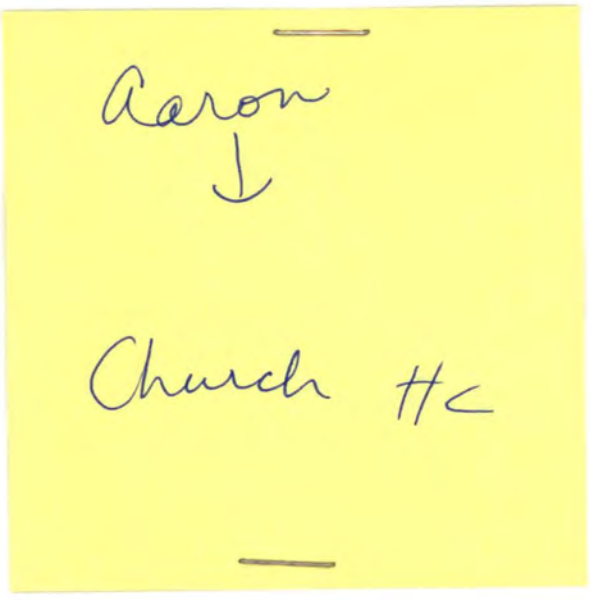
OFFICE OF THE FIRST LADY
BOX 3 OF 8

LISTING OF MELANNE'S FILES
HEALTH CARE

hank aaron
aarp
abortion
academic health centers
alzheimer
ama
aha
anti-trust reform
arkansas children's hospital
background info
balanced budget
biotech industry
breast cancer
budget scenarios
business jobs
business
brt
catholic health association
centrist 7
chafee
choice in dying
church/hc


Aaron
Church #c

HENRY AARON

PHOTOCOPY
PRESERVATION

H. Aaron

Henry J. Aaron
22 March 1994

Draft Specifications of a Compromise Plan

1. *Employer Mandate*

Mandate employers larger than (say) 50 to 100 employees to contribute 50 percent of the cost of health insurance. An individual mandate would apply to everyone else. Employers would be required to withhold employee premiums from earnings (as with personal income and worker payroll tax payments)

2. *Purchasing Cooperatives [Alliances]*

Establish a public alliance; permit voluntary alliances so long as membership exceeds a stipulated minimum -- say 5,000. Require employees of small companies (with fewer than, say, 500 employees) and individuals to buy insurance through an alliance

Define alliance boundaries on the basis of geographical subdivision used for some other public purpose -- Census regions, FRB districts. But ***do not*** leave the drawing of boundaries to states. Require an up-or-down vote (like base-closings).

3. *Subsidy Structure*

Company subsidies. Companies are subsidized for low-earning workers, so that total premiums do not exceed a stipulated fraction of that worker's earnings

Individual subsidies. Each household is required to pay a stipulated fraction of income for health insurance, starting from a modest fraction from the first dollar of income (as in administration proposal) and jumping to a higher fraction above the poverty threshold. This calculation is done on a separate 1040 form and includes information, to be provided on the W-2, regarding the subsidies provided that household by the employer.

Tax exclusion. Exclusion of employer-financed premiums would be retained in full; but no deduction would be permitted for individual premium payments. Employees who choose less costly plans than the most costly plan for which employers make contributions would be entitled to receive the difference tax free.

The low-wage worker subsidy avoids the incentive to reorganize companies to maximize subsidy payments that arises under a "low-wage company" structure. The individual subsidy saves budget costs because it embeds the employer mandate and subsidies paid to employers within an accounting framework that converts all subsidies into household subsidies based on family *income*. The tax exclusion preserves incentive for employers to continue paying for insurance, since their withdrawal is equivalent to a wage cut. The tax-free payment to workers of the difference between the most costly plan and the one actually selected is mathematically the same as denial of exclusion above the least cost plan (the Cooper approach), but it is a reward, rather than a punishment. [Gas stations met howls when then charged people premiums for using credit cards; but no one complained when gas stations gave discounts for cash.]

4. *Benefit Package*

Reduce benefit package from 50th percentile of corporate plans to (say) 15th to 20th percentile, by increasing deductibles and (perhaps) cost sharing and by narrowing benefits (child dentistry, mental health, substance abuse, or other elements)

5. *Calendar*

Full implementation of mandate by 2000 to 2003

6. *Cost Control*

Adopt "put-up-or-shut-up" approach to managed competition. Set national health care spending targets. Enact regulatory controls (premium caps or other devices), ***but defer implementation*** for, say, five years. If spending targets are met, the regulations remain in reserve, but are not implemented. If spending targets are not met, regulations are put into effect. If regulations are triggered by a failure of managed competition to deliver promised cost control, higher taxes will also be necessary to cover subsidy costs; these too must be enacted at the front end.

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6. *Cost Control* – Shift to deficit issue

Adopt "put-up-or-shut-up" approach to managed competition. Set national health care spending targets. Enact regulatory controls (premium caps or other devices), ***but defer implementation*** for, say, five years. If spending targets are met, the regulations remain in reserve, but are not implemented. If spending targets are not met, regulations are put into effect. If regulations are triggered by a failure of managed competition to deliver promised cost control, higher taxes will also be necessary to cover subsidy costs; these too must be enacted at the front end.