MANAGED COMPETITION

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MANAGED COMPETITION

file

TO: Melanne
FROM: Jennifer
DATE: 4/12/94
RE: Ellwood Meeting

Attached please find the latest draft of Managed Competition II. I thought you might like a copy for the meeting with Ellwood tomorrow at 4:30.

MEMO TO FIRST LADY HILLARY RODHAM CLINTON
FROM: WALTER ZELMAN
RE: JACKSON HOLE PROPOSAL, "MANAGED COMPETITION II"
Tuesday, March 29

Jennifer Klein asked me to prepare a brief review of this proposal.

MAIN POINTS OF THE NEW PROPOSAL
WITH AN EMPHASIS ON CHANGES FROM PRIOR JACKSON HOLE PROPOSALS

1. **STEP BY STEP APPROACH:** Notes great uncertainty regarding impact of reform; advocates moving from guaranteed "access" to guaranteed "coverage" by a step-by-step approach aiming at achieving universal coverage by about 2002.

2. **MANDATES:** Suggests legislation include a mandate (employer/individual or individual only) to be implemented about 2002 if goals of expanded coverage are not met.

   - Prior Jackson Hole papers accepted an employer mandate from the outset. The new version is more tentative, leaving implementation of a mandate, and decision to impose it, to the future.

   - Appears to favor a straight individual mandate.

   - Employer mandate, if used, would be phased in. Would apply only to firms of over 100 full-time-employees. Others would be under an individual mandate.

   - Advocates a "free-rider" tax to be collected by the IRS from all individuals who don't have insurance.

2. **ALLIANCES:** Expresses fears that one alliance per region could encourage more regulation and less choice; now advocates multiple alliance approach. This is a change from past advocacy of a single alliance per region.

   - Argues that all alliances must offer all plans; opposes HSA provision that grants alliance the right to reject plans charging 20% over the average.

   - Maintains provision that all in the small group market (100) that purchase insurance must do so through an alliance.

3. **COMMUNITY RATING:** Maintains emphasis on community rating.

   - Would allow health plans to reward "healthy lifestyles" by discounting charges to individuals.

4. **TAX DEDUCTIBILITY OF BENEFITS:** Continues Jackson Hole advocacy that this is a core ingredient of reform. Would set cap not at the "lowest cost plan" but at "average accountable health plan price in lowest quartile."

   - Would allow individuals choosing plan below "tax cap" to keep the difference in a "health bonus account" to defray cost-sharing expenses or pay for additional benefits.

5. **POINT OF SERVICE:** Acknowledges consumer demand for choice; would require that all alliances offer at least one plan with a point-of-service option. (There is no guarantee of a fee-for-service plan or that all health plans offer such an option. But this is further than Jackson Hole has gone previously).

6. **BUDGET:** Acknowledges need for "fiscal discipline," and for keeping expenditures in line with revenues. But opposes any form of fee schedule, premium cap or other regulation.

   - Advocates allowing market to work with no government interference.

   - Mandates that government then tailor government spending to fit the market. I.e., if costs rise government must either raise more revenue, cut subsidies, reduce benefits, slow technological growth, etc..

   - Advocates an ongoing public debate on these issues.

   - Advocates setting spending targets, with National Board making recommendations if targets not met.

7. **MEDICAID:** Forms separate pool, with separate alliance, for AFDC and SSI eligibles. (Eventually these individuals would be moved into alliances serving the larger population). Envisions having state and federal governments pay full "actuarially sound" cost for these individuals.

   - Envisions phased-in government subsidy program for other low-income individuals who would purchase insurance through alliances with rest of population.

   - Proposal hopes that market reforms, including tax cap, and subsidies will reduce costs and expand access enough so that mandate may not be necessary. About 95%, they hope, should be covered.

8. **MEDICARE:** Treated similar to treatment in HSA with heavy emphasis on encouraging Medicare eligibles into HMOs.

ANALYSIS

Overall the approach is less like the HSA than prior Jackson Hole proposals. It takes a more cautious, phase-in approach, backs away from mandates, and tolorates multiple alliances in one region.

The proposal must be seen as reflecting its proponent's fear of any government intervention in the market. Jackson Hole members have been very critical of every element of the HSA that smacks of regulation: premium caps, fee schedules, any restrictions on who can participate, large market-share alliances (which they fear will lead to a single payer system).

SOME ELEMENTS OF THE PROPOSAL THAT MAY BE OF PARTICULAR INTEREST OR CONCERN

1. **COMPETING ALLIANCES:** The proposal would: require all alliances to accept all health plans: require plans to offer the same community rate to all alliances: require all plans to cover the entire alliance region. Alliances would compete only on their overhead and customer service.

   Such an approach gives up enormous benefits in efficiency, consumer protection and simplicity for the appearance of more "competition" and less "regulation." Ultimately, all will be offered the same plans at the same prices. Since alliance "overhead" will be less than 2% of total premiums, there isn't much to "compete" over.

   The decision to move to multiple alliances obviously reflects fears that an HSA type alliance will become too "regulatory," and would push the system towards a single-payer result.

2. **A JACKSON HOLE BUDGET:** The proposal envisions no government intervention in the market. But given public demand for more, new technology, the numbers of decisions that still rest with providers, and the overall value to the health care sector of higher levels of spending, it is hard to see such a scenario leading anywhere but to higher health care spending. (Plans may still want to be a low-cost plan --but all have an interest in more dollars going into the health care sector in general).

   The Jackson Hole answer invokes pleas for the toughest kinds of government action: cut benefits or subsidies, slow technological growth, raise taxes. It is interesting how a plan that so fears government intervention can expect government to wisely and continuously make such tough decisions.

3. **CHOICE:** By HSA standards the proposal leaves much to be desired. But Jackson Hole advocates are determined to encourage the growth of managed care systems. They want the market, and nothing else, to protect the consumer's right to choose.

4. **FEARS OF GOVERNMENT REGULATION:** Increasingly over the past year, Jackson Hole proponents have become fearful of too much government intervention in the marketplace. Some have suggested they believe the Administration's ultimate goal is to create a single payer system.

   This fear of government intervention leads to an ultimate paradox in Managed Competition II. While coming close to advocating an individual mandate, the paper lists as a "disadvantage" of such an approach the fact that all individuals might demand access to the alliance. The result of such a demand --which, they admit, Congress couldn't resist-- would be increasing numbers in the alliance and greater consumer pressures for cost control, leading to more regulation and a single payer system.

   In short, the better the alliance works, the more it is to be feared.

JACKSON HOLE GROUP

Paul M. Ellwood, M.D.
President

TO Jennifer - dept R — has Ira also responded?

Hillary Rodham Clinton
Office of the First Lady
White House, 214 E. Wing
Washington, DC 20500

March 7, 1994

Dear Mrs. Clinton,

Ever since our September 15, 1993 meeting we have been searching for the bipartisan bicameral middle ground that will bring Universal Coverage, of the type that you would find acceptable. I think we are getting very close.

I have enclosed a copy of the latest draft of Managed Competition II, which we expect will go through one more revision in response to comments before we circulate it on or about March 16. If you or your staff have any suggestions, of course they would be invaluable.

Sincerely,

Paul M. Ellwood, M.D.

cc: Roger Altman
Ira Magaziner
Donna Shalala

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MANAGED COMPETITION II
FAX REPLY FORM
PLEASE REPLY BEFORE 3/14/94
FAX NUMBER (307) 739-1177

Universal Coverage

1) 2000 would be set as a target date for universal coverage.

☐ Agree ☐ Disagree

2) Universal coverage would be defined as 97% of Americans insured with standard benefits or traditional Medicare.

☐ Agree ☐ Disagree

3) A decision regarding mandating coverage would be deferred until more is know about the residual uninsured population—2000. No decisions on individual and employer mandates versus other forms of compulsory coverage would be made now.

☐ Agree ☐ Disagree

4) If universal coverage has not been achieved by 2000, Congress would commit itself to act in every subsequent year by either increasing low-income and Medicare funding and/or passing some form of mandated coverage.

☐ Agree ☐ Disagree

Comments:

Low-income Assistance

1) Low Income Subsidy Program, Part 1 (LISP 1): A subsidy program for the current categorically needy (those receiving AFDC and SSI benefits) acute care portion of the Medicaid program would be created to end Medicaid and merge it into the managed competition system.

☐ Agree ☐ Disagree

2) Initially, LISP 1 would be pooled separately, and the state would negotiate actuarially sound capitation rates for coverage in AHPs for this population.

☐ Agree ☐ Disagree

3) To avoid government imposed cost-shifting, AHPs would not be compelled to participate in the LISP 1 program.

☐ Agree ☐ Disagree

3) Low Income Subsidies Program, Part 2 (LISP 2): A subsidy program for individuals below 200% of poverty, and ineligible for LISP 1, would be created.

☐ Agree ☐ Disagree

4) LISP 2 eligible individuals below 100% of poverty would receive total payment vouchers; for individuals between 100% and 200% of poverty, subsidies would be graduated based on income.

☐ Agree ☐ Disagree

5) LISP 2 vouchers would be used through the appropriate sponsor, their large employer or the HPPC.

☐ Agree ☐ Disagree

Comments:

Medicare

1) Medicare would make a defined contribution toward AHP premiums. The defined contribution would be set at the national per capita average Medicare expenditures, adjusted for cost of living and health status, but not medical prices.

☐ Agree ☐ Disagree

2) Newly eligible Medicare recipients must continue to purchase health care from AHPs.

☐ Agree ☐ Disagree

3) Present Medicare recipients would retain their FFS option.

☐ Agree ☐ Disagree

4) The current regional AAPCC reimbursement program would be phased out.

☐ Agree ☐ Disagree

5) AHPs serving Medicare beneficiaries would be required to offer the same standard benefits package available to the general population.

☐ Agree ☐ Disagree

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6)Reject above, AAPCC should be maintained with additional adjustment for health status.

☐ Agree ☐ Disagree

Comments:

Balanced Health Security Budget

1) Medicare and LISP expenditures would be financed through a balanced health security budget.

☐ Agree ☐ Disagree

2) Congress would set a balanced health security budget every year.

☐ Agree ☐ Disagree

3) The NHB would set a standard benefits package to keep the health security budget in balance.

☐ Agree ☐ Disagree

Comments:

Competing HPPCs

1) Multiple competing HPPCs would be allowed within a single health market region.

☐ Agree ☐ Disagree

2) HPPCs would not negotiate premiums, they would compete only on their administrative efficiency and customer service.

☐ Agree ☐ Disagree

3) HPPCs would still be the sole sponsors for employers with less than 100 employees and individuals in that tax preferential treatment for this population would be conditional upon purchasing coverage through a licensed HPPC.

☐ Agree ☐ Disagree

Comments:

POS Option

1) All sponsors would be required to offer at least one AHP with an out-of-plan provider option.

☐ Agree ☐ Disagree

Comments:

Defined Contribution for Large Employers

1) Large employers that pay for some portion of health coverage would be required to make a defined (flat dollar amount) contribution towards health coverage, regardless of plan chosen by employee, and the tax deduction and exclusion would be limited to the weighted average premium.

☐ Agree ☐ Disagree

Comments:

Medisave

1) Individuals who chose an AHP priced below the weighted average premium would be allowed to deposit the difference into a tax-free Medisave account.

☐ Agree ☐ Disagree

Comments:

MANAGED COMPETITION II

A DRAFT Proposal
February 1994

INTRODUCTION

Health care reform is stalling over a number of issues with the resulting danger that either ineffectual or even no legislation will pass. The Jackson Hole Group, the originators of managed competition, view this as unacceptable, and remain committed to comprehensive reform of the health system including universal coverage. Having come this close to achieving health care security for the American people, the task is now to craft a reasonable, affordable compromise out of the thoughtful proposals that face Congress in 1994.

Perhaps nothing threatens to undermine reform more than the unpredictability of costs and of the effectiveness of cost containment efforts. Estimating costs with even the most elaborate cost-estimation models produces point estimates that are very unreliable, particularly as one extrapolates into the future. Their principal value is in defining the relationship between variables. Other areas of uncertainty include the ability of different mandates to achieve universal coverage, the unpredictable effects of price controls or global budgets and whether it is possible to enforce them, the lack of capacity that may result from a continued shortage of primary care practitioners or delays in accountable health plan (AHP) formation, how employers will use savings, the effects of increased consumer involvement in the decision-making processes, and any savings that may be achieved by reducing the amount of ineffective care.

With these and other factors in mind, this document presents a revised version of the original managed competition proposals that takes into account the inherent uncertainties of reform and builds on the lessons learned since the proposals were first introduced. The document proposes a commonsensical approach to government health care financing that is always in balance, and a rational stepwise approach to universal coverage. Whatever reform measures are adopted it is imperative that they add to the reforms already underway in the private sector and in states, by strengthening incentives to reduce costs and improve quality, and that

they extend reforms to the small and non-group markets and public programs including Medicare.

MANAGED COMPETITION II

Prior to introducing the modifications under consideration to the original managed competition proposals, it is worth while revisiting the core elements of the managed competition model that remain unchanged. These are presented in Table 1.

ACCOUNTABLE HEALTH PLANS (AHPs) "The Providers"

AHPs are the engines of reform and would shift the emphasis in health care from disease and intervention to prevention and wellness. AHPs are organizations that:

- Both finance and deliver the full range of a nationally defined package of health benefits.
- Are accountable to the public for satisfaction of their members and the effect of their services on members' health.
- Comply with established solvency and underwriting standards, including community rating and guaranteed issue and renewal provisions.
- Adhere to uniform data reporting requirements as established by a National Health Board.

SPONSORS "The Health Plan Store"

Large employers, government, and HPPCs would all act as sponsors that facilitate individual choice of health plan. In general the role of the sponsor is to:

- Arrange for individuals to selects AHPs.
- Minimize the incentives and ability of AHPs to select good risks.
- Set rules to assure equitable coverage of all members of the sponsored group.

STANDARD BENEFITS "The Universal Entitlement"

A standard benefit package would:

- Facilitate side-by-side comparison of AHPs (increasing elasticity of demand), and promote efficiency through standardized claim forms and issuing requirements.
- Provide a rational vehicle for defining services to be made universally available to all Americans and put private and government programs on the same footing.
- Be continuously amended by the NHB and approved by Congress through a process insulated from inordinate political interference.
- Be based on scientific documentation of efficacy, including cost-effectiveness.

THE NATIONAL HEALTH BOARD (NHB) "The Referee"

The NHB would be an independent federal agency to guide, oversee, and facilitate a transition to a new health system. NHB powers and responsibility would be explicitly limited in legislation to:

- Recommending a standard benefits package to Congress,
- Balancing the "health security budget" (see below),
- Coordinating a standardized data reporting system,
- Setting standards for and registering AHPs and HPPCs,
- Disseminating information and making recommendations on risk adjustment,

Three years of circulation and application of the original managed competition proposals have led to a wealth of experience and feedback, leading to consideration of the following policy changes.

COST CONSCIOUSNESS OF CONSUMERS

Consumers will be cost and quality conscious only to the extent that they are responsible for the difference in cost between plans and informed about differences in quality. Many have questioned the logic of a limit on tax-free health benefits, especially those that enjoy rich tax free benefits packages, but a tax cap remains the best way to instill cost-consciousness, control government expenditures, and raise revenue for low-income subsidies without increasing marginal tax rates. A revised tax code would include:

- Equalizing tax treatment of health expenditures for employers and individuals, including expanding tax preferential treatment for individuals.

- Making preferential tax treatment and government subsidization contingent upon purchasing coverage through the appropriate sponsor (i.e., large employer or HPPC).

- Capping tax deductions and exclusions at the level of the weighted-average price AHP in the area (instead of at the level of the low-cost AHP). Consumers would be free to spend additional after-tax dollars on health care.

- Allowing those who choose an AHP priced below the tax cap to keep the difference in a tax-free health spending account (Medisave) to be used to defray the costs of copayments, deductibles, and benefits not included in the standard benefits package and/or an individual retirement account. Alternatively, to save the costs of administering tax-free spending accounts, individuals could simply submit receipts and deduct expenses against their taxable income for tax purposes.

We anticipate that because of a revised tax code, most employers would limit their contribution to health coverage for employees, regardless of plan chosen, to the tax-preferred amount. However, some employers with union contracts that require they pay the full price of any health plan an employee chooses may still find this difficult. Therefore a requirement that employers contribute a fixed dollar amount, regardless of plan selected by employee, may be necessary at some point to ensure full employee cost-consciousness.

HEALTH PLAN PURCHASING COOPERATIVES (HPPCs)

As introduced in the original managed competition proposals, HPPCs in a reformed system would act as sponsors for individuals and small employers, giving them the ability to pool risk, achieve economies of scale, and drive the competitive process through informed individual choice. It is important to stress that the JHG believes that HPPCs should not be regulatory or price setting agencies. HPPCs would not negotiate, or limit choice of AHPs, rather they would offer an informed set of choices so that individuals could weigh personal priorities in health plan selection. HPPCs that negotiate (i.e., refuse to offer plans whose prices are too high) would not only limit individual choice in health care, they would also threaten to undermine a functioning and competitive market by concentrating too much purchasing power in a single entity.

While many private sector initiatives are proving effective in holding down health costs, especially purchasing efforts of large employers, the problems associated with the small group and individual markets appear to be worsening. The need for HPPCs has not gone away. However, the original managed competition design of a single exclusive HPPC per geographic area has two weaknesses when examined in light of public concerns and the reality of implementation obstacles. First, monopoly HPPCs do not structurally prevent HPPCs from becoming regulators. Secondly, monopoly HPPCs leave some consumers with no choice in purchasing alternatives, and thus no protection from inefficiency. These concerns have led us to propose a system of competing HPPCs. To borrow an analogy, we believe it is preferable

to have the U.S. Postal Service serving the country with competition from Federal Express and other private carriers, rather than to have a non-competitive mail delivery system. States would be charged to make certain there is a "post office" but alternatives would be allowed provided they met specific standards outlined below.

HPPCs would still be the exclusive sponsors for the small group and individual markets in that tax preferential treatment of health expenditures would be conditioned upon purchasing coverage through a licensed HPPC. This competing HPPC structure would require special measures to ensure that the market is not undermined by adverse risk selection. Private sector organizations or associations could become licensed as HPPCs if they met criteria designed to ensure that all HPPCs open enroll, offer all AHPs, and conform to other HPPC standards including a requirement to cover entire HPPC regions and a prohibition against conflict of interest. AHPs would offer the same base community rate to all HPPCs in designated regions. HPPCs would compete only on their administrative overhead (the cost of which would be added to premiums) and their customer service. Competing HPPCs that negotiated premiums would undermine community rating in the small group market. In a system of competing HPPCs, states would have to take on the additional responsibilities of dividing their territory into HPPC regions, and coordinating risk adjustment and standardized data collection. Designed this way, competing HPPCs can still achieve the original HPPC goals, and should satisfy those that contend there is a need for significant reform of this market.

CHOICE

The original managed competition proposals did not limit what type of health care delivery organizations would compete in a reformed market. However, the public has clearly expressed that they value choice of physician and for this reason all sponsors should be required to offer at least one AHP with an out-of-plan option, which allows enrollees to use non-AHP providers at increased cost. A requirement for sponsors to offer at least one POS plan would best balance the public's priorities of more accountable, longitudinal health care

with the desire to maintain patient choice of physician. Experience is that only 5-10% of individuals with an out-of-network option exercise it, but the option is probably important to many more.

BALANCED HEALTH SECURITY BUDGET

The original managed competition proposals did not examine closely the financing aspects of attaining universal coverage, believing that public finance was an issue best left to individuals with expertise in this area. As various financing schemes have been proposed in legislation, it has become clear that the financing of health reform has implications for how structural aspects will interact. A managed-competition approach to structural reform requires a managed-competition approach to financing.

The establishment of a balanced health security budget would instill fiscal discipline into the health care system by guaranteeing that federal coverage costs do not grow faster than revenue, that private health security costs do not grow faster than the economy, and by promoting an honest and explicit debate regarding federal health care expenditures. One can think of it as a ledger that continuously matches revenues to expenses. Federal health spending covered by the balanced health security budget would include Medicare, LISP 1 and 2 (see below), and possibly the Federal Employee Health Benefits Program (FEHBP).

Under such a system, government health expenditures would be disbursed on a pay-as-you-go basis, and the health system would move toward universal coverage in carefully monitored stages. Legislators would agree either to raise enough money to pay for the standard benefits for the covered population or limit the scope of the health security benefits package or the subsidies available to individuals to help pay for them. Such an approach would ensure that the health security system is not undermined by excessive cost-shifting or open-ended entitlements.

To enforce the balanced health security budget, the NHB would be charged by Congress to continuously match available revenues to health priorities based on effectiveness, cost, and public values. If the rate of growth in expenditures exceeds the rate of increase in the budget, the NHB would either adjust the benefits package (the benefits package would be voted on in a manner similar to the military base closing procedure), slow the expansion in low-income subsidies or convey other recommendations to the Congress for keeping the budget in balance. If Congress failed to accept these recommendations it would have to appropriate more money. While it might be preferable to have an explicitly earmarked health tax as the funding source for the balanced health security budget, ultimately what matters is that Congress keeps the budget in balance, and that we focus the debate on the most explicit, reliable, and equitable sources of federal health care funding.

GETTING TO UNIVERSAL COVERAGE

The public is convinced of the need for universal coverage. We believe a requirement that everybody contribute to the cost of their health care through a system based on efficient, progressive taxes to finance those unable to pay for themselves, is still the best way to achieve universal coverage. However, given that it will take time to build strong health plans, to evaluate progress, to accumulate savings from managed competition, and to allow individuals to avail themselves of the reformed system, it is appropriate to first set up a universal access system by helping people who need it most (i.e., poorest of poor individuals through subsidies, plus individuals and small employers through purchasing cooperatives and insurance reform). A functioning universal access system should allow a smooth transition to universal coverage by 2000 if Congress passes legislation in 1994.

Under any health insurance system, it may be impossible to ensure every single citizen is actually covered by an AHP, therefore a definition of universal coverage should reflect this reality, much as the definition of full employment falls short of 100% employment. A reasonable working definition would be that universal coverage is attained when it can be

verified that 97% of the population have coverage. As reform proceeds, this percentage could be adjusted to reflect the point at which the additional cost of bringing individuals into the health security system through government actions such as a mandate or increased outreach is too great for the public to accept. At some point it makes sense to adopt a policy that promotes uniquely targeted care for the residual uncovered, rather than devoting limited resources to the difficult and expensive task of pulling every last individual into the private system.

If universal coverage, as defined by Congress, has not been achieved by 2000, Congress would have to act in every subsequent year by increasing Low Income Subsidy Program (LISP, see below) funding or passing a mandate until it is achieved. A requirement to take action in every year after 2000 should ensure that legislation attains universal coverage within a reasonable time frame.

Given that many lessons will be learned as experience with a reformed system is accumulated, reform should defer a decision on implementing a mandate until after 2000. By then broad low-income subsidies would be at or near full phase-in, competing AHPs would be functioning, group purchasing for all and health insurance reforms would have been in place for some time, and the residual uninsured population would likely be much less significant in number, and much different in character from the presently uninsured population. Only with good information regarding the number and percentage of uninsured by employment status and wealth can an informed decision be made regarding what type of compulsion, if required, would best lead to universal coverage. For example, if primarily low-income, unemployed individuals are uninsured it is unlikely that any form of mandate would be effective, instead changes to the LISP program would be required. On the other hand, if wealthy, non-working individuals were uninsured, a free-rider tax would probably be the most effective way of getting to universal coverage. Finally, if large numbers of employed individuals were uninsured, an employer mandate might be more appropriate. If universal coverage is not attained by 2000, and in a subsequent year a mandate is deemed the effective policy response, the two alternatives discussed in the appendix should be considered first.

Universal coverage will require that public programs are folded into a managed competition system and that a true universal access system is created in the interim. To facilitate this public spending would primarily be directed at three programs: LISP 1, LISP 2, and Medicare.

Low Income Subsidy Program, Part 1 (LISP 1): A subsidy program for the current categorically needy (those receiving AFDC and SSI benefits) acute care portion of the Medicaid program

Perhaps the greatest and most consistent challenge faced by state governments in recent years has been the dramatic increase in and unpredictability of costs in their Medicaid programs. While more states, like the private sector, now look to managed care as a means of tackling the cost and quality problem, still little over 10% of Medicaid beneficiaries are in true managed care programs like HMOs. This process needs to be accelerated if financial discipline is to be instilled and predictability of costs and accountability for quality is to be realized where neither have existed for some time.

States would be responsible for the administration of their respective LISP 1 programs, which would be fully funded in the first year of reform and designed as follows:

- The AFDC and SSI population would be maintained, at least initially, as a separate risk pool that is covered by AHPs (except where adequate AHP contracts cannot be negotiated).

- Each state, or contracted sponsor acting on behalf of the state, would base capitation rates for the LISP 1 population on actuarially sound estimates of the average reasonable costs across AHPs of delivering a standard benefit package adjusted to the special needs of this population. To avoid state imposed cost-shifting, AHPs would

not be compelled to participate in the program, and there would be room for negotiation around this rate.

- The federal and state governments would jointly contribute 100% of the price of benefits for LISP 1 beneficiaries. However, because states would be required to maintain their current level of financial commitment to Medicaid and uncompensated care (current expenditures would be trended forward according to LISP 1 experience), they would be relatively more at risk for their AFDC and SSI populations.

- Using a voucher, the LISP 1 eligible population could choose from among participating plans through their own LISP 1 HPPC at the time of annual open enrollment. For individuals who fail to select a health plan, the LISP 1 HPPC would choose one for them.

- Once the LISP 1 population had experience in managed care programs and their risk could be predicted with relative accuracy, they would move to the general HPPCs, where government would pay a competitive community rate on their behalf. The phase out of LISP 1 would be a logical part of ending welfare as we know it. Additional benefits that were not part of the standard benefits package available to the general population would be added on as wrap-around benefits funded jointly by states and the federal government and provided by AHPs.

- While costs for LISP 1 beneficiaries should be mitigated so coverage is within their reach, they like everyone else will be paying some portion of the cost of their care to instill some degree of cost-consciousness.

The rationale for initially maintaining the AFDC and SSI population as a separate risk pool rather than pooling them with the HPPC population stems from the belief that the former population may be above average risk. A separate risk pool would ensure explicit financing of the program and minimal cost-shifting. However, because of the potentially limited choice of

plans, it would move into the general HPPC and AHP programs as soon as costs and unique needs are understood. If the below poverty population is higher risk, then everyone should bear the additional costs, not just the HPPC-eligible population (i.e., individuals and small employers).

Low Income Subsidies Program, Part 2 (LISP 2): A subsidy program for individuals below 200% of poverty, and ineligible for LISP 1

According to the Employee Benefits Research Institute (EBRI) analysis of the March 1993 Current Population Survey (CPS), the below poverty uninsured population number some 10.8 million individuals or 28.1% of the uninsured, while the 100%-200% of poverty uninsured population represents an additional 32.5% of the uninsured, or 12.5 million individuals. In addition to the implicit subsidy available to everyone through preferential tax treatment of benefits up to the weighted average cost plan in a region, further subsidies need to be made available to this population to offer meaningful access to the health system. Though LISP 2 eligible individuals would receive subsidies in the form of vouchers, they would purchase their coverage through their local HPPC or large employer, depending upon employment status, thus minimizing the government's role in the program. For some LISP 2 eligible employees these funds may make it affordable to join their employer plan. LISP 2 funding would be phased in as funds accrue to the government (see table 2). The initial targets could be that LISP 2 eligible individuals below 100% of poverty would receive vouchers for 100% of the cost of the low-cost plan and subsidies for LISP 2 beneficiaries between 100% and 200% of poverty would phase out on a sliding scale.

The phase-in could be structured as follows:

Year 1

Financing Goal:	Up to X% of poverty eligible for LISP 2.
Participation Goal:	Y% of eligible individuals should be covered.

Year 2

Financing Goal:	Up to X+% of poverty eligible for LISP 2.
Participation Goal:	Y+% of eligible individuals should be covered.

Year 3

Financing Goal:	Up to X++% of poverty eligible for LISP 2.
Participation Goal:	Y++% of eligible individuals should be covered.

Year 4

Financing Goal:	Full LISP 2 targets should be met.
Participation Goal:	Y+++% of eligible individuals should be covered.

Table 2: Expansion of LISP 2 program.

Prior to the beginning of each year, the NHB would determine LISP 2 eligibility by reconciling the revenue made available by Congress, through the balanced health security budget, with the predicted participation rate. Expected failure to meet the eligibility target, as expressed in the financing goal, might trigger reduction in the benefits package upon the recommendation of the NHB, reduced eligibility for subsidization, or increased taxes upon approval of the Congress. Reduced eligibility for subsidies would be the default fallback written into the law, since it could be automatically calculated.

At the end of each year, participation in LISP 2 would be compared to the participation goal set forth for the year. Failure to meet this goal might result from insufficient subsidies (except for those fully subsidized), a complex or inefficient subsidization mechanism, inadequate outreach, or the fact that individuals simply chose not to purchase coverage—free riders. Possible policy solutions would include increased subsidization, a new subsidization

mechanism, or increased outreach and education. Although the subjective nature of these failures would prohibit automatically triggered responses, legislation could require the adoption of one of the preceding policies if goals were consistently missed. Policy will require evaluation of the tradeoff between devoting additional resources to expanding outreach and education activities and to increasing premium assistance levels.

State experimentation in subsidy levels, eligibility criteria, and phase-in strategy of LISP 2 would be encouraged to close in on an optimal LISP 2 design more quickly. For example, at some level, subsidies at only a percentage of their targeted level may provide meaningful access to health care, thereby making phase-in of the level of subsidization an appropriate policy. This would have the desirable effect of increasing the eligible population, minimizing the risk to the federal government of overshooting on spending, as well as ensuring a sliding scale phase down of subsidies to prevent a marginal tax rate cliff. Creating a true universal access system will require flexibility in and the ability to improve upon the design of the subsidy program to meet coverage targets: the full and partial subsidization points may need to be adjusted to achieve satisfactory access and a gradual enough benefit reduction rate.

The present Medicaid program creates substantial disincentives for going back to work, since beneficiaries completely lose coverage once they cross the eligibility threshold. Combined with the loss of other welfare benefits such as the earned income tax credit, food stamps, and housing subsidies, this threshold represents a disincentive to earn more. While any phase-out of health care subsidies would be an improvement over the current system, the pressing need to tackle welfare reform in conjunction with, or very soon after, health care reform is apparent. To increase incentives for work, the threat of higher health insurance costs associated with moving to a higher income bracket should be as small as possible. Minimizing this risk would necessitate a gradual phase-out of subsidies. Up until now this expanded entitlement has been regarded as too expensive. Ultimately, we are being asked to decide how much we are willing to pay in taxes for health care on behalf of those who cannot pay themselves.

Medicare.

The Medicare program ultimately should be structured the same as the rest of the health care delivery system. Medicare recipients should have the opportunity to receive the same standard benefits and provider choice as all other Americans. The standard AHP benefit will most likely be more comprehensive than current Medicare benefits, potentially eliminating the need for Medigap policies. Beneficiaries ought to have the opportunity to join AHPs, and the same motivation to save money and pursue prevention and health maintenance measures as the general population. This reform cannot be immediate, however, since many beneficiaries, particularly those with serious health problems, value the present program. Cost cutting measures as proposed by Congress and implemented by HCFA would continue to be utilized to control tradition Medicare expenditures. Medicare would start to be integrated into a managed competition environment as follows:

- The Medicare population would be maintained as a separate higher risk and cost group. Medicare beneficiaries would be eligible to join AHPs which must offer the full standard benefits package. Regional Medicare HPPCs would, at the time of an annual open enrollment period, allow present Medicare beneficiaries to choose between traditional HCFA administered Medicare, with the present Medicare benefits, and competing AHPs offering the standard package. Beneficiaries would have a greater choice of AHPs than present law permits, including AHPs that offer an out-of-plan provider option.

- For beneficiaries who chose an AHP, the federal government would make a defined contribution toward premiums. The defined contribution would be set as a function of the nation-wide average per capita expenditures for the Medicare program. This average would be adjusted by a regional index that reflected general differences in the cost of living and the health status of beneficiaries, but not differences in the cost of medical care. Beneficiaries who choose an AHP would be responsible for paying the difference between the government contribution and the cost of their plan of choice. Present employer sponsored retiree health benefits that pay for wrap-around coverage could be redirected

toward the difference between the government's defined contribution and an AHP's premium. Equally, employers and retirees might agree to reconfigurating retiree health benefits into a defined contribution such that those who join AHPs get the savings from their actions.

- Beneficiaries that age into the Medicare program would be required to continue purchasing coverage from AHPs.

- The price of AHPs available to Medicare beneficiaries would be based on a health status adjusted, market-determined community rate across the Medicare population within a Medicare HPPC region. AHPs could offer their services at whatever competitive price they thought would attract Medicare beneficiaries.

- Eligible low income beneficiaries would continue to receive premium and cost-sharing assistance.

- The present red tape that impedes HMOs from participation in the Medicare risk contracting program would be aggressively reduced. There would be a significant shift in public policy that supports the development of Medicare-oriented AHPs and encourages them to serve beneficiaries.

As AHPs find ways to improve efficiency, they should be able to offer rates that are at or below the defined contribution set by government, even though they offer the richer standard benefits package. The opportunity to obtain more benefits at no additional, or only slightly higher cost, as well as continuity of care through primary care physicians, the reduced paperwork, and the obviated need to purchase a Medigap policy, should motivate Medicare beneficiaries to join AHPs. However, present Medicare beneficiaries who place more value on the fee-for-service alternative would retain the opportunity to stay in the current system. The reliance on nationwide based AHP capitation rates should serve to eliminate the geographic inequities in the distribution of Medicare reimbursement.

If AHPs succeed in lowering their costs below fee-for-service Medicare program costs, the federal government could save significant amounts of money as Medicare beneficiaries choose to enroll in AHPs.

Appendix: Discussion of mandates

Combination of individual and employer mandates

Employer Mandate for Large Employers

- All employers with more than 100 employees would have to offer a choice of AHPs offering the standard health benefits package to employees, and their dependents, who work more than 30 hours a week and would be required to make a defined contribution of a minimum of [50-80]% of the price of the low cost plan to the health care premiums of their employees. To minimize employment effects, the mandated contribution requirement would be phased in over a period of time. A prorated contribution would be required for part-time workers who worked more than 1,000 hours per year and a payroll tax of X% would be paid for workers who work less than 1,001 hours per annum.

- To assuage effects on employers near the HPPC threshold size, there would be a gradation of their financial obligation in accordance with firm size (i.e., firm size 100-125, 20%; 126-150, 40%; 151-175, 60%; greater than 175, 80%.). These employers would not be relieved of their obligation to offer standard health care benefits. If the gradation was used in combination with a phase-in, the obligation for all firms would be phased in equitably.

Individual Mandate for Individuals and Small Employers

- Part-time workers working less than 1,001 hours per annum for an employer with more than 100 employees and all individuals not employed or those employed by firms with less than 100 employees would be obliged to purchase coverage through their local HPPC.

- At the direction of their employees, small employers would be required to make a monthly payroll deduction and send the amount to the appropriate HPPC.

A combination of employer and individual mandates best builds upon the current employment-based system, and would ensure that the 99% of companies above the 100-person threshold which currently offer coverage to their employees would continue to do so.

To the extent that large businesses compete with small businesses in the same industry, employee compensation packages would differ, but since there would be a mandate in both sectors, total compensation in any individual firm should not be different. However, if employees do not recognize the trade off between wages and benefits, small employers would have a hiring advantage. A combination of employer and individual mandates would increase the incentives for firms to game the threshold by engaging in such actions as hiring temporary personnel and splitting companies into separate entities. However, this may be mitigated by phasing in the percentage requirement with firm size.

Low income is the major determinant in access to health insurance, not size of firm in which one is employed. Therefore, for a combination approach to be equitable and efficient, the subsidization formula used would have to be consistent across mandate environments, and tied to income level not employment status, as in the LISP program. Individuals eligible for LISP subsidization would use their vouchers either through their large employer or the HPPC to defray the cost of coverage.

If, on the other hand, subsidies under the employer mandate were targeted at employers, as opposed to individuals, the employer mandate portion of the combined mandate would represent an inequitable and inefficient financing mechanism. Firm subsidies based on average payroll are inefficient because they subsidize high as well as low income individuals. For firms with high average payroll but some low income employees, subsidies would be insufficient, and employers would be forced to pick up the burden for government programs or lay off workers. For firms with low average payroll but some high income employees, the subsidies may be too generous, and the government would bear unnecessary costs.

The most expedient, efficient, and politically viable way to enforce the individual portion of the mandate would be through a free-rider tax. Individuals choosing not to purchase coverage would be required to pay a tax. Advantages of a free-rider tax are that it could be progressive and enforced by the IRS. The free-rider tax would be equal to a fixed amount plus a penalty that would be directly proportional to income. While such an enforcement strategy would not perfectly attain universal coverage, it would go a long way towards ending the free-rider problem while minimizing societal and economic dislocation.

Many legislative proposals, including the Administration's, have embraced employer mandates and subsidies targeted at firms because they allow the government to shift some of the burden of public programs onto employers and create the perception that no one is paying the price. While fiscally attractive to the government, this type of mandate perpetuates cost-shifting, and it is the kind of mandate that will cause the most economic dislocation because it effectively raises the minimum wage in many firms. To the extent that employers were unable to take the additional costs of health premiums out of wages, an employer mandate would cause some unemployment, especially in firms not currently offering coverage and in firms with low wage workers.

Individual Mandate

- All individuals would be required to purchase coverage as of the date of implementation, or pay a free-rider tax.

- All employers, while not required to finance coverage, would be required to offer coverage, either through the HPPC if they have fewer than 100 employees, or directly for large employers.

- Voucher eligibility and preferential tax treatment would be contingent upon purchasing coverage through the appropriate sponsor.

Adoption of an individual mandate has an inherent logic to it if one pursues a program of universal access first. Since individuals are already targeted for low income subsidies to make them more explicit, efficient, and equitable, it makes sense to target a mandate at individuals as well. An individual mandate could be easily and quickly implemented without disrupting present purchasing arrangements. It would satisfy those who believe the ultimate obligation to purchase health care should be on the individual, not employer, and that health care coverage should be divorced from employment status.

The greatest potential disadvantage of an individual mandate is the risk that companies that are currently active, value-based health purchasers will cease these activities, and will perform the minimum duties necessary to fulfill the obligation to offer coverage. It is not possible to predict the extent of this behavior. However, business leaders suggest that competitive forces in the labor market may be a strong enough force for maintaining an active employer role, especially if there is a stipulation that predicates tax preferred treatment of health expenditures on purchasing through the appropriate sponsor (the large employer for its employees). In addition, in a mandated environment, employees will value health purchasing that maximizes the wage portion of their compensation and secures quality health care. Employees of large firms (with no access to HPPCs) will look to their employers for purchasing expertise, since most employers purchase coverage for employees today. If large employers prove to be inefficient purchasers, it would be possible for employees to pressure their employers to go to secondary purchasers such as purchasing coalitions, to purchase coverage.

Another potential serious disadvantage of an individual mandate is that upon passage, all individuals might demand access to HPPCs. It is unlikely that Congress would have the political will to deny this. If the public then demanded that HPPCs exercise greater control over the cost of health care, the result could be slow, but steady, progression toward a great majority of the population in the HPPC—leading to regulation and possibly a single payer system. To some extent, competing HPPCs should mitigate this danger.

MANAGED COMPETITION UNDER HSA

- HSA would slow the growth rate of health costs through market, management, and administrative reforms aimed at enhancing competition.

- Let me explain how the reformed system would work:

  - For the first year the National Health Board (NHB) would calculate premium targets for each alliance. Such targets would reflect the cost for services in the benefits package and be based on health costs in the alliance area. Each year the NHB would update the targets using a health care inflation factor.

  - In a given year, plans submit premium bids to alliances. If the weighted average premium for all of an alliance's plans exceeds that year's target, as calculated by the NHB, the over-target plans may resubmit lower bids. If the alliance's average still exceeds the target, payments to plans over the target would be reduced according to a formula set in the HSA. These plans would have to make comparable reductions in their providers' payments.

MANAGED COMPETITION UNDER HSA (CONTINUED):

- The increase in the cap from year to year is based on the Consumer Price Index plus changes in an alliance's population. An additional cushion of 1.5 percentage points would be allowed in 1996, dropping to 1.0 in 1997, 0.5 in 1998 and no cushion in 1999 and 2000. NHB would recommend to Congress a method to determine future premium caps. If Congress does not act, HSA provides default future caps based upon increases in GDP and population.

- Some people have equated this process with price controls.

- But I must stress that there is an important distinction between price controls and HSA premium caps. Price controls involve government regulation of the prices of products in the economy. Such controls are difficult to implement and regulate, requiring considerable government resources and bureaucracies that interfere with private sector decision making and limit efforts to improve efficiency.

MANAGED COMPETITION UNDER HSA (CONTINUED):

- In contrast, premium caps do not involve micro regulation. They are, in essence, budgetary limitations within which private health plans must operate similar to budgets under which many private and public entities operate today. Within these overall budgets, the health plan has the freedom to manage its operations to provide quality care and control costs in a variety of ways, including through more efficient administration, more reasonable provider reimbursement, and more flexibility to determine the best allocation of resources.

- An illustration of price controls is the Medicare fee schedule, which sets specific payment levels for each service. In contrast, a budget concept is more akin to a capitated payment level which allows more flexibility in payment for individual services as long as the total payments stay within an overall budget.

PREVENTING AN UNDESERVED WINDFALL: IMPORTANCE OF SETTING THE INITIAL PREMIUM

- The savings from moderating health costs should accrue to the federal government, businesses and families, not to the health industry as an undeserved windfall.

- Critical to this effort is establishing a mechanism under which the health industry does not get paid twice for uncompensated care -- that is, for the care of the currently uninsured.

- Universal coverage will bring the currently uninsured into the health system and fully compensate the health care industry for their care.

- This is different from the current system in which the uncompensated care of the uninsured is passed on to people with private insurance in the form of higher premiums. Today, uninsured people pay only 21 percent of their health costs. The remaining burden is passed on to people with private insurance, whose premiums are significantly higher than they would be were it not for the cost shifting due to uncompensated care.

PREVENTING AN UNDESERVED WINDFALL (CONTINUED):

- Under health care reform, all Americans will have health insurance and the health care industry will be directly compensated for all individuals. **Thus, private insurance premiums will no longer need to be inflated to cover the shortfall from the uninsured.**

- If premiums continue to be inflated, the health industry would be paid twice for the currently uninsured, conferring a huge windfall on the health care industry.

- Premium levels must reflect the new reality that insurers will be directly compensated for the care of all the currently uninsured and the uncompensated care surcharge built into the current premium will be taken out. If not, businesses and families will be out billions of dollars in higher premium payments. That would be a huge and undeserved windfall to insurers and providers.

PREVENTING AN UNDESERVED WINDFALL (CONTINUED):

- The HSA provides full compensation to insurers for the currently uninsured, while maintaining the current treatment of costs for Medicaid. Therefore, there are no losses for the health industry when the premium for the first year is set at the HSA level. And in fact, CBO corroborated that HSA's initial premium level would allow providers to receive the same payments, on average, that they do today.

- The bottom line is that providers and insurers are held harmless, while keeping costs to families, businesses and the federal government at a reasonable level.

- Absent a mechanism which effectively deals with uncompensated care, there is no guarantee that premiums will be constrained in the first year. Competitive forces may work to avoid a windfall to the health industry for uncompensated care. But they may not. Instead the health industry might keep the windfall, resulting in higher initial premiums, and huge cost to businesses, families and the government.

PREVENTING AN UNDESERVED WINDFALL (CONTINUED):

- In fact, the Health Insurance Association of America and Hewitt & Associates estimate that, absent constraint, insurers would set premiums higher than the initial premium in the HSA.

- Now, I happen to believe that managed competition will work to contain health care costs. However, any legislation considered in the Senate is governed by CBO scoring, and CBO will not score significant savings from managed competition alone. CBO will only score the full anticipated savings if we have a back-up in place, like premium caps.

- As you all know, CBO scoring is important because there is a 60 vote point of order against any bill which CBO determines is not deficit neutral over ten years. In fact, if we brought the HSA to the floor today it would have a 60 vote point of order against it because CBO estimates it would increase federal costs by $126 billion over ten years. That is why many of the options I've discussed reduce costs relative to HSA.

PREVENTING AN UNDESERVED WINDFALL (CONTINUED):

- Without premium caps, CBO would estimate that federal costs of the HSA would increase substantially. It would be extremely difficult to offset these substantial costs, virtually guaranteeing that the bill would increase the deficit and have a 60 vote point of order against it.

- The HSA's premium caps give maximum latitude to competition, while at the same time ensuring that CBO will give us maximum credit for the savings associated with health care reform.

IMPORTANCE OF SETTING THE INITIAL PREMIUM
AN EXAMPLE

- Now I'd like to outline the implications -- using private actuarial estimates -- of a premium cap structure in which the initial premium is not constrained, but subsequent growth is controlled by the HSA caps. The only difference between this example and the HSA is that HSA constrains the initial premium, and this alternative does not.

- The results of an unconstrained initial premium are dramatic. Under this example, total costs relative to HSA could increase significantly between 1996 and 2004, transferring as much as $600 billion from businesses and families to the health industry. Federal costs over that period could also increase substantially due to higher premium levels.

[NOTE: The Administration has asked that you not include in your presentation an estimate of federal cost increases under this example. If you are specifically asked, however, they recommend that you use a range of between $130 billion to $450 billion over the 1996-2004 period, with the exact costs dependent upon how much of the windfall the health industry keeps.]

AN EXAMPLE (CONTINUED):

- These amounts represent windfalls that would be shared between providers and insurance companies. They would be the real winners from universal coverage; significantly increasing their profits at the expense of business, families and government.

- Further delaying implementation of the annual cap constraint could worsen the financial impact on government, families and business, transferring even more windfall to the health industry.

ALLOWING HIGHER GROWTH RATES AFTER THE FIRST YEAR

- You can see why it is important to set the premium at an appropriate level in the first year.

- However, if an appropriate baseline is set, one could consider allowing greater growth rates thereafter than those in HSA. Such changes are not as prohibitively expensive as proposals which would leave the initial premium unconstrained.

- To illustrate this point, let me briefly present two options that we discussed at the retreat: (1) Allowing growth rates each year that are 1 percentage point higher than HSA; and (2) Allowing growth rates in 1999 and 2000 that are 1 percentage point higher than the HSA.

- The first option -- higher growth rates each year -- responds to concerns that growth rates in the HSA are generally too low. Relative to HSA, it could increase the federal cost of subsidies by $27 billion between 1996 and 2000, and by $74 billion between 1996 and 2004. Businesses and families could also pay substantially more than under HSA.

HIGHER GROWTH RATES AFTER FIRST YEAR (CONTINUED):

- The second option -- allowing a 1 percentage point higher growth rate in 1999 and 2000 -- responds to concerns that it is too constraining to allow health care costs to grow only at the inflation rate by the end of the decade. Relative to HSA, it could increase the federal cost of subsidies by about $6 billion between 1996 and 2000, and by $16 billion between 1996 and 2004. And as in the previous option, costs to businesses and families could also increase relative to HSA.

- I do not want to minimize the magnitude of cost increases under either of these options. Even allowing higher growth rates in only 1999 and 2000 could erode some of the deficit reduction we would achieve under the models I have already presented to you.

- But in contrast to the financial risk we would be taking by failing to set an appropriate premium level in the first year of reform, the cost of permitting somewhat higher growth rates after the first year may be more manageable.

FEDERAL COSTS OF RELAXING HSA GROWTH RATES
($ billions)

	1996-2000	1996-2004
Increased Costs Relative to HSA:		
Growth rate 1% higher than HSA every year.....	$27	$74
Growth rate 1% higher than HSA in 1999 & 2000.....	$6	$16

Administration estimates based on CBO premium estimates.

CONCLUSION

- Slowing health care costs is a fundamental goal of health care reform.

- The HSA attempts to constrain growth by enhancing competition, but as a backstop also includes premium caps. Such caps are also necessary to get full credit from CBO for the savings associated with lower health care costs.

- To effectively contain costs, we must (1) set a first year premium which does not confer a windfall onto the health industry, and (2) moderate the growth rate of health care costs thereafter.

- As I've demonstrated, failing to set the initial premium at an appropriate level creates severe financial risks for American families, businesses, and the federal government.

- Once the initial premium is set, relaxing future growth rates could increase costs relative to the HSA, but would not be as prohibitively expensive as proposals which would not constrain the initial premium.

INTRODUCTION

- Slowing health costs is a fundamental goal of health care reform.
- HSA would constrain health care growth rates through management, insurance market, and administrative reforms that enhance competition.
- As a backstop to competition, HSA also includes premium caps. Caps are also critical for CBO scoring.
- Cost controls must (1) ensure the initial premium level confers no windfall on the health industry and (2) moderate the growth rate of health care costs thereafter.
- This presentation illustrates the consequences of:
  - not setting the initial premium at an appropriate level, and
  - allowing a somewhat higher premium growth rate over time than does HSA.

MANAGED COMPETITION UNDER HSA

- Under HSA's managed competition:
  - In the first year the National Health Board (NHB) calculates premium targets for each alliance, reflecting cost of services in the benefits package and health costs in the alliance area. NHB updates targets annually based on a health care inflation factor.
  - If the average premium for all of an alliance's plans exceeds target, the over-target plans may resubmit lower bids. Ultimately, payments to over-target plans would be cut according to an HSA formula. Over-target plans also would have to reduce payments to their providers.
  - Annual cap increase is based on CPI plus changes in alliance population. A cushion of 1.5 percentage points is also allowed in 1996, dropping to 1.0 in 1997, 0.5 in 1998 and no cushion in 1999 and 2000.
- This process differs from price controls, which are inflexible government regulation of product prices in the economy. Such controls are difficult to implement and regulate; interfere with private sector decision making; and limit efficiency improvements.
- Premium caps, in contrast, do not involve micro regulation. They are budgetary limitations within which private health plans have the freedom to manage their operations to provide quality care and control costs in a variety of ways, including through more efficient administration, more reasonable provider reimbursement, and more flexibility to determine the best allocation of resources.

PREVENTING AN UNDESERVED WINDFALL: IMPORTANCE OF SETTING THE INITIAL PREMIUM

- Reform must include a mechanism under which the health industry does not get paid twice for uncompensated care.

- Today, uncompensated care costs of the uninsured are passed on to those with private insurance in the form of higher premiums.

- Under health care reform, all Americans will have health insurance -- the health care industry will be compensated for all individuals. **Private insurance premiums need no longer be inflated to cover the shortfall from the uninsured.**

- If the uncompensated care surcharge built into the current premium is not taken out, the health industry would get a windfall by being paid twice for the uninsured, while businesses, families and government would have to pay billions of dollars in higher premiums.

- The HSA's initial premium holds the health industry harmless by fully compensating insurers for the currently uninsured, and maintaining current treatment of Medicaid costs. CBO estimates that HSA's initial premium would give providers the same payments, on average, that they get today.

- Absent a mechanism to deal with uncompensated care, there is no guarantee that competitive forces will constrain first year premiums.

- In fact, the Health Insurance Association of America and Hewitt & Associates estimate that, absent constraint, insurers would set premiums higher than the initial premium in the HSA.

- While many believe that managed competition will moderate health costs, health care reform legislation is governed by CBO scoring. CBO will not score significant savings from managed competition alone. It will score full anticipated savings only if there is a back-up in place, like premium caps.

- CBO scoring is critical because a 60 vote point of order lies against legislation which CBO estimates increases the deficit over ten years. Without premium caps, CBO would substantially increase its estimate of HSA's costs. Absent substantial cuts to offsets these additional costs, the bill would increase the deficit and have a 60 vote point of order against it.

IMPORTANCE OF SETTING THE INITIAL PREMIUM AN EXAMPLE

- The importance of setting the initial premium is illustrated by a premium cap structure under which the initial premium is not constrained, but subsequent growth is controlled by the HSA caps.

- Under this example, total costs relative to HSA could increase significantly between 1996 and 2004, transferring as much as $600 billion from businesses and families to the health industry. Federal costs over that period could also increase substantially due to higher premium levels.

- These amounts are windfalls to providers and insurance companies, who would increase their profits at the expense of businesses, families and government.

- Further delaying implementation of the annual cap constraint could worsen the financial impact on government, families and business, transferring even more windfall to the health industry.

ALLOWING HIGHER GROWTH RATES AFTER THE FIRST YEAR

- If an appropriate initial premium is set, allowing greater-than-HSA growth rates in subsequent years would not be as costly as proposals which don't constrain the initial premium.

- Two options presented at the retreat illustrate this:

  -- Allowing annual growth rates 1 percentage point higher than HSA; and

  -- Allowing 1999 and 2000 growth rates to be 1 percentage point higher than HSA.

- The first option could increase federal subsidy costs by $27 billion between 1996 and 2000, and by $74 billion between 1996 and 2004. Businesses and families could also pay substantially more than under HSA.

- The second option could increase federal subsidy costs by about $6 billion between 1996 and 2000, and by $16 billion between 1996 and 2004. Costs to businesses and families could also increase relative to HSA.

- While these options could erode some of the deficit reduction possible under other models, the risk is substantially less than an option which fails to set an appropriate premium level in the first year of reform.

FEDERAL COSTS OF RELAXING HSA GROWTH RATES
($ billions)

Increased Costs Relative to HSA:	1996-2000	1996-2004
Growth rate 1% higher than HSA every year.....	$27	$74
Growth rate 1% higher than HSA in 1999 & 2000.....	$6	$16

Administration estimates based on CBO premium estimates.

CONCLUSION

- Slowing health costs is a fundamental goal of health care reform.
- HSA would slow growth of health care costs through enhanced competition, with premium caps as a backstop. Caps are also necessary for CBO scoring.
- Effective cost controls must (1) set a first year premium which does not confer a windfall onto the health industry, and (2) moderate the growth rate of health care costs thereafter.
- Failing to set the initial premium at an appropriate level has severe financial risks for American families, businesses, and government.
- Once the initial premium is set, relaxing future growth rates could increase costs relative to the HSA, but would not be as expensive as proposals which would not constrain the initial premium.