDICAID AND \$124 BILLION FROM MEDICARE THAT MORE THAN PAYS FOR THE ADDITIONAL \$152 BILLION IN LONG-TERM CARE AND DRUG BENEFITS. THE MEDICAID SAVINGS COME FROM PUTTING ALL OF THE MEDICAID RECIPIENTS IN THE NORMAL PRIVATE SECTOR SYSTEM INSTEAD OF THE MEDICAID SYSTEM THAT NOW GOES UP BY 16% A YEAR.

THIS ESSENTIALLY PAYS FOR IT. OTHER TWO THINGS PAY FOR THE \$29 BILLION PLUS SOME DEFICIT REDUCTION.

SHOW OVERALL BALANCE SHEET.

III. HOW DO WE KEEP COSTS LOWER SO AVERAGE PEOPLE GET LOWER PREMIUMS AND BUSINESS SPENDING ON HEALTH CARE GOES DOWN:

WHETHER OR NOT ONE AGREES WITH OUR POLITICAL ASSESSMENTS; WHETHER OR NOT ONE AGREES WITH OUR POLICY JUDGMENTS AS TO HOW FAST HEALTH CARE SPENDING CAN BE LOWERED, IT IS IMPORTANT TO AT LEAST HAVE COMMON GROUND ON THE VALIDITY OF THESE NUMBERS.

THE MAIN DISAGREEMENT THAT PEOPLE HAVE HAD IS THAT THERE IS DIFFERING OPINIONS AS TO HOW MUCH COST CAN COME DOWN.

1. COSTS WILL COME DOWN THROUGH ENDING THE SHIFTING THAT COMES WITH UNCOMPENSATED CARE. [CHART ON THIS] [UNCONTROVERSIAL -- SHOULD BE LAID OUT SEPARATE AND AT BEGINNING]

2. WE BELIEVE THAT COSTS CAN COME DOWN OVERALL FROM GETTING RID OF WHAT WE BELIEVE ARE PERVERSE INCENTIVES IN OUR HEALTH CARE SYSTEM.

CHARTS ON PROBLEM:
HERE IS GDP COMPARISON
PAPER WORK

CHARTS ON SAVINGS FROM REFORM

CHARTS ON EVIDENCE

IV. WHAT IF SOMETHING GOES WRONG?

NOW SOME WILL SAY, THAT WHAT THEY WANT TO KNOW IS WHAT IF SOMETHING GOES WRONG? WHAT IF WE DON'T GET ALL THE SAVINGS WE SAY? I WANT TO ADDRESS THE MAIN ARGUMENTS ONE BY ONE.

1. CAN GET MEDICARE: TAKE IT ON, HEAD ON. AT END SAY, IF PEOPLE FAIL TO SEE WHAT A GOOD DEAL IT IS FOR SENIORS WE WILL PHASE-IN SLOWER.

2. WHAT IF GROWTH DOESN'T COME DOWN THAT FAST. GIVE EXAMPLE, AND SHOW THAT WE CAN LIVE WITH IT. PREMIUMS AND SUBSIDIES COULD GO UP, BUT IT IS MANAGEABLE. WHY SHOULD WE SHOOT SO LOW? CAPS AS DISCIPLINE MECHANISM.

3. ALSO SHOW THAT THINGS COULD GO RIGHT. GIVE STRONG ARGUMENT ON COST-SAVINGS FROM PREVENTATIVE CARE AND SAY HOW THAT IS NOT EVEN SCORED.

Isn't any other plan that even reached the 1st stage of analysis - Confidence in these #'s. - more analysis than anyone's ever done. Extraordinary resources brought to bear. Fundation is secure - may change blocks.

HEALTH CARE AND ECONOMIC MESSAGE

AGENDA

September 19, 1993

analysis of critics

haven't come close.

we've set a very high standard than ever been attempted.

FINANCING AND JOBS COMMUNICATIONS:

Goal: To ensure that top economic and health spokesperson for the Administration agree on the message for major economic issues and questions. We should leave with understanding of answers for key questions. These agreed on answers will be circulated on Monday morning.

Unprecedented process

FINANCING:

Major Decisions:

I. Framework for Addressing Financing Issue:

- How to frame the issue: overall health care costs or as federal deficit issue
- Public as audience
- Elite Press and Congress as audience

most anyone pay 3.7% of their income
Avg person 1.9%

very state-run region

II. The Case for the Numbers:

- Unprecedented Process
- Describing Stage: final or preliminary
- How much could numbers change
- CBO: expectations and deference

Likely Questions for Economic Team:

1. Deficit Reduction and GDP
2. International and Domestic Evidence that Costs Can be Cut to this level.
3. How to Describe Budget and Cap Process: (Refuting the regulatory charge. Do we make this debate about seriousness over the deficit. Entitlement caps.)
4. Sin Taxes + Corporate assessments - no more than 1.5%

5. Medicare:
 - Why it is real
 - Why it seniors still benefit
 - Why it is comparable to other both health care and entitlement cap proposals

We're controlling rate of growth in premium & drug costs

6. Corporate Assessment
7. Describing Who Pays; Who bears costs?
 - What do we explicitly say as to who does better or worse?

Reinvested in Medicare

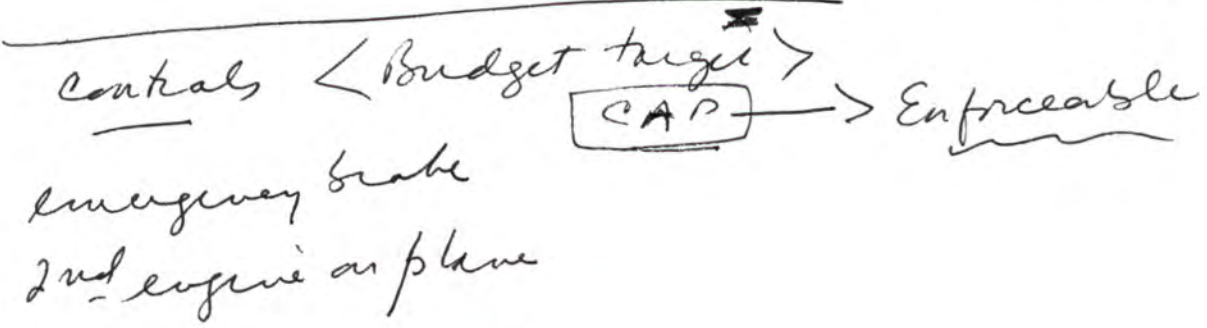
Private sector savings come from caps + other things. Fightes than public

- ① Those now don't pay will - ϕ business
- ϕ more, get better benefits
 - ② Sin tax
 - ③ Medicare/Medicaid
- ϕ young who think immortal

Rejected -

- ① a pure good solution
- ② broad-based tax

Get something
money can't buy:
Security



Minnesota example:

→ Gallenice goes over budget,
plans in that alliance
premiums are adjusted down -
the providers have to deal with that

- 1- Confident #'s
- 2- " of unprecedented process
- 3- ?'s about politically achievable or right mix

JOBS ISSUE:

Major Decisions:

I. Overall Message:

II. Is there an official Administration Number or Study?

- likely criticism
- distinguishing between straightforward economic proposals (like jobs bill) and complex moving parts like NAFTA and health care.
- Better to look at job and competitiveness trends

Recommendation:

1. (Current Studies are Bogus:)
2. Administration could come up with positive jobs number, but we really feel that because of the complexity of the issue, it is not appropriate.
3. Clear, however, that good for the economy because the cost of doing nothing is so great.
4. Furthermore, there is plenty of good evidence that this will be good for competitiveness and jobs.

If don't do anything, we will be job loss & wage stagnation. Could be big increase.

- small firms with insurance -
 - fastest growing small businesses -
 - manufacturing jobs -
 - minimum wage studies - doesn't cost jobs
 - Hawaii & state-by-state show no negative job loss
 - job growth in home-care service (+750,000)
 - business certainty that fixed health care cost will not escalate
 - CEOs would not support job loser - health costs killing bus & billions need in system
- eliminates job lock
- people off welfare
- retirees is not job loss*

Over #'s are going to hold up - Best process ever put together

#'s: (We don't appreciate signing w/ change in #'s) Changes as choices are made.

consequence about #'s - Bone about policy

Melanne

QUESTIONS AND ANSWERS ON FINANCING

Q: How can you cover everybody and maintain quality and give comprehensive benefits and add preventive care and new drug benefits and look at me with a straight face and say that you're going to pay for all that by cutting waste?

A: I'm glad you asked that because that's not how this plan will be financed. Let me tell you how we propose paying for health care reform.

There are three basic sources of funding.

1. *First*, we ask the 37 million people who don't have insurance and companies who don't provide it to their employees to take responsibility and contribute to the system. Right now, all of the rest of us are paying the price for the uninsured -- and that's just not right. But it's also not right to continue a system in which the vast majority of the uninsured -- 85% of them who are working people or their families -- can't afford health insurance. We're going to ask them to take responsibility to help finance the health care system, but we're also going to make sure they can afford to -- with discounts for low income workers, the unemployed, and low-wage and small businesses.

Two-thirds of the financing for premiums to ensure that all people are covered comes from asking employers and employees who don't pay now, to start taking some responsibility.

Now, there are a number of different proposals about how those 37 million should contribute to the system. We propose an extension of the current system where employers take the primary responsibility, but individuals share that responsibility. That's a pretty conservative idea which was first introduced by Richard Nixon. Others believe that primary responsibility should be only with the individual -- an individual mandate, not an employer mandate. Many fear that an individual mandate will disrupt the current system: that it will cause employers to drop people from their coverage. I assume that's a debate that Congress will have in the coming months.

2. **Second**, we are going to limit the growth of government spending. We all know that it's tough to stop government spending, but we do think we can slow it down. And unlike other proposals in the past, we won't do it with vague caps. We will do it with specific, scorable, line-by-line savings proposal.

In the past, we haven't been able to achieve savings in the growth of Medicare or Medicaid for a few reasons: First, because it was outside the context of health care reform, savings were assumed to be from the cuts in the middle class or poor. Let me be clear, this President has no intention of putting those beneficiaries at risk. Indeed, Medicare recipients will see their benefits increase through the President's plan.

II. GOVERNMENT IS NEEDED TO PROVIDE PROTECT JOBS AND PROVIDE SECURITY WHEN AMERICANS LOSE THEIR JOBS:

A health plan could, of course, do nothing more than require all employers and employees to pay their fair share. If this were all we were doing we could rely solely on private sector financing, and our plan would affect only those who do not provide or get health coverage.

This system leaves three holes that are still left by even making this system.

First, we believed that it would be too hard on business and some low-income individuals to require those who do not provide to do so right away with no transitional help from government. We believe that everyone should be responsible, but we recognize that as it has not been that way, we must provide assistance to business -- particularly small business -- so that the cost of transition is manageable and will not hurt job growth.

Some have said our discounts to small business and to some large manufacturer have been generous -- and to this we plead guilty. But I think we need to find a way to have small businesses that create jobs and provide health care to their workers and I think we cannot ignore the harmful effects to our competitiveness and manufacturing base when a car made in America has \$1100 more dollars due to health care than one in Japan.

Second, another key reason that an requiring all employers to provide alone would not be significant, is that this alone would not provide the core of our plan and the core of what we believe Americans most want -- health security. Employer coverage alone, does not provide every American with true security because it does not answer the question of what we do for Americans who lose their jobs, their health insurance and potentially all of their savings if they were to fall ill when they are unemployed.

So we need public sector funding if we are to say to every American that they will always be covered even when they are unemployed.

All together the subsidies and discounts needed to provide discounts to small -- and some large -- business, and to the working poor and the unemployed comes to \$160 billion -- a \$169 billion if you include the 100% deduction to the self-employed between now and the year 2000.

The third reason that we believe we need to look to benefits beyond full employer responsibility is that we believe that there are holes in the coverage we provide senior citizens. While Medicare works well overall, its costs rise too high and therefore means we spend such high rates on provider payments that we do not have enough funds to pay for benefits seniors very much need -- drug benefits and long-term care.

Therefore, our plan cuts provider payments on Medicare so that we can shift those funds to pay for the long-term care and drug benefits.

Unlike other proposals in the past, we won't do it with vague caps. We will do it with specific, scorable, line-by-line savings proposal. In the past it has also been difficult to achieve significant savings in the growth of Medicare or Medicaid for a few reasons:

First, because it was outside the context of health care reform, savings were assumed to be from the cuts in the middle class or poor. Let me be clear, this President has no intention of putting those beneficiaries at risk. Indeed, Medicare recipients will see their benefits increase through the President's plan.

For every \$1 of savings we are calling for that affect Medicare beneficiaries, we are proposing \$3 in increased benefits in long-term care and drug benefits.

Second, past proposals weren't reforming the private sector side, people rightly worried that costs would be shifted to the premiums of the insured middle class and small businesses who were already taking the worst hit, and

Third, this would create a differential between Medicare patients and others. In the context of a plan to bring down private sector costs, however, we can reduce Medicare savings without shifting costs or creating a differential.

The costs of the long-term care program over five years is \$80 billion and the costs of the prescription drug benefit is \$72 billion. As with the under 65 benefits, the financing of these benefits is straightforward and largely uncontroversial. 80% of the costs are paid for by \$124 billion in Medicare savings. The rest is more than paid for by capping the amount of Medicaid spending by taking these Americans out of Medicaid and putting them with everyone else in the private, alliance system.

Now, many may not agree with our policies. Others may not think you can pass these many Medicare savings. Again, we disagree. But let's be clear. These are line, by line specific scorable savings in Medicare, and it is a disservice to public discourse for people to in any way say that these are not real.

Our plan and every Democratic and Republican plan that has been proposed recognizes that with national health care reform, we can save money in the rate of growth in Medicare and Medicaid. Indeed, the other serious proposal so far have comparable Medicare savings, and the Senate Republican budget proposal received 43 votes and received had at least as much savings – with no offsetting benefits. You will debate how fast those savings can be achieved and how big those savings can be, but I think we all agree that there will be savings that will be our second major source of financing for health care reform.

PRIVATE AND PUBLIC NUMBERS ON HEALTH SECURITY PLAN

I. PRIVATE FUNDING OF HEALTH SECURITY PLAN

- Two-thirds of premium cost of ensuring health security for all Americans, comes from making all those who don't pay now, and can afford, start bearing responsibility for health care.
- That means in the first year (1994 dollars), the overall costs would be approximately \$61 billion. \$25 billion would be from business spending; \$14 billion from households, and \$21 billion from government.

[NOTE: The \$21 billion government cost grows to average \$32 billion a year, \$160 billion over five years, because of inflation and of because of a \$20 billion cushion built in as a contingency against uncertainty.]

ILSEVEN YEAR TOTAL FEDERAL COSTS FOR HEALTH SECURITY PLAN

USES OF FUNDS FOR HEALTH CARE REFORM:

Long-term Care	\$80 billion
Medicare Drug Benefit	72 billion
Public Health/Admin Costs	29 billion
Discounts for Businesses and Workers	160 billion
100% Self-Employed Deduction	<u>9 billion</u>
Total For Health Care	\$350 billion
Deficit Reduction	91 billion
TOTAL HEALTH CARE/DEFICIT REDUCTION	\$441 billion

SOURCES OF FUNDS:

Medicare	\$124 billion
Medicaid	114 billion
Reductions in Federal Programs	47 billion
Reduction in Growth of Tax-Free Benefits	51 billion
Sin Taxes/Corporate Assessment	<u>105 billion</u>
TOTAL	\$441 billion

THE \$259 BILLION SHIFT: The Clinton plan has inaccurately been described as calling for \$700 billion more in government health care spending. The source of this confusion is the shift of \$259 billion among federal programs, which amounts to an accounting change. Currently, under Medicaid, the federal government and the states reimburse providers. Now, rather than sending that money directly to providers, the government will send the same money to cover the same people through the regional alliances. If a company spent \$1 million on employee health insurance through Insurer A, and then shifted to Insurer B, no one would see that company as spending \$1 million more. The same is the case here. In addition, more Medicare beneficiaries who work will have employer-paid insurance as their primary payer, reducing costs to the Medicare program.

III. EVIDENCE AND EXAMPLES OF WHY THE CLINTON HEALTH SECURITY PLAN WILL BRING SAVINGS:

There are many people who doubt that we can save money when we reform our health care system. But evidence in this country and abroad shows that the kinds of changes we are proposing -- increased competition backed up by a limit on premiums -- can control costs.

1) By reducing uncompensated care, we will achieve clear savings.

Today, the government reimburses doctors and hospitals for \$25 billion worth of "uncompensated care" -- care given to uninsured patients who can't afford to pay their medical bills. With universal coverage, that cost will disappear.

2) Our international competitors control costs and provide security to all their citizens.

Germany and Japan have been able to keep the growth in their health care costs down to GDP while ours have been growing at 9% and 10%.

3) States that have tried reform have been able to control costs.

Look at Minnesota. It has kept its annual rates of increase 2% below statewide trends for the last two years after reform.

4) Health plans today that are cost-efficient, provide high-quality care, and emphasize prevention can control costs.

The Mayo Clinic has kept its growth down to 3.9%.

In Northern California, Kaiser Permanente members have 25% fewer hospital days per capita than other residents.

5) More information about health outcomes can point to potential areas of savings. More money spent doesn't always mean higher quality care.

Open-heart surgery that costs \$21,000 in one Pennsylvania hospital costs as much as \$84,000 in another hospital in the same state. And, the lower-cost hospital had better outcomes.

The Central Florida Health Care Coalition persuaded hospitals to analyze why costs and quality of care differed for patients with the same illnesses. With this information, costs per hospital discharge fell 2%.

6) Streamlining administration and cutting paperwork will save money.

Under today's system, up to 30-40% of the premiums paid by small firms goes to administrative costs. Under reform, firms with 5,000 or fewer employees will join together to lower administrative costs.

A growing share of the health care dollar pays for processing paper. For every doctor hired at a hospital, there are four administrators hired. Under reform, a single claims form replaces the hundreds of different forms. One comprehensive benefits package, and standardized reimbursement rules, procedures and regulations will cut administrative costs.

7) Putting consumers in the drivers' seat and forcing health plans to compete for their business will bring down costs.

In California, when consumers joined together in a large purchasing pool, they received bids on one plan that were as much as 55% lower than the same plan offered by the FEHBP.

In Orlando, the 78-member Central Florida Health Care Coalition succeeded in negotiating better prices with regional hospitals that enabled the Orange County School Board to keep 20 teaching jobs it had planned to cut.

In Memphis, eleven employers, the Memphis Business Group on Health, commissioned a study in 1987 that found that some hospitals charged as much as 80% more for the same service. The group published the findings and took competitive bids for its business (25,000 employees). One hospital, Baptist, offered discounts of up to 20%, and the members of the coalition believe that they have saved tens of millions of dollars.

8) Prevention will save money in the long-run.

Look at Birmingham, Alabama. In 1983 the city government's health care expenses were rising at twice the national average. Officials launched a full-scale prevention program. From 1985 to 1990 the city's health costs did not rise, even as the price of care skyrocketed. By investing \$3 million in health promotion, Birmingham officials estimate they saved \$10.5 million over five years.

SUMMARY OF FINANCING FOR HEALTH SECURITY PLAN

I. THE MAIN WAY WE PAY FOR HEALTH INSURANCE IS BUILDING OFF THE OUR SYSTEM OF PRIVATE SECTOR FINANCING THAT WORKS BEST.

Under our current system, most people are covered through their employers. Currently, 90% of Americans who have private insurance through their employers.

Yet, some do not pay, which is bad for millions of families without insurance who live in fear, and bad for those of us with who end up paying for the costs of the uninsured, because when they get sick we don't turn them away, we give them care in emergency rooms and the rest of us pay the bill.

Because a fundamental premise of our plan is to build on the building blocks of our health system that work, our plan builds on the employer-based, private sector provision by making employers who do not provide insurance to their workers pay for comprehensive care for all of their workers. Some call this an employer mandate, but we think it is about responsibility, about ending the penalization of firms that do provide insurance for their employees.

Many people who are interested in financing have missed the basic fact that the substantial portion of the financing for health security comes from extending our current system. Currently, insured employees and their employers cover 140 million Americans. As you can also see today, 22 million receive inadequate coverage and 37 million receive no health insurance. The major piece of financing for those under 65 is the requirement that all employers and employees will be responsible for their health care. Indeed, of the funds needed to pay for proving all Americans health security, two-thirds comes from the simply making all American employers and employees who can bear responsibility for health care.

So the simple answer to the question, how can we cover so many people without a general tax increase is that we are asking every employer to be as responsible as the great majority of employers are today.

So while we believe that nearly every American will be better off through the Health Security Plan, there is no free lunch. Those who do not pay for health coverage for their employers or themselves currently, will pay more under our plan.

For every \$1 of savings we are calling for that affect Medicare beneficiaries, we are proposing \$3 in increased benefits in long-term care and drug benefits. Second, past proposals weren't reforming the private sector side, people rightly worried that costs would be shifted to the premiums of the insured middle class and small businesses who were already taking the worst hit, and that third, this would create a differential between Medicare patients and others. In the context of a plan to bring down private sector costs, however, we can reduce Medicare savings without shifting cost or creating a differential.

Our plan and every Democratic and Republican plan that has been proposed recognizes that with national health care reform, we can save money in the rate of growth in Medicare and Medicaid. Indeed, the other serious proposal so far have comparable Medicare savings, and the Senate Republican budget proposal received 43 votes and received had at least as much savings -- with no offsetting benefits. You will debate how fast those savings can be achieved and how big those savings can be, but I think we all agree that there will be savings that will be our second major source of financing for health care reform.

3. *Third*, we're going to place a tax on tobacco. This plan has no broad-based tax, but I think it's appropriate when we're trying to encourage health in this country to put a tax on tobacco which everyone acknowledges will help discourage smoking and therefore promote good health. And finally, we're going to ask those large corporations that form their own alliances to help support the backbone of our health care system -- academic health centers and research.

Other plans that have been proposed suggest a different approach to taxes -- a tax on health care benefits above the comprehensive benefits package. Most of these proposals would call for taxing the benefits of at least 35 million American workers. We would prefer to raise around \$100 billion through a cigarette tax and corporate assessment. Again, these are things that we can debate, but I think most of us agree that no broad based tax is needed and Congress will debate what new revenue sources are appropriate.

Those are the three primary sources of private and public sector funding that will pay for health security for every American. That will guarantee that every American has a comprehensive package of benefits that can never be taken away. We believe that it is a fair approach to financing: one that asks responsibility of everybody involved. It is also a conservative approach. We are not counting in cost savings that we believe will come from emphasizing prevention, and by encouraging competition in the health care system.

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The White House

Health Care Reform Today

September 13, 1993

◆ **The financing estimates in the administrations proposal are both conservative and credible.**

Our financing proposed was developed under the most rigorous and conservative forecasting standards. While some of the specific preliminary numbers leaked by outsiders last week may change as fine-tuning occurs in the consultation process, the overall financing structure is rock solid and will remain intact.

From the very beginning, the Administration has devoted countless hours developing the most credible and conservative estimates ever in the history of health care forecasting. A group of actuaries, health economists and other financial analysts from within and outside government have been working together almost daily.

The group includes representatives from every federal agency involved in fiscal accounting and financial projections, including the Department of Treasury, the Department of Health and Human Services, and The Office of Management and Budget. This is the first time all federal health care forecasting efforts have been brought together.

◆ **Administration officials are not considering a new Federal tax on hospitals.**

The administration is not considering a new tax on hospitals. Ira Magaziner, senior policy advisor to the President made it crystal clear at a White House briefing yesterday: "...the administration is not considering a tax on hospitals in order to pay for this reform. There have been no discussions of such a thing since May when we were considering every idea that was presented to us. And any suggestion to the contrary is absolutely untrue. We feel that hospitals must remain the cornerstone of our health care system and our plan fully recognizes their critical role.

◆ **The administration proposal will not cut Medicare and Medicaid, forcing reductions in the quality and amount of health care services.**

There are no Medicare or Medicaid cutbacks in the reform proposal. The plan calls only for slowing the rate of growth in future Medicaid and Medicare spending. Under this proposal, Medicare and Medicaid will continue to grow at a rate faster than private sector health spending and faster than other goods and services in the economy.

The proposal does not cut benefits to seniors. It protects what they have and gives them more -- prescription drugs and better long-term care. Every cent -- and then some -- of Medicare savings will go toward new long-term care and prescription drug benefits for Medicare recipients.

For the next two years, Medicare and Medicaid will continue to grow at their current projected rates -- which are substantially in excess of the growth in private sector health expenditures. For 1994 and 1995, Medicare will still grow at 11.2%.

To solve the problem of skyrocketing health expenditures, we have to address what's going on in Medicare and Medicaid. These programs are growing at astronomical rates -- 11% and 14% respectively, compared to about 7.5% in the private sector. If we let them continue to grow at these rates, they will be responsible for over 2/3 of the increase in government spending during the next decade.

It also must be remembered that savings in Medicare and Medicaid will come alongside billions of new revenues for providers from the creation of millions of newly insured paying patients. Doctors and hospitals will not be beggared, and access will not be diminished.

Finally, the savings in these programs must be taken in the context of restraints on private sector health spending growth. That eliminates the question of whether federal program cuts will shift costs to private patients.

◆ **Hospitals dependent on Medicare will not close. This plan will not have a real impact on low-profit and high Medicare population hospitals,**

The administration reform proposal guarantees universal coverage and access to every American. Specific provisions increase funding for hospitals and other providers serving inner city and rural communities and strengthens them.

◆ **Firms that now do not insure some or all of their workers would be able to purchase insurance at a discounted rate.**

Requirements that firms not now insuring contribute to coverage would amount to only \$1 per day per worker in the lowest--wage small firms -- roughly a 75% discount from what would be an already much lower prevailing premium. And that's for solid, comprehensive guaranteed coverage. The vast majority of small firms that don't insure now because they can't afford to would leap at an offer like that.

A firm with an average payroll of \$20,000 per full-time worker would pay no more than \$1100 per worker, or approximately \$3 a day.

◆ **President Clinton's health care plan will mean higher costs and fewer benefits.....quite the opposite.**

The two things that people will see that's fundamentally different from what they get today are that they will never lose their health coverage and that they won't face skyrocketing increases in their premium rates. As they do today, most Americans will have most or all of their health care costs paid for by their employers. More than they do today, all Americans will have a choice of health plans and doctors. Finally, the benefit package, as comprehensive as what's offered by most Fortune 500 companies, is the minimum level of benefits guaranteed to all Americans. Employers who want to offer more benefits can continue to do so under our plan.

◆ **Many people whose entire cost of health care is now provided by their employers would not be required to pay as much as 20 percent of the premium price.**

That's not true. The plan sets a floor on employer contributions (at least 80%), not a ceiling. Firms paying 100% of premium now can continue to do so without penalty.

◆ **The plan does not call for government to set and monitor price controls on public and private-sector health spending.**

The emphasis in the news media on what it calls "caps" in the rate of growth for health insurance premiums and on major government health programs misses a critical point:

The Clinton plan for health reform is built around making the competitive market in health coverage work to control costs and bring down rising premiums, prices and government spending.

There are no government price controls in the plan. There is an emergency brake that stands as an extra safety net to guard against the outside chance that competitive forces will not prove strong enough to control rising health care costs in some areas.

But it is an emergency brake - - not the mechanism for bringing the rising cost of health care under control. Under the Clinton plan, employers pay a **minimum** of 80% of the cost of the comprehensive benefit package. As they do today, some firms may choose to pay the full share of the premium.

Health-Care Reform Costs: Rumor Is Scariest Than Reality

Policy: An understanding of current spending will make it easier to accept the more "expensive" forms of change.

By THEODORE MARMOR and JERRY MASHAW

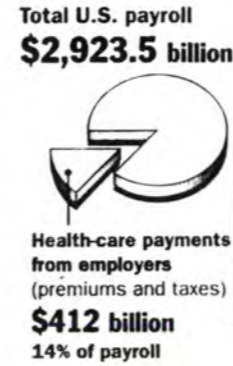
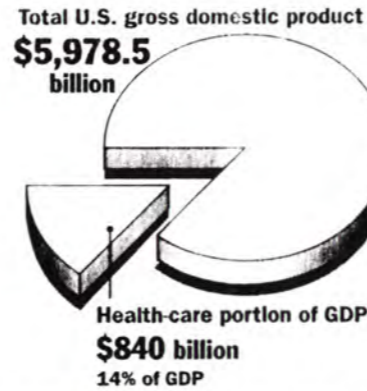
Much of the current interest in health-care reform focuses on how much it will "cost" and how it will be financed. There has been plenty of hype, but little attention to the fact that most of the cost of reform will be substituted for what we already pay, not added on top of it. And we already pay, from one source or another, a double-digit chunk of national income for health care.

A recent Times headline speculated: "Health Plan May Call for 12% Payroll Tax on Firms." As reported, the 12% estimate was for the "most generous of the three possible benefit packages" presented to President Clinton. The suggestion was that less generous plans would "cost" less, maybe 7% to 9% of payroll.

Let's compare these proposed payments into a new national system to the way we currently pay for medical care.

1 WHAT WE PAID LAST YEAR

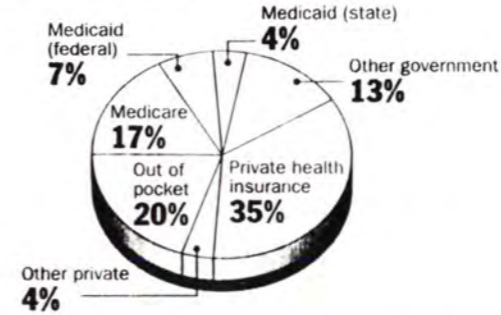
First, put the speculative proposals in context:



Source: Economic Report of the President, January, 1993

2 WHERE HEALTH-CARE MONEY COMES FROM

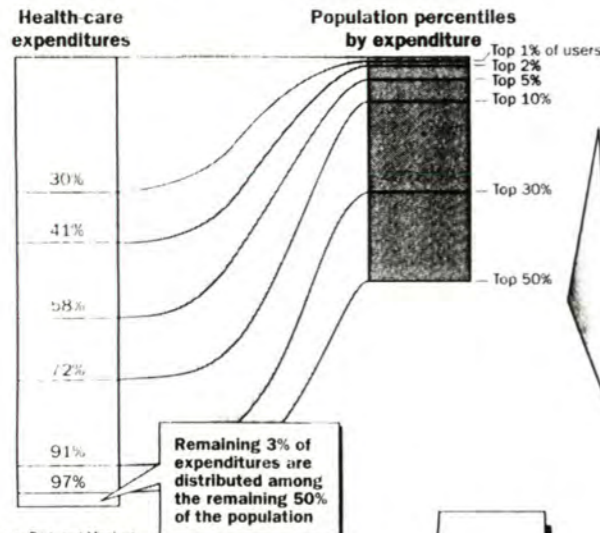
The \$840 billion of spending on health care in 1992 comes out to about \$3,330 for every man, woman and child in the United States. (That would mean \$13,000 per year for the hypothetical average family of four.) But payment for the bill comes from several sources. Figures for 1991:



Source: Congressional Budget Office, "Managed Competition and Its Potential to Reduce Health Spending"

4 WHO USES MEDICAL CARE DOLLARS

The amounts spent on behalf of individuals, of course, differ radically. For example, 1% of the population accounts for 30% of health-care expenditures; half of the population uses almost no health-care dollars. This is another way of saying that most of us are not seriously sick most of the time and that insurance—private or public—redistributes burdens from the well to the sick and, sometimes, from the rich to the poor.

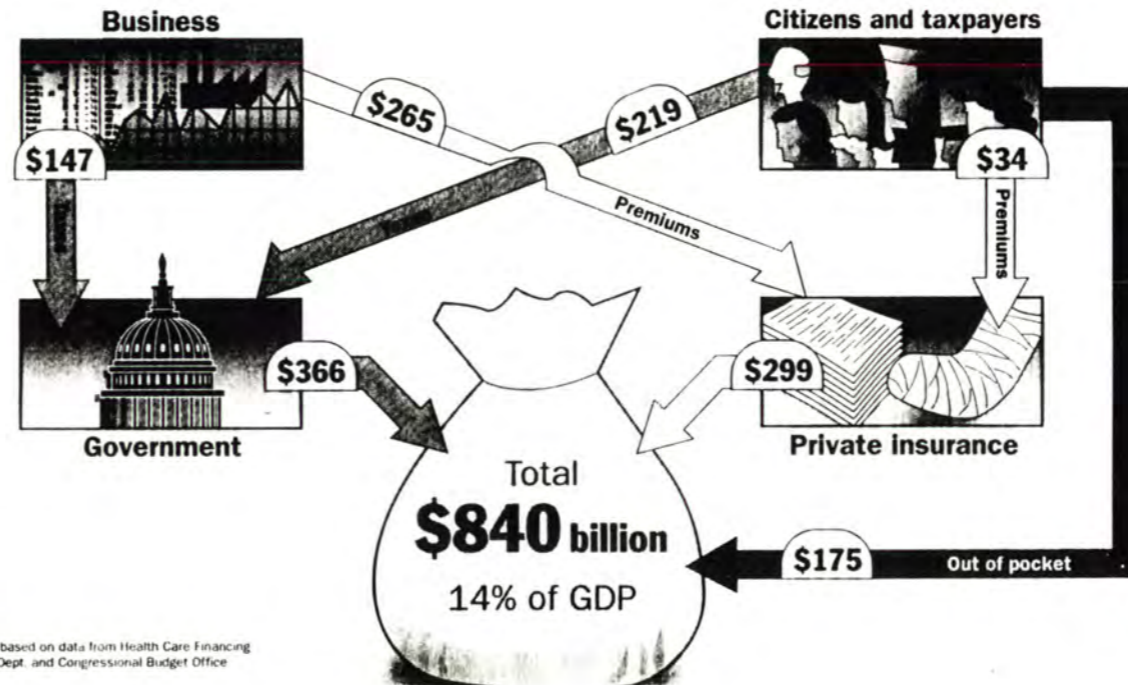


Source: Berk and Monheit, "The Concentration of Health Expenditures: An Update," Health Affairs (Winter, 1992)

3 HOW IT'S PAID

Current financing is a jumble of payers. Any national plan must start from this state of affairs:

In billions



Sources: Estimates based on data from Health Care Financing Admin., Commerce Dept. and Congressional Budget Office

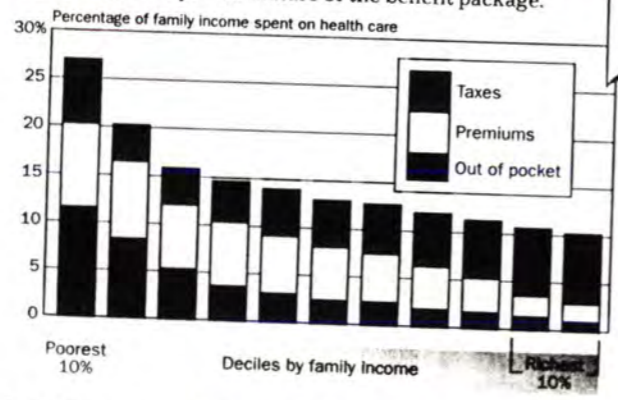
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Los Angeles Times 7-6-93

5 HEALTH-CARE COSTS AS A PERCENTAGE OF INCOME

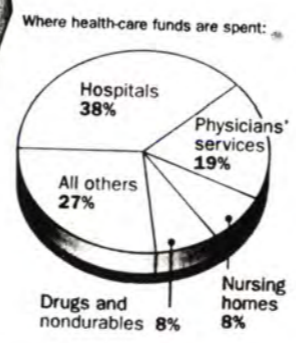
On the other hand, the higher their income, the lower the proportion of their income that Americans pay for medical care. Families in the bottom 10% (incomes below \$6,000 a year) spent a whopping 27% of their money on medical care (including the portion of taxes that goes to government health programs). By contrast, the figure was 15% for families with incomes of \$22,000 to \$27,000 and only 10% for families with incomes above \$93,000. Any effort to have all Americans pay a comparable proportion of their incomes for universal health insurance will obviously produce winners and losers, no matter what the precise nature of the benefit package.



Source: Rosell et al. Economic Policy Institute, briefing paper, April, 1993, based on 1987 data

6 CUTTING UP THE MEDICAL DOLLAR

This chart illustrates the confusion created by focusing on the "costs" of various reform plans, some of them more generous than others. Just because a plan excludes some service does not mean that the service or its costs would disappear.



Source: Congressional Budget Office, "Managed Competition and Its Potential to Reduce Health Spending," May, 1993

Conclusion: Costs Can Be Controlled, but Not By Wishing Them Away

Imagine a Clinton proposal that excluded hospital care in its "least generous" plan. Would hospital care not be provided, its costs not incurred? Not on your life. The costs would just be in different accounts and in somewhat different amounts.

So, what benefits are "covered" influences but does not determine what is spent or by whom. Yes, private insurance companies currently estimate costs by what what is covered in a particular plan. For them, more extensive benefits necessarily mean greater costs. But this is accounting, not economics, and certainly not public finance economics.

Another way of proceeding, employed in much of the developed world, is to set a national medical budget, cover what ordinary Americans regard as medical care, then let the medical professionals,

within that budget, allocate care to the sick.

With 14% of our national income allotted to medical care, we spend more than any other society on Earth. To expand insurance coverage to all, with a broad range of services eligible for payment, is certain to mean we will not spend less than that, at least initially. But there is no reason to believe we must spend 14% or more forever. And there is even less reason, given the level of current expenditure, to regard 12% of payroll as an astounding amount. If our total outlays are very large, the component parts of our financing will have to be large. The only way to reduce those outlays is to pay less for the care we give, give less care, pay less for administration or do some of all three.

Limiting benefits to only some of the procedures that are widely

regarded as ordinary medical care in order to control costs would be very shortsighted. Even the costs of a "generous" package of benefits are controllable by a combination of budgeting, negotiation and regulation.

That is the lesson of reforms in Hawaii, Maryland and New York—not just Canada, Germany and Japan. And surely it is this sort of reform that Americans want—not some misbegotten effort at fiscal prudence that "saves" dollars by drawing artificial boundaries between covered and uncovered medical care.

Theodore Marmor teaches management and Jerry Mashaw teaches law at Yale University. They are co-authors of "America's Misunderstood Welfare State" (Basic Books, 1992)

THE WHITE

Melanne Verveer
Office of the First Lady
Room 101 OEOB

Office of the P

For Immediate Release

September 21, 1993

PRESS BRIEFING

BY

DIRECTOR OF COMMUNICATIONS MARK GEARAN,
ASSISTANT TO THE PRESIDENT ON ECONOMIC POLICY BOB RUBIN,
OMB DIRECTOR LEON PANETTA,
TREASURY DEPUTY SECRETARY ROGER ALTMAN,
COUNCIL OF THE ECONOMIC ADVISORY CHAIR LAURA TYSON

The Briefing Room

1:16 P.M. EDT

MR. GEARAN: Let me start out with giving you a road map of what we're about to do today. We have Bob Rubin --

Q Mark, before you do that could we just get a little reaction to what's happening in Russia?

MR. GEARAN. I'm going to do that, yes. Yes. I'm going to do road map, then reaction. It's not alphabetical.

Bob Rubin, Leon Panetta, Laura Tyson, and Roger Altman, who will give a briefing on some of the questions that have been raised in terms of the financing of the health care system. They have a limited amount of time, so we'll go to them quickly.

Let me give you just a preliminary on events in Russia. We are just learning of the events unfolding in Russia ourselves at this time. We're in the process of getting more information and will be assessing it as the hours progress. We expect to have a statement later on in more detail and with more information than we're receiving at this point.

Q So we were not informed before the action by Yeltsin?

MR. GEARAN: No. Mr. Pickering was called in with some of the other foreign ministers in advance of it.

Q In advance of it?

Q How far in advance?

MR. GEARAN: Soon in advance of it. It was not --

Q Well, they're saying in Moscow less than an hour. Is that correct?

MR. GEARAN: I think that's correct.

Q What were they informed? The details of what Yeltsin would say, or just that Yeltsin would speak?

MR. GEARAN: They were informed of the speech. Let me leave it at that. That's about all we can provide.

Q When was the President informed?

MR. GEARAN: As the events were proceeding.

MORE

Q Mark, what form will the statement be?

MR. GEARAN: I'm sorry.

Q What form will his statement --

MR. GEARAN: We're waiting to see who will best respond or how we'll do that -- and whether it will be someone from the White House or Secretary Christopher will --

Q Do you know who told the President of these developments?

MR. GEARAN: The national security staff.

Q Before or after the National Service event?

MR. GEARAN: It was -- I'll have to confirm that. My understanding -- I think it was afterwards. Let me confirm that for you in terms of when he was told.

Bob.

MR. RUBIN: Thank you, Mark. I'm Bob Rubin, the Assistant to the President for Economic Policy. We're going to discuss the financing of the health care plan, which seems to be a subject of some interest. And let me start with a few general comments, and then we'll get into the specifics of the financing.

As was true in the economic plan -- and you heard the President say this in reference to the economic plan -- he'll say the same thing about the health care plan. From the very beginning, he insisted that we take enormous care with the numbers with respect to accuracy; that we have accurate, conservative, valid numbers, and that our policy decisions be based on such numbers so that there will never be a question about our numbers.

With the economic plan and again with the health care plan, his position was that he's happy to have all the debates people want to have about policy, but he does not want to have anybody validly questioning the validity of his numbers. And it's on that -- with that mandate that these numbers were developed.

There obviously will be a debate -- a national debate on health care policy, and there will be all kinds of issues. But what there shouldn't be any debate on is the validity of these numbers. They were developed with enormous care and enormous carefulness with respect to making sure that we had numbers that would withstand any kind of challenge.

I've been involved in my own career with enormous numbers of number developing processes. (Laughter.) I guess that fits together. And I can tell you, this was an exhaustive process. HHS, OMB, Treasury, CEA, actuaries, internal within the government involved with developing the numbers. And then there were external -- accountants and actuaries reviewed the models and reviewed the development of the numbers.

I can remember early in the process when there would be disagreements and there would be debates about the numbers. And Ira's position throughout it was that we had to have accurate numbers and then we make our policy decisions and these differences will eventually narrowed and brought down to numbers that everybody could agree on.

Finally, let me make one more comment on the process, itself. This was an exhaustive process of debate and discussion. We

had endless meetings amongst ourselves, and then with the President. Well, the ones with the President weren't endless, but we had endless meetings amongst ourselves and a goodly number of very lengthy meetings with the President. We all the ability to state whatever it is we wanted to state. There were healthy debates, there were lengthy debates, there were real differences of opinion just as there were with the economic plan. The groupings would be different over each issue. We had one grouping on one issue, another grouping on another issue. And out of it all came a plan, as was true in the economic plan, that all of us felt was a good plan and that realized the purposes that the President started out with, which was to develop a way of reducing or eliminating the enormous excess expenditure, which is I think unquestionable in our health care system, and then utilize those savings to fund the realization of his objectives. And that's what this plan is all about.

With that, let me turn it over to Leon Panetta, who will get much more involved in the specifics of the numbers.

DIRECTOR PANETTA: Let me again, preface these remarks by trying to compare a little bit of this to the economic plan. I mean, the fact is with the economic plan, there were models that were in place over the years. We had very good estimates about various proposals, either on the tax side or on the cut side, that have all been estimated before. There are economic consequences that have pretty well been estimated. So we basically had models in place that made us much more comfortable, obviously, with the numbers that we're dealing with.

In this instance, we're dealing with an unprecedented effort at reform of the entire health care system in this country. And the problem we had from the beginning is obviously to develop models that could estimate the impact of that kind of broad reform with regards to health care. What happens when you suddenly pick up almost 60 million Americans who are uninsured or under-insured, and bring them into a health care system? What are the costs of that? What is the impact on the health area? What are the behavioral consequences of bringing people into that kind of system? Then determining the cost impact, not only on business, but on employees, individuals as well as the health industry, as well as the Treasury. So, obviously, those were the questions that we had to develop approaches to if we were going to try to develop the most accurate numbers that we could develop in the reform plan.

Over the last six months, we have basically been involved in trying to develop that kind of modeling system. We've had representatives from OMB, from Treasury; economists who have been part of that, HHS, the various actuaries that are involved with health care issues generally have participated in that effort. And so at the conclusion of that, we tried to develop the most credible and conservative kind of estimates of the impact of health care reform as we could. You have to look at again, what -- if you develop a basic benefit plan, what does that look like? What are its impacts? What are the characteristics of the people that we're dealing with? What are the households that we're going to be impacting, employers, employees, and obviously just the whole cost issues.

After six months, we believe we've developed I think the most sophisticated models in the business of analyzing health care costs. They are the best in the business. There aren't any others, really, out there. And that was our problem. But I think that as a result of the work that we've done, we've got the best in the business. And so the estimates that we have here, I believe, are credible and I believe, again, can be defended when we present the plan itself to the Congress.

Like the economic plan, I think it's important to understand that people can question the policies, they can question the politics. And, obviously, that's a process we're going to go through after we've presented the plan to the Congress and to the country, and that's legitimate. But if, in fact, we can get all of these elements passed by the Congress, then we believe we can hit these numbers.

Now, let me speak a little bit about the specific numbers that we're working with in terms of the elements of the program and the financing for those elements. Let me begin with a very important promise here that I think a lot of people are losing sight of. The most important premise that we're operating with is that most of the money comes from where the money now comes from to pay for health care, which is the contribution by employers and individuals into a premium process to pay for their health care plans. That process is still there. That premium base is still there. People who are now paying for health care will continue to pay health care premiums. So that is a base that's there and that is going to continue to be funded through the premium process.

With regards to the federal side of it, let me describe what those elements are, because that's where legitimate question can be asked: how is the federal government then going to pay for those benefits? Again, I want to condition all of this to say that it's subject to continuing adjustments. We're still looking at these numbers and there will be, I think, minor modifications in the final numbers that appear in the bill. But right now, the numbers that I'm going to present to you are estimates between largely 1995 and the year 2000. Some of these numbers basically will ratchet-in, depending on the particular program that you're looking at.

On the new benefits, let me describe the new benefits that will be part of the program. The new benefits include a long-term health care program for the elderly, and that program largely targets on home health care, community-based health care for seniors. The estimate on that is about \$80 billion.

Q Over?

DIRECTOR PANETTA: That is between -- it ratchets in starting in I believe 1995 -- '96, and goes to the year 2000.

Q Is that an annual number?

DIRECTOR PANETTA: That's the total number for that period of time and it ratchets in.

Q Four years?

DIRECTOR PANETTA: Five-year numbers.

Q Does it start low and grow? I mean, that's --

DIRECTOR PANETTA: Essentially, in this area it ratchets in and it starts to escalate in terms of the costs.

On the Medicare drug benefit, it's the same over that period of time. That's about \$72 billion. That basically provides for drug benefits to those on Medicare with a deductible, small deductible. That's \$72 billion.

The third piece of it is that there are public health care investments that are part of this, in which there are targeted increases, particularly for rural clinics and community clinics that try to serve those at the low income levels. And there will be about -- in addition to that piece, there are start-up costs for the basic

system itself that will come to \$29 billion over that period of time.

We will be providing a 100 percent self-employed deduction for those who pay in, those who are self-employed with regards to their payments. They'll have a 100 percent deduction. That costs \$9 billion.

And then lastly is the largest portion here, which are the discounts for subsidies, as they've been called, to businesses and the employees at the low income level who would qualify. And the price tag on that is \$160 billion. And that's the one, very frankly, that continues to -- we need to continue to scrub that number, because we need to analyze just exactly who's going to receive those subsidies as we work through the plan. But that's -- \$160 billion is the estimate right now. So that the total cost we're looking at of the new benefits that will be provided by the federal government are \$350 billion.

How do we pay for this in terms of trying to make sure that each of these is covered? The first area, obviously, deals with the two principal health care programs that are the costliest at the federal level: Medicare and Medicaid. And let me preface this by saying that, again, all of you know that we're dealing with programs that, in terms of the federal budget, are escalating at double and triple the costs. We're looking at taking these programs from roughly three to four times the rate of growth in the economy down to about two times the rate of growth. So we're basically trying to reduce the very high level of growth that we're seeing in these programs.

On Medicare, we're looking at about \$124 billion in savings over that same five-year period. These savings will be specific. We're not talking about a cap. As you know, there's often times been a discussion in the Congress about setting some kind of arbitrary cap with regards to these expenditures. We are going to present specific proposals to achieve these savings. An example of some of those proposals would be requirements for additional co-pays, competitive bidding with regards to medical equipment, some lab co-insurance requirements. These are proposals that have been in the mix in terms of the discussions on Medicare savings as long as I've been involved in the budget process. And we are selecting, we think, they policies that make sense, both from a substantive point of view as well as a savings point of view.

The same thing is true on Medicaid, which will be \$114 billion in savings over that period of time. Most of that will come from a reduced cost on the disproportionate share, which is basically what we now pay hospitals that are the targeted hospitals that serve an excess number of individuals on Medicaid. We think we obviously will be able to reduce that disproportionate share provision as a result of the other elements of health care reform.

The second area is the savings that we hope will flow, and we were confident will flow from the fact that other federal programs that serve people, people will be moving gradually into the health care system itself, into the alliances, and we estimate that we will get savings from veterans programs, from Department of Defense programs, and also, obviously, from the federal employee health programs where we now cover all of those costs, federal employees will be part of the new health care system. We expect savings there of about \$47 billion.

The fourth area of savings relates to our ability to move away from tax-free benefits, which we now provide in large measure, obviously, through deductions in which we cover health care payments. Our hope is that obviously as we reduce the cost of those payments, that not only will we reduce the amount of benefits we have to provide through the tax system, but in addition, we will incur

some additional revenues from those who receive profits and additional wages as a consequence of that. And that's a pretty fair estimate that we generally use. It's a little bit like looking at a mortgage deduction, and as you reduce interest rates obviously the consequence of that is to produce more money to the individual which then becomes subject, hopefully, to additional taxes flowing to the federal government.

The estimate there is \$51 billion, what we estimate in that area. And this one that we, again, in terms of our own process we're trying to nail down with Treasury and with OMB looking at these numbers continually.

The last area is sin taxes. Sin taxes are approximately \$105 billion. The final decision on the exact elements of that have not been decided, but --

Q You're kidding.

DIRECTOR PANETTA: Whose kidding? (Laughter.) No, I'm not kidding. They have not been decided. We're looking obviously at cigarette taxes, and whether we go beyond that, or how much the cigarette taxes will be is still being discussed.

Q How can you come up with \$105 billion figure without knowing precisely what is involved?

DIRECTOR PANETTA: Well, there are proposals that are on the table and we estimate that we have to look at somewhere between \$100 billion to \$105 billion in order to make these numbers work. And that's what needs to be done.

Q How big does the cigarette tax have to be without some other kind of taxes in order to come up with that amount of money?

DIRECTOR PANETTA: Well, if you're just looking at cigarette taxes you're probably looking at somewhere around \$1 a pack. But if you were doing less on cigarettes then you've got to make it up elsewhere.

The total number on that from what we estimate in income is \$441 billion from what I've just described, meeting a cost, as I said, of about \$350 billion, and that is what leads us to a hoped-for deficit reduction of around \$91 billion over that period of time. And that's particularly important from my perspective because I think I've often argued that if you're going to get the deficit down further you've got to be able to get this kind of return on health care.

Now, let me just conclude by saying that as always, you know, when you're putting numbers like this together based on the models that we've developed, the numbers fit just as they did in the economic plan. But just as what we faced in the economic plan, obviously, there will be political implications of a continuing consultation process with the Hill, the concerns that are raised on Capitol Hill as we go through the process, and that will obviously require some adjustments as we work through the legislative process.

Secondly, there is going to be a continuing assessment on the numbers themselves. We are currently in the process, between OMB and Treasury, over these next two weeks, where we are going to be scrubbing all of the numbers I've just presented to you. And we do not expect -- I should make clear -- we do not expect any major changes from that process, but there may indeed be some adjustments that will have to be made as we again revisit these numbers.

I think the President's goal is to begin this process. And this is the beginning of the process of the debate on health care reform in this country. He has presented -- and I think it was his intention and the First Lady's intention to present a bold plan for health care reform to the country. But like any smart negotiators we know that there are going to be bargaining that's going to have to be done with the Congress. We're going to face a number of special interests who are going to force us to fight this battle. And our view is that it's much better to start with a bold approach as we begin that process.

DEPUTY SECRETARY ALTMAN: I'm so happy to be here that I'm compelled to be brief. Secretary Bentson would have been doing this instead of me, except that he is in New York, on his way to speak to the Economic Club of New York tonight.

As Leon alluded, Treasury has responsibility for estimating the revenue issues, the revenue impacts of this plan. The sin taxes, the revenue effects of the mandate, the self-employed deduction, and the others. I simply want to say that we're using the same Treasury estimating model and the same methodology that was used in the economic plan and that is always used to assess possible changes in tax policy or legislative initiatives.

We are continuing to scrub these numbers. It will be a couple of weeks before we finally finish doing so, together with OMB and others. There may be some moderate changes before the final details are released. But I'm confident that the numbers we do release will withstand the scrutiny -- which will be very tough -- that, of course, they'll be subject to.

I think we've been very cheered so far by the congressional reaction. A lot of us have been up on the Hill for the last couple of days in various workshops, which have been extraordinarily well attended, I might add. Extraordinary how many members of Congress have come for hours on end. And they've all said, among other things, even some that aren't happy with the plan, that we've put forth the most-detailed and the best-researched health care plan that's ever been put on the table by a lot.

As Leon said, the congressional process is just beginning. It will take quite a few months, there will be undoubtedly changes in the proposal that we put forward and we welcome that process.

The only point I'd add in addition is that in the event that anyone does point out a true flaw in our numbers -- can prove to us that they're off, well, then, of course we'll adjust them. And we'll adjust them on the cost side. In other words, if it turns out that people convince us that something we've estimated at X will cost more than that, well, we'll reduce costs in some other area. What we will not do, beyond the sin tax proposal that will be made shortly, what we will not do, is to propose any further changes on the revenue increasing side, on the tax side.

I think Laura's next.

MS. TYSON: I will just end by reaffirming or emphasizing, the comments made by Bob Rubin at the beginning. The process by which these numbers was developed was a process which was exhaustive and inclusive. The CEA and other agencies of government were involved in the process from the very beginning. We did not just rely on internal experts, however. We consulted a wide variety of external experts on all aspects of the health care system. So it really was, as the First Lady has correctly said, an unprecedented process in terms of inclusiveness, exhaustiveness and precision. So I don't think there really is any question about the numbers.

Now, it's been reported in a number of places that I have raised questions about these numbers and that the CEA has raised questions about the numbers. That, in one sense, is true and in one sense is misleading. It is true in the sense that it is the role of the CEA to raise questions. We love to raise questions, that's one of our jobs -- we raise questions. The reports are misleading because they seem to indicate often that our questions were not answered. That is not correct. Our questions have been answered. They have been answered as part of this exhaustive process. So, for example, if we raised a question about Medicare and where the Medicare savings would come from, there are now precise, specific policy proposals backing up the Medicare savings.

So the process has been unprecedented and exhaustive and, I believe, has moved the information base on how the current health care system is functioning and what we need to do forward by an order of magnitude relative to anything anyone knew when we started. So I think one should, at this point, welcome debates about policy and welcome debates about politics. But really, the numbers, it seems to me at this point, are not really debatable. They came from a very credible process and a very exhaustive process. And that's really all I wanted to say.

Q Despite the fact that you insist that there aren't going to be new taxes, we have a poll out today that says 80 percent of Americans still believe that that's how it's going to be paid for.

DIRECTOR PANETTA: Well, interestingly enough, we ran into the same problem with the economic plan. I mean, obviously, everybody felt that when you debate any kind of revenues or indicate that even if there's going to be sin taxes, that people automatically assume that somehow there's going to be some sort of broad-based tax. And, as we pointed out in the economic plan, 80 percent of that affected those of \$200,000 and above. I think people are beginning to understand that now. And as we go through the debate on this, I think people will also understand that there is no broad-based tax here.

Now, again, having said that, the premium is here. Let's make clear that the premiums that people are paying now, that most of the money in this process for this health care reform, is going to come from the same area that it comes from now, which is businesses and people paying taxes on health care. That needs to be made clear now, because I think there's a sense that there's these other taxes. It's based largely on the premium base.

Q You presumably realize some savings from the elimination of cost shiftings since everyone is now included. Under which number, or numbers, is that included? Where is that number reflected?

DIRECTOR PANETTA: You're basically in the -- I think it's going to be in the reductions. While the reductions in federal programs will probably be part of that, I think the Medicare to the extent -- I mean, we're going to be doing specific savings on Medicare, so you --

Q I know, but that's going to affect nearly -- that cost shifting is paid for by all the private consumers of health care insurance. Presumably there will be a saving to them of some untold sum of money. What is the sum and where is it reflected here?

DIRECTOR PANETTA: Okay, we think that when the plan is fully implemented, that there's about \$25 billion in uncompensated care that's currently embedded in what private insurance and what private payers pay. That is, everybody gets coverage so that money will go away over time. So the dollars are really reflected in the premiums that we are estimating. So they're not specifically shown

in this line item here that the Director has talked about. But rather, if you reduce uncompensated care, the premiums that people will have to pay for health insurance, those costs will fall.

Q Do you really think that you're going to see \$91 billion in deficit savings at the end of five years? Do you think that these models clearly estimate people's behaviors?

DIRECTOR PANETTA: I don't think -- no, it's not a problem of the models. I think that if we achieve these kinds of savings with regards to these kinds of costs, then I think we can produce that much in savings in terms of deficit reduction. I mean, that's our goal. Our goal was basically to start with making sure that we achieve deficit reduction over this period.

Obviously, I have to tell you -- as I think we found out on the economic plan, where our investments were vulnerable, I think the deficit reduction number is going to be vulnerable on Capitol Hill. The large question for Capitol Hill to answer is do you want to achieve this much in terms of deficit reduction, or do you want to lessen the amount of deficit reduction and lessen the hit in terms of some of the other programs. You're going to see some trade-off here.

Q In terms of trade-offs, it was so difficult to get to the \$57 billion in Medicare savings. What makes you think you're going to reach \$124 billion?

DIRECTOR PANETTA: As long as I've dealt in the budget process, every time we've dealt with Medicare and Medicaid savings, I have heard all of the expressions of fear -- that the hospitals are going to close, that the doctors are going to go out of business, et cetera, et cetera, et cetera. And it hasn't happened. The fact is that there are tremendous cost increases that are taking place in the Medicare and Medicaid program. We know that. We see that in the budget. And I think as a result of that, we have been able to outline a whole series of very specific proposals that from a policy point of view I think makes sense.

Now, you're asking me really what I think is more a political question than a substantive question, because sitting in that room people are always nervous -- do we want to cut Medicare this much? Can we cut Medicaid this much? But ultimately, if you can justify the policies based on substance, then I think we can come very close to these numbers. And that's going to be the test.

Q Mr. Panetta, can I ask you a question about -- you started your account by saying that the bulk of the money was, of course, going to come from where it now comes from -- from the private sector. And yet, what all of you have said addresses only the public portion of this. We need to give the American people a picture of the whole thing. Could you tell us what the private portion of this is going to look like? And it would be very helpful if it was year-by-year what the business sector is going to pay, what the household sector is going to pay, and what you either think they're going to save or net -- have to pay to make this system work?

DIRECTOR PANETTA: Oh, Ken? (Laughter.)

MR. THORPE: We didn't pass that out? (Laughter.) Of course, we're -- as we continue to go through this, we focus first in terms of our -- first step of an estimate is to try to get a handle on what the federal and state and local piece of this is. And we're in the process right now of doing exactly what you've asked. As you've seen from your documents, that's -- I'm sure that you've read through. We do have a table in the back that looks at the change in national health expenditures under the proposed plan. We will, during the course of the next several weeks, be developing exactly

what you're talking about -- a sector-by-sector impact during that time period.

Q That chart at the back is entitled National Health Expenditures. Is that the chart you're referring to?

MR. THORPE: Right.

Q It appears to show that in the first three years of this, if I understand how to read it, that the private sector in aggregate is going to bear -- one year it's \$23 billion in extra costs, the next year it's \$50 billion in extra costs, the next year it's \$30 billion. And only in the very end of the five-year period are you going to see it -- the savings, in effect, be greater than the costs. Is that true? In essence, the private sector is going to bear increased costs during the early years?

MR. THORPE: No, we think that due to the fact that we're covering \$37 million under uninsured and we're providing comprehensive benefits not only to that population but to individuals that don't have as comprehensive benefits -- that is, you can see from the chart that for the first two or three years that the amount of spending in the system will rise slightly. But by 1998 -- I don't have the figures with me. It's in the back of your --

Q The point is that the private sector is going to bear --

MR. THORPE: No, that's total spending -- public and private. What we don't have and what you could not infer from that chart would be the specific public-private impacts which we are still working on.

Q Ms. Tyson, could you tell us whether or not the proposal will increase --

MR. THORPE: I don't have the figures with me.

Q Mr. Panetta, could you tell us --

DIRECTOR PANETTA: Could I -- Andrea, let me just add another point that I think is important on the Medicare and Medicaid aspect of this. Normally, the cuts in Medicare and Medicaid have usually been done for the sake of deficit reduction in the sense that you basically are doing it as part of an economic plan. In this instance, you're doing it as part of comprehensive health care reform with a long-term health care element as well as a drug benefit element. And I think that gives us a little better arguing point with regards to those that are concerned about who's going to be impacted by that.

Q Mr. Panetta, one of the central features of your plan is cost controls on the growth of insurance premiums. How can you convince the public that their services aren't going to be held down, constrained, rationed by the doctors and hospitals as they're living under these insurance caps at a time when you're trying to cut inflation and health care in half?

MR. THORPE: Well, again, we think that if you take -- again, you can't just look at the cost containment piece. I think it's important to look through and look at the plan in its entirety. Because what we're proposing in the health reform proposal is really comprehensive change in the delivery system. We believe that there are substantial administrative savings in hospitals and physicians, as well as insurance companies that we've talked about. We've talked a little bit about reductions and uncompensated care that's sitting out there.

And one thing I think that will be useful to do is that if you look at the dollar savings, don't look at the percent changes, but actually look at the dollar savings in the private sector associated with what we're proposing. And if you look at what we think is going to happen in the system in terms of cost conscious selection of health plans, administrative savings, reductions in uncompensated care, moving toward a delivery system that is no longer an open ended, uncoordinated delivery system. It is really something to focus on much more effective and we believe, not only cost effective, but better quality medical care. That any one of those, individually or serially, will develop and create the types of underlying cost reductions that the plan is talking about.

Q But you and Mr. Rubin can stand here today and assure people there will be no rationing of care under this Clinton package?

MR. RUBIN: Let me try as a nonprofessional to take a shot at that. Having sat through, I guess it's six or seven months now of meetings with enormous numbers of health care professionals on, as you know, a very complex subject -- when you hear them come through all this, I think where you come out is it sounds from what they've said -- let me put it differently. I came away persuaded having listened to them, that this thing ought to work, that the odd ought to be very, very high that there is very substantial excess expenditure in the system. And you compare the 14 percent of GDP that we spent on health care with less than 10 percent in any other developed country, and I think it sort of validates that notion. And it ought to be possible to create a plan that does that without creating untoward effects.

But if there are problems there is a contingency in these numbers, number one. Number two, as you know, it's going to be phased in somewhat gradually so the first dates, hopefully, will come in '95, and they will continue to come in through '97. So if you start to see problems you can correct course.

And thirdly, and I find personally most importantly, there is tremendous flexibility in this system and there is tremendous flexibility within each state to adjust the system as it goes along. So I think you have, in effect, a self-correcting mechanism if problems develop.

Q Laura, can you comment on the job impact, what your models have shown in terms of --

DR. TYSON: We're actually going to have a briefing on that issue on Thursday. We'll talk about the employment effects on Thursday. Secretary Reich will -- we are trying to sort of have a discussion today of financing, and a discussion on Thursday of --

Q What is the hold up in figuring out how the sin taxes are going to be apportioned and are there discussions going on with, for example, representatives from tobacco states as you're figuring out how these taxes are going to be apportioned?

DIRECTOR PANETTA: I think it's -- you know, it's obviously -- the issues are on the table with regards to the elements of sin taxes. The one question is this corporate assessment and whether or not we will look to this corporate assessment for additional revenues as part of that package. And that -- frankly, it's that element that's being evaluated right now. We have not come to any conclusions on that. But depending on whether or not you include that element, that tells you a lot about what you do then on the sin tax.

Q How much might that produce, the one percent corporate assessment?

DIRECTOR PANETTA: I mean, again, it depends on how many corporations are going to be impacted, and that's something we're analyzing right now. Because it depends to some extent on which ones are dropping out of the process and which ones stay in the process.

Q The goal was to --

Q Can we just clear up the payroll tax?

DEPUTY SECRETARY ALTMAN: We're not going to give you an exact number, because we're continuing to refine that. But it's not a huge number in the context of this plan. You have to make certain assumptions about which businesses opt into the alliances and which businesses, 5,000 and over, employees may opt out and so on. But it's not a gigantic number.

Q There may be no decision on alcohol tax by tomorrow night, is that correct?

DEPUTY SECRETARY ALTMAN: I don't know the answer to that. Someone asked that question earlier about when the sin tax decision was going to be made.

Q Are you deliberately not deciding to not ignite the lobbyists more?

DEPUTY SECRETARY ALTMAN: I heard somebody say the President's upstairs having a drink and a cigar and would make that decision shortly. (Laughter.)

Q You said the President's goal was to have a situation where people could argue politics and policy, but not about the numbers. It hasn't been hard for people here to find economists and politicians who are arguing about the numbers. What is the problem? Where is the disconnect?

MR. RUBIN: Let me take one shot at that and let other people take another shot at it. You know, when you read the reports and then you speak to some of the people -- and I've done both -- I think there is a bit of a muddling here. And I think sometimes when people talk about concerns about the numbers, they're really talking about the politics or they're talking about the policies. And I think if you take somebody and you say, okay, you've said you have concerns about the numbers, what do you really mean?

Usually, at least in my experience, it has turned out to be either they simply need more information, or they're really raising a question about political feasibility or policy impacts. And that, I think, is -- to an awful lot of it.

Q Well, to what extent did you --

MR. RUBIN: Can I make just one more comment? These are very complex calculations. I've heard a lot of it developed, and I'll tell you -- and I've had a lot of experience in developing numbers -- these are very complex numbers developments. And I think what's going to happen over time is, people who have serious questions about numbers as opposed to policy or politics, they'll sit down with the people who developed it, and I think they'll come out satisfied on the numbers.

Q To what extent did you factor in political feasibility in creating your models?

MR. RUBIN: Well, numbers are one thing and political feasibility, I think, I would argue, a separate one.

DIRECTOR PANETTA: There is no model you can develop for that. (Laughter.)

MR. RUBIN: Leon has a perfect model for political feasibility, and he comes out with -- (laughter) --

Q obviously, there are policy assumptions that are going into the numbers. I mean, you seem much more optimistic than a lot of independent experts about how quickly waste can be gotten out of the system, for example. I mean, those assumptions are built in --

MR. RUBIN: Those assumptions are in here, as we said. You've got an interactive process with OMB, Treasury, HHS, you've had outside actuaries and outside accountants, and enormous numbers of them, and they've come out and concluded that these kinds of savings can be achieved in these kinds of time periods.

Q Mr. Altman, you said in your remarks that if you were convinced your numbers were wrong, you would make adjustments on the spending side, not the revenue side. Does that mean if Senator Moynihan is correct, that it's not politically possible to achieve this level of Medicare savings, that would put at risk these proposals for new long-term and drug benefits for seniors?

DEPUTY SECRETARY ALTMAN: No, I didn't say that. I didn't say that at all. I simply said that if anyone can prove to us that there are flaws in our estimates of the costs of this, I mean, really prove it, which I doubt, I strongly doubt, as I mentioned earlier -- we would make adjustments on the cost side. We would --

Q You're talking about a technical thing, you're not talking about --

DEPUTY SECRETARY ALTMAN: Well, if someone could prove to us that we've underestimated the cost of X or the cost of Y, you know, really win the argument --

Q But it's all based on predictions of future behavior of all kinds.

Q You're saying --

Q -- what would you cut, then --

Q -- which is kind of an interesting standard, isn't it?

DEPUTY SECRETARY ALTMAN: -- in some other area the costs to offset that. All I'm trying to say is, we would not turn to the revenue side of the equation.

Q But would that affect the core benefit package then?

DIRECTOR PANETTA: Let me mention -- you've got -- all of the pieces are here now. And, obviously, there's going to be some adjustment on these pieces as we go through the political process and as we go through, obviously, the discussions with regards to the accuracy of the numbers and what have you. But there are key pieces now that you can work with here.

If we decide, for example, that we want to do a phase-in, a longer phase-in on this, we have some phase-in already built into the process. That's something obviously that can be looked at. It doesn't mean you're reducing the benefits; you're reducing the benefits in the short term for some, but in the long run everyone's going to get the same benefit.

But we have the ability now with the plan that we're working on to give us the flexibility to make those kinds of adjustments without impacting on the basic principles that the President wants to present in the health care plan.

Q Given the record of economic modeling over the last 10 or 12 years, don't you approach the modeling of this entire sector of the economy with some humility?

DIRECTOR PANETTA: Humility and trepidation.

Q Can you tell us, is there any reaction from the President on the Moscow coup?

MR. GEARAN: In terms of events in Russia, we have no further reaction to that.

Q The President did not react at all?

MR. GEARAN: We'll just leave it at that. We'll keep you posted whether there will be a further statement.

END

1:55 P.M. EDT

To Find Out Whether Clinton Numbers Add Up In Health Plan, Ask People Who Crunched Them

By DAVID WESSEL
And RICK WARTZMAN

Staff Reporters of THE WALL STREET JOURNAL
WASHINGTON — Richard Helms winced as he listened to one particular passage in President Clinton's health speech to Congress last week.

"So then we gave these numbers to actuaries for major accounting firms and major Fortune 500 companies who have no stake in this other than to see that our efforts succeed," the president said. "So I believe our numbers are good and achievable."

Mr. Helms, an executive at Principal Financial Group, a Des Moines insurer, is one of those actuaries. "If it gave someone the impression that we looked at all of the numbers in fine detail and signed off on them," he says, "it was potentially misleading."

Mr. Helms and others on the seven-man team of actuaries consulted by the White House agree that the administration put the proper price (an average of \$4,200 a family) on the insurance package the president wants to guarantee all Americans, and that the methods used to calculate government subsidies are sound.

But they don't all accept that Mr. Clinton can squeeze as much waste and inefficiency out of the health system as swiftly as he envisions without disrupting the market or undermining the quality of care — an assumption that is crucial to many of the numbers in the plan.

"That's the real question. Is it [Mr. Clinton's proposed cap on spending] so tight that you couldn't make it? That's hard to say," says Richard Ostuw, chief actuary at Towers Perrin, who led the outside team. "There would be some places where there would be problems. But I don't know if that's 1% of the population or 50% of the population."

Ira Magaziner, designer of the health plan, says in an interview that the actuaries weren't supposed to judge whether the proposed caps anticipate squeezing savings out of the system too rapidly — but that other outside experts did.

Yet Mr. Clinton's economic adviser, Robert Rubin, said much the same thing as the president when he assured the press last week that "enormous numbers" of government experts and "outside actuaries and outside accountants" have "concluded that these kind of savings can be achieved in these kind of time periods."

In an interview yesterday, Mr. Rubin said, "I just spoke to Ira Magaziner a few minutes ago and he reconfirmed that outside experts have checked the savings and found them to be reasonable." If Congress differs, he added, "and it'll obviously have a thorough process of its own, then we'll have to work with Congress to adjust the programs accordingly."

This is no small issue. If the government promises benefits but savings don't materialize, taxpayers are on the hook. Deborah Steelman, a health-industry lobbyist who worked in Ronald Reagan's budget office, calls it "the flip side of the

[David] Stockman deficit trap." Mr. Stockman, Mr. Reagan's budget director, cut taxes and figured spending cuts would follow; they didn't. Mr. Clinton, she says, would enact popular benefits now and must be counting on tax increases later. Mr. Clinton insists broad taxes aren't needed. If competition doesn't keep health-care spending down, he says, then the spending caps written into law will.

For the Clinton planners, even getting the math right wasn't simple. Health-care numbers are huge, even by government standards. The new Medicare drug benefit by itself is said to cost \$14 billion a year, double the Environmental Protection Agency's entire budget. The numbers are so big that administration officials call some disagreements over \$2 billion a year "rounding errors." David Ellwood, Mr. Clinton's welfare-reform expert, once joked that he would gladly accept as the entire budget for welfare reform the difference between cost estimates of any part of the health plan made on two different days.

But the issue isn't whether the numbers add up. "Of course they add up. They're not dopes," says Theodore Marmor, a professor at Yale's School of Organization and Management. "The critical question is what assumptions do you make to make the numbers add up."

In Washington, numbers often drive policy, a point that wasn't lost on Mr. Magaziner. Early on, he took control of the numbers. He bypassed a layer of veteran government number-crunchers by assembling a team that reported primarily to him and economist Kenneth Thorpe at the Department of Health and Human Services. He used private economic models to challenge, and sometimes change, government estimates. Only now, after all the major decisions have been made, are the senior analysts at the White House budget office and Treasury "vetting" the numbers, as Mr. Magaziner puts it. The budget office recently sent Mr. Magaziner 30 pages of questions.

"We have done things differently," he says. "We have ruffled a lot of feathers. We have basically gotten a lot of stuff out to the surface that is usually buried. We thought it was the only way to get it done in a decent amount of time where I could look the president in the eye and say, 'I understand what's in the models.'"

Mr. Magaziner's staff held tedious meetings to figure out why estimates from one arm of HHS, the Health Care Financing Administration, were so different from those at another, the Agency for Health Care Policy Research. One conference call among number-crunchers during the spring began at 9 a.m. and lasted until 5 p.m., with an hour off for lunch, and covered only three narrow topics. Afterward, Mr. Magaziner's aides met with him from 6 p.m. to 10 p.m. to brief him.

For the "quantitative analysis" team, as it was known, the rub was that the plan kept changing. Changing any one number

changed scores of others. David Cutler, a White House economist among the inner-core of number-crunchers, likens the endeavor to "a huge Rubik's Cube."

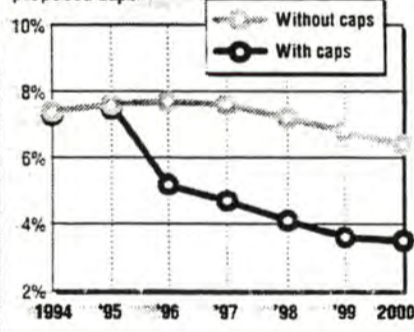
Take the projection in the leaked draft of the plan that the government will collect \$51 billion in taxes over five years because companies will spend less on health care. The Treasury assumes that whatever employers don't spend on tax-free health care will be given to workers in taxable cash. But that figure wasn't based on all the same projections as the rest of the draft. When the final figures are issued later this month, the estimate is likely to be smaller. "Instead of 51, it may be 41 or 31," Mr. Magaziner says.

Even that multibillion-dollar issue is minor compared with the big one: the terms of the cap on private insurance premiums and government health spending. Mr. Magaziner argues that the advent of competition will bring down health spending so the caps may never bind. But because of the way congressional score-keeping works, the caps drive the numbers. If they were looser, there would be less money to subsidize employers and families or to pay for new Medicare benefits. Allow private premiums and public health spending to grow just one percentage point faster than Mr. Clinton's proposed caps provide, and projected federal spending goes up by about \$5 billion in 1997 and about \$13 billion in 2000.

While a host of health-care experts question the wisdom of imposing such strict caps as quickly as Mr. Clinton proposes, Mr. Magaziner hasn't any doubts. "We didn't set these budget caps by sticking our finger in the air," he says.

Applying the Brakes

White House estimates, as of Sept. 7, of the growth rate of private-sector insurance premiums with and without the Clinton-proposed caps



He offers a list of experts who back the Clinton approach. But some of them raise questions about the caps. Phil Nudelman, chairman of Group Health Cooperative of Puget Sound, calls the plan "realistic" and an "excellent foundation," but adds in an interview that the private-sector premium caps "may be a slight bit ambitious." Urban Institute economist Stephen Zuckerman says that the inefficiencies are there, but wonders whether the machinery to squeeze them out can be built as quickly as the plan anticipates. John Wennberg, a Dartmouth physician-researcher, is sure that "there is sufficient excess capacity so patients don't have to worry about being harmed" by the Clinton plan, but says he doesn't have the expertise to vouch for the specific caps.

In the end, Mr. Magaziner draws on a lesson from his days as a management consultant. Just as the Japanese forced the steel and consumer electronics industries to cut costs faster than U.S. executives ever thought possible, spending caps will do the same for the bloated health-care industry. "I think they will meet as tough a goal as they have to," Mr. Magaziner says. "That's human nature."

White House Poised to Offer Energy Initiative

Plan Calls for Tax Incentives To Boost Natural Gas, Domestic Oil Industry

By TIMOTHY NOAH

Staff Reporter of THE WALL STREET JOURNAL
WASHINGTON — The Clinton administration is preparing to propose tax incentives and other measures in an effort to stimulate the domestic oil and natural gas industries.

The proposals, according to a partial draft obtained by The Wall Street Journal, include expanding tax breaks aimed at encouraging gas and oil exploration, increasing research and development funds, and reducing regulatory barriers at both the federal and state levels.

The administration's aim in part appears to be to soothe the oil industry, which has complained that the administration is more focused on conservation and promoting renewable fuels than on boosting domestic oil production.

Shut Out of Negotiations

Industry officials were all but shut out of the negotiations leading to Mr. Clinton's proposed tax on nearly all forms of energy based largely on heat consumption as measured in British thermal units. But fierce lobbying efforts by the industry helped to quash the BTU tax and replace it with a milder transportation tax.

Now, the Clinton administration is eager to show its sympathy for the oil industry's woes. "This is an industry that has lost 450,000 jobs over the last decade," said an Energy Department official. He said the energy initiatives would "create jobs," "stimulate markets for natural gas," and reduce dependence on foreign oil.

The partial draft — a table of contents for the report that lists the energy initiative — doesn't indicate the projected costs of the proposed initiatives, which were arrived at through talks between the Energy and Treasury departments and other executive branch agencies.

The Energy Department is expected to issue the report later this month, and a department spokesman warned that the initiatives still are being developed and that many of the items listed in the draft already have been dropped.

But the policy initiatives included in the draft document give a clear signal that the Clinton administration wants to ease burdens faced by the oil and gas industries. The draft proposals include:

—Creating tax credits to stimulate new oil and gas exploration, aimed specifically at encouraging new exploration technologies.

ATF Top Officials Told Deliberate Lies About Waco Raid, U.S. Report Charges

By CHRISTI HARLAN

Staff Reporter of THE WALL STREET JOURNAL
WASHINGTON — Top officials of the federal Bureau of Alcohol, Tobacco and Firearms deliberately lied about the raid of the Branch Davidians compound that cost four agents their lives, the Treasury Department concluded after a five-month investigation.

As a result, Treasury Secretary Lloyd Bentsen removed five ATF officials from their posts, pending disciplinary action. Mr. Bentsen said some allegations against the officials may be referred to the Justice Department for possible criminal action. He also said more members of the agency will face disciplinary measures.

The Treasury report dealt only with the ATF's role in the Feb. 28 raid of the Branch Davidians compound near Waco, Texas, where agents believed illegal firearms and grenades were being manufactured. An attempt to serve a search warrant at the compound turned into a firefight after cult leader David Koresh learned of the impending raid and ambushed the agents.

—Reducing regulatory and legal barriers to export of oil from Alaska's North Slope, which is now restricted largely to domestic use.

—Accelerating the process for receiving tax deductions for geological and geophysical costs.

—Urging states to eliminate regulations that inhibit the use of natural gas in vehicles.

—Funding a research program aimed at "everyday problems" of small independent oil companies.

—Creating tax incentives for oil exploration on the outer continental shelf, principally in the Gulf of Mexico.

—Removing "net income limitation" for independent companies that claim deductions under the percentage depletion program; currently these deductions are capped according to income.

—Expanding existing credits that encourage "enhanced oil recovery," or oil exploration requiring sophisticated methods such as steam injection.

—Expanding, or considering expansion of, the Energy Department's role in research and development on combating oil spills.

Many of the draft proposals, such as accelerating depreciation for capital-equipment costs associated with environmental regulation, were considered by the Bush administration but never became law.

Also listed in the table of contents is a proposal to create floor prices for oil and gas through an oil import fee. But this proposal has since been dropped, an administration official said.

killing four and wounding as many as 20.

The Federal Bureau of Investigation then stepped in, overseeing a 51-day siege that ended April 19 when agents pumped tear gas into the compound. After a few hours, cult members set the compound on fire, and more than 71 people died.

Justice Department Report Due

A Justice Department report of the FBI's actions is expected to be released next week, as is a Justice Department-Treasury report on how law enforcement agencies can deal with similar situations. Mr. Bentsen said he couldn't comment on the Justice Department report, but that he hoped it would be as candid as the Treasury report.

The extensively detailed report was hardest on the top ATF officials who insisted that the raid supervisors didn't know that the Branch Davidians were aware of the impending raid.

"Disregarding the far more persuasive, and rapidly growing, evidence that their account was false, ATF's top managers uniformly said, in substance, that ATF's raid commanders had not known that the element of surprise had been lost before they made the decision to go forward," the Treasury report said.

The report stopped short of accusing outgoing ATF Director Stephen Higgins of deliberately lying about the raid, but faulted him for relying too heavily on his top law-enforcement officials, who were accused of ignoring evidence that contradicted their statements.

Magaw Named Acting Director

Earlier this week, Mr. Higgins said he would retire effective Oct. 30, saying he disagreed with some of the findings and recommendations in the report. Mr. Bentsen named a 26-year veteran of the Secret Service, Director John Magaw, as acting director of the ATF. Mr. Bentsen picked Guy Caputo to be acting director of the Secret Service.

Mr. Bentsen also named the special agent in charge of the ATF's New York office, Charles Thomson, the acting top law-enforcement official at the ATF. Mr. Thomson oversaw the ATF's investigation of the World Trade Center bombing, which came two days before the Texas raid.

Mr. Thomson succeeds Daniel Hartnett, one of the officials removed yesterday. The others placed on administrative leave were Edward Conroy, Mr. Hartnett's top aide; David Troy, the ATF's chief of intelligence; and two supervisors of the Houston office, which oversaw the raid.

Mr. Hartnett and Mr. Conroy have said they intend to retire from the ATF. They and Mr. Troy couldn't be reached for comment.

Mr. Bentsen said the Treasury's findings shouldn't be a factor in considering the Clinton administration's proposal to merge the ATF into the Justice Department. But he said he isn't opposed to examining merger possibilities to "see if you can save the taxpayers some money and see if you can preserve the expertise" of the ATF.

Bradley (D-NJ), "whose state is home to many pharmaceutical companies." And before the budget conference commenced, the CEOs of Baxter Int'l, Warner-Lambert and Searle visited House Ways and Means Chair Dan Rostenkowski (D-IL), pointing out drug cos. operating in Puerto Rico buy \$380M/year in products from the Chicago area. Chairs at Pfizer, Merck, American Home Products and Bristol-Myers Squibb Co. "recently pressed their case with Rostenkowski and Rep. Charles B. Rangel (D-NY)." They also hired ex-Rep. Beryl Anthony (D-AR), a "close friend" of Clinton, to lobby the WH (Michael Weisskopf, 7/27). N.Y. TIMES reports Moynihan and Rostenkowski have agreed on the Senate's proposal for reducing Puerto Rican tax breaks (Rosenbaum, 7/28).

AARP: COX NEWS reports AARP is opposing proposed Medicare cuts and increases in Social Security taxes. While conferees "tentatively have agreed to increase the threshold on the Social Security taxes," AARP's Judith Brown says the higher threshold could still force elderly people with high medical or long-term-care bills into poverty (Larry Lipman, 7/26).

ROSTY: NEWSWEEK's Howard Fineman: "Unless and until he's actually indicted, he has more clout up there than just about any other member of either the House or the Senate. ... He is necessary for the mechanics" of the budget deal, "but he's death on the politics of it" ("Equal Time," CNBC, 7/27).

COMMENTARY: Balto. SUN editorial: "And while the country adjusts to new taxes and spending cuts, the uncertainty that has plagued business and discouraged new hiring will remain. Why? Because health care reform, which will require new revenues from somewhere, will hang out there as next year's fiscal question mark" (7/28).

===== ELEMENTS OF REFORM =====

*3 THE PLAN: WH ADVISERS BACK FINANCING PROPOSAL

"Employees would pay 20% of their medical insurance premium under a health care reform financing plan favored by [WH] advisers," USA TODAY reports. Premiums would vary regionally, but employers would pay 80% and workers would contribute 20%. A mandate on employers not currently providing insurance would be phased in and small businesses would be subsidized (Judi Hasson, 7/28). In a separate article, USA TODAY reports employers would pay a pro-rated share of premium costs for part-time workers. This proposal "apparently carries more weight than past trial balloons because top [WH] health advisers are behind it. It replaces a much-criticized payroll tax." While the concept of employers and employees sharing health costs "will be familiar to most people," the "difference" is that "all employers -- even those with just one worker -- would be required to provide insurance" (Judi Hasson, 7/28). For example, "even those who hire only a domestic worker like a nanny" would have to provide coverage. The admin. would place \$60B in expected savings from reform in a fund to provide coverage for the uninsured and to subsidize premiums for low-income workers and small businesses (Hasson, 7/28). The expected savings include: \$9B in Medicaid and \$11B in Medicare, since some current recipients would get

Taxing Payrolls For Health Care Is Out of Favor

Clinton Advisers Push Plan For Employers to Pay Portion of Premiums

By HILARY STOUT
And JEANNE SADDLER

Staff Reporters of THE WALL STREET JOURNAL
WASHINGTON — President Clinton's advisers have generally ruled out proposing a payroll tax to finance the administration's health plan.

Instead, officials are pushing a proposal that would require all employers to pay a portion of each employee's health insurance premium, probably 80%. Though Mr. Clinton will make the final decision, a White House official said administration advisers generally agree that businesses and individuals will be more "comfortable" with a standard premium than a payroll tax. Some details of the premium-based plan were first reported by USA Today.

The prospect of a payroll tax has been controversial. Many of the president's aides became enamored of the idea, which they termed a "wage-based premium," this spring, largely because they considered it more progressive than assessing a flat premium on all firms. But others within the administration, including a number of the president's economic advisers, warned that financing health coverage through a percentage of payroll was too radical a change.

What administration officials are now coalescing behind is actually a hybrid of the two concepts. They want to require that all employers pay a portion of the market premium for a health plan for employees and their dependents. But to make sure premiums don't break small, low-wage firms, the administration probably will propose that each employers' share of the premium not be allowed to exceed a certain percentage of its payroll.

In a meeting with members of the House Small Business Committee yesterday, Hillary Rodham Clinton, who is leading the administration's efforts to overhaul the health-care system, tossed out a cap of 3% to 4% for small, low-wage firms as a possibility. But an administration official said those numbers weren't definite.

President Clinton has been preoccupied with his budget package, the Midwest floods and other matters, officials said, and probably won't turn to the hard decisions on his health plan until after the budget is passed, probably next month.

Mrs. Clinton described key components of the health-care package to the committee. In a session lasting more than an hour, she stressed the parts of the plan that are likely to be attractive to small concerns, including phasing in compliance, a cap on costs for small firms and a "rainy-day fund" to help pay health-care costs for business owners who can't afford insurance. Mrs. Clinton also said self-employed people would be able to deduct the entire cost of their health insurance from their taxable income, and the cost of workers' compensation insurance would be included in the insurance premiums employers pay under the plan.

Committee Chairman John LaFalce, (D., N.Y.), who in the past has supported a single-payer national health-care system, said after the meeting that the plan will be "sensitive to small businesses that can't afford coverage." The committee's ranking Republican, Rep. Jan Meyers of Kansas, said the plan Mrs. Clinton outlined could offer some stability to small companies that already offer health insurance, but would be a new burden for those that don't. "In general, Republicans don't like government mandates," she added. It wasn't clear after the meeting exactly how the plan would hold down costs for very small businesses, Mrs. Meyers said. "The meeting lasted only an hour and 15 minutes; she was talking fast and obviously we were listening fast," she said.

Study Supports Early Use Of AZT for Slowing AIDS

WALL STREET JOURNAL News Roundup
New research, conducted by a European-Australian AIDS research group, contends that the Wellcome PLC drug AZT slows the progression to AIDS when taken by people in early stages of infection.

The study, financed by the Wellcome Foundation, which is affiliated with Wellcome PLC, is published in this week's edition of the New England Journal of Medicine.

Researchers said 993 patients with symptom-free HIV infection were randomly assigned to receive capsules of AZT or a placebo for two and a half years. Among treated patients, the risk of worsening disease was reduced to about half that of the control group.

These new findings will add fuel to an already fractious debate between U.S. proponents of early treatment, and authors of an Anglo-French study that disputed the benefits of early treatment. Last month, an expert panel convened by the National Institutes of Health backed away from its prior recommendation in favor of early treatment, leaving it simply an option to be decided between doctor and patient.

In an editorial accompanying the new study, John G. Bartlett of Johns Hopkins noted the early treatment debate is complicated by questions of cost, side effects, and viral resistance. None of the studies disputes that the antiviral drug is useful in treating AIDS, and all three recognize that AZT's benefits are limited.