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Folder Title:
Health Care Reform Options - Final Paper

Stack:	Row:	Section:	Shelf:	Position:
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WHY HEALTH CARE REFORM?

- * U.S. health care costs are very high and increasing rapidly.
 - 11.2% of U. S. GNP vs. 7.1% in the EC and 6.8% in Japan.
 - Health spending is growing twice as fast as the economy as a whole and will reach 15% of GNP by the year 2000.
 - Higher costs in the U. S. have not resulted in better outcomes.
- * Higher costs threaten competitiveness and consume resources for investments in the future.
 - Many U.S. corporations are calling for government action.
- * 31 million Americans lack health insurance.
 - Deferring health care may lead to serious illness or disability.
 - Lack of access may worsen as cost spiral forces employers to cut back on health insurance.

NON-TAX OPTIONS FOR COST CONTROL

1. Major Federal effort to develop tools needed to better manage health care cost and quality.
2. Allow opt-out of State laws requiring that health plans cover costly but non-essential health care services.
 - Current opt-out is limited to employers that self-insure;
 - Opt-out could be extended to small employers and others.
3. Major Federal effort to reform medical malpractice liability to reduce costs and access problems.
4. Extensive Federal ^{or} of State regulation of health care system.

CURRENT TAX POLICY ISSUES

Current Policy

- * Health insurance fringe benefits are 100% tax free for employees.
- * Health benefits are 100% deductible for incorporated firms, but only 25% deductible for unincorporated firms and the self-employed.

Concerns

- * Excessive tax subsidy for employee health benefits:
 - Weakens market forces and hinders competition among health plans that could control costs;
 - Encourages employees to demand wasteful first dollar coverage that results in overutilization.
- * Workers with employment-based health insurance (generally middle to upper income) receive substantial tax benefit at the expense of those without such insurance (generally lower income).
- * Less generous treatment of unincorporated firms and the self-employed is unfair and discourages provision of health benefits by small firms.

TAX CAP -- HOW IT WOULD WORK

Premium contributions by employer above cap level would be:

- * Reported as taxable income on the employee's 1040 form.
- * Included in the employee's Social Security wage base increasing the payroll tax paid by employer and employee.

Example:

Assume cap at \$1200 a year, employer pays \$1500 in premiums,

Employer can deduct \$1500 fully as a business expense.

Employee must report \$300 as taxable income on the 1040.

Social Security wage base would increase by \$300.

Alternatively, cap could be structured as a limit on employer's business deduction: amounts above cap could not be. Has less justification on economic grounds and would result in some distortions, but avoids the appearance of imposing a tax on workers

OPTIONS FOR IMPROVED ACCESS

Minimal Cost Options

1. Provide seed money and technical help to "voluntary buyer groups" open to small employers and other for purchase of health insurance.
2. Allow opt-out from State laws mandating that health plans cover costly but non-essential health care service.
3. Encourage States to enact indigent care programs.

Substantial Cost Options

1. Expand Medicaid, possibly with low income "buy in".
2. Subsidize vouchers for private health plan coverage for the uninsured.
3. Establish refundable tax credit to help low income individuals purchase health insurance.
4. Provide "tax umbrella" to States for their own new health programs.

OPTION 1: PRESENT FY 1991 BUDGET, THEN WAIT AND SEE

- * Propose no major initiative at this time.
- * Draft FY 1991 Budget includes:
 - Further cost restraint in Medicare for hospitals and doctors.
 - Promotion of managed care:
 - o PPOs in Medicare;
 - o Medicaid incentives.
 - Targeted access improvement, especially for problem of infant mortality.
- * Examine options for reducing medical malpractice cost and access problems.
- * Wait for Pepper and Steelman commissions reports in 1990.

OPTION 2: TEST THE WATER

- * Propose limited initiative in early 1990:
 - Tax cap with level set so as to raise minimal revenues initially.
 - Include preference for "managed care".
 - Research initiative to develop better tools to help private sector better manage cost and quality of care.
 - Include some or all of the following minimal cost access measures:
 - Seed money and technical assistance for small employer "voluntary buyer groups";
 - Allow opt-out from State laws mandating that health plans cover costly but non-essential health care services.
 - Encourage States to enact indigent care programs.

OPTION 3: BROAD BLUEPRINT

- * Propose broad initiative in early 1990; specifics to be provided subsequently. Include all elements of Option 2, with the following changes:
 - Set tax cap at lower level to raise substantial revenues in FY 91 (approximately \$5 billion) and to provide a more immediate impact on incentives and choice of health plans.
 - Include preference for "managed care".
 - Use tax cap revenues to fund new access program to help 5 to 10 million low income Americans either by a
 - Subsidizing vouchers for private health plans,
 - Establishing a refundable tax credit for purchase of health insurance, or
 - Funding state programs through a UI-type "tax umbrella".
 - Alternatively, could use a sizeable portion of tax cap revenue for deficit reduction.

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POLICY TOOLS AVAILABLE FOR HEALTH CARE REFORM

- * Draft FY91 Budget: Continued Medicare spending restraint and promotion of managed care in Medicare and Medicaid.

ADDITIONAL OPTIONS INCLUDE:

- * Research initiative to develop tools and data needed to better manage costs and quality of care.
- * Grants or other assistance for State and private sector initiatives.
- * Allow health plans to opt-out of State laws that increase health care costs.
- * Incentives and disincentives through the Tax Code.
- * Direct regulation of the health care system.

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POSSIBLE OBJECTIVES FOR TAX POLICY

1. Promote health care competition and prudent purchasing by helping to correct market distortions that result from excessive tax subsidies.
2. Encourage employers and employees to select efficient health plans.
3. Promote the reorganization of the Nation's health care system by favoring "managed care" (either HMOs or broader definition).
4. Greater tax equity for workers without employment-based health insurance and for unincorporated firms and the self-employed.
5. Generate revenues for expanded access to health care or for deficit reduction.

DESIGN ISSUES FOR TAX CAP

1. Incidence of cap: limit on exclusion for employee vs. limit on deduction for employer.
 - Better economic rationale for cap on employees vs. politics of taxing workers.
2. Initial level of cap and subsequent increase.
 - Gradual phase-in (set cap high, but increase slowly) vs. immediate impact (lower cap, with increase).
 - Phase in could reduce opposition, but cap would have little impact on strengthening market forces over the next five years.
 - May need to maintain substantial tax subsidy in the out years to ensure widespread employment-based health insurance.
3. Geographic or other adjustments to ensure equity. (A serious issue because of wide geographic variations in premium costs.)
4. Nature of preference (if any) for "managed care".

NON-TAX OPTIONS FOR COST CONTROL

1. Major Federal effort to develop tools needed to better manage health care cost and quality.
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GENERAL ISSUES REGARDING ACCESS

- * Role and responsibilities of Federal and State governments, employers and individuals need clarification and definition.
- * High cost is the biggest obstacle to expanding health care coverage.
- * Revenues from a tax cap could fund expansion of access, but universal coverage would require a major tax increase or employer mandate.
- * Using tax cap revenues to fund access is probably needed to undercut political opposition to cap from unions and others.
- * But, proposing a new Federal access initiative may encourage unrealistic expectations and give added momentum to mandated benefits and other initiatives the Administration would oppose.

OPTIONS FOR IMPROVED ACCESS

Minimal Cost Options

1. Provide seed money and technical help to "voluntary buyer groups" open to small employers and other for purchase of health insurance.
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TAX CAP PROS AND CONS

Arguments For Cap

- * A tax cap helps the private sector with the rapid increase in health costs by giving employees a reason to seek cost restraint.
- * Reagan Administration proposed a tax cap.
- * If coupled with a health insurance tax credit, net revenues would not be raised. (Could be characterized as a revenue neutral change within the tax code to promote equity.)
- * Or, cap could be structured as "tax umbrella" with new revenues flowing directly to the States. (Similar to UI tax.)
- * Finally, cap could be set at a high level so that minimal revenues would be raised at least initially.

Arguments Against Cap

- * Any change from strict "no new taxes" could open the flood gates.
- * The public may not accept the distinctions noted above.

PROBABLE REACTION TO TAX CAP

Likely Support

- * Many corporations.
- * Many leaders in the health care industry.
- * Some in insurance industry.
- * Media (if proposal deals both with cost and access).

Likely Opposition

- * Unions (opposition could be undercut, if all revenues from cap are used for low income access).
- * Some in insurance industry.
- * Dentist, mental health professionals, and other providers of services that might be dropped from health plans with tax cap.

Likely Criticisms

- * Doesn't go far enough in providing access and won't directly control costs.
- * Will force employers and employees to drop "needed" services.
- * Uniform cap is unfair to areas of the country or groups with high health costs.

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OPTION 4: FOCUS ON DEFICIT REDUCTION AND INTERNATIONAL COMPETITIVENESS

- * Same as Option 3, but with less emphasis on access.
 - Tax cap would be set to generate substantial revenues with a sizeable fraction going to deficit reduction.
 - Proposal would be described as a health reform to control health care costs and improve competitiveness.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
ROUTE SLIP

TO Arlene Holen	Take necessary action	
Bill Roper	Approval or signature	
Hans Kuttner	Comment	x
	Prepare reply	
	Discuss with me	
	For your information	
	See remarks below	x
FROM David Kleinberg <i>DKK</i>	Date December 11, 1989	

REMARKS

Attached is a draft set of briefing materials on health care reform prepared by Steve Bandeian at my request.

These materials could assist in the meeting with the President this Thursday.

The materials incorporate the content of the papers developed by Bill Roper (also attached). They have been formatted in a way that may be helpful in explaining the issues at the meeting.

The options are structured in a way to present the key issues that could be considered by the President at this time.

If the materials appear to be useful, please comment by close of business on Tuesday to expand, modify, or clarify the points made. (Steve Bandeian x4926.)

HIMD FORM 1
Sept 87

WHY HEALTH CARE REFORM?

- * Health care costs in the U.S. are very high and increasing rapidly.
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 - Higher costs in the U.S. have not resulted in better outcomes.
- * Higher costs can compromise competitiveness and consume resources needed for investments in the future.
 - Many U.S. corporations are calling for government action.
- * 31 million Americans have no health insurance.
 - Needed care may be deferred leading to illness or disability.
 - Problem may worsen as cost spiral forces employers to cut back on health benefits.
- Govt buys 40%. ~~Fast~~ Continuing increases faster than revenue means less \$ for ~~no~~ purposes besides health care or higher taxes.

POSSIBLE OBJECTIVES FOR HEALTH CARE REFORM

- * Assist private sector in controlling health costs.
- * Promote competition among health plans by correcting distortions caused by government policies.
- * Improve equity of current tax policy.
- * Make progress in improving access.

POLICY TOOLS AVAILABLE FOR REFORM INITIATIVE

- * Incentives and disincentives through the Tax Code.
- * Direct regulation of the health care system.
- * Preemption of State laws that increase health care costs.
- * Grants or other assistance to State and private sector initiatives.
- * Research initiative to develop tools and data needed to better manage costs and quality of care.

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1. Provide seed money and technical help to "voluntary buyer groups" open to small employers and others for purchase of health insurance.
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3. Encourage States to establish assigned risk pools to help individuals and small employers buy insurance at affordable rates.

Substantial Cost Options

1. Expand Medicaid, possibly with low income "buy-in".
2. Provide grants to States for new programs.
3. Establish refundable tax credit to help low income individuals purchase health insurance.

All options need further analysis before final recommendation.

TAX CAP AND "NO NEW TAXES PLEDGE"

Arguments For Cap

- * Short of direct regulation, a tax cap is the only means of helping private sector with the rapid increase in health costs.
- * Reagan Administration proposed a tax cap.
- * If coupled with a health insurance tax credit, no new revenues would be raised. (Could be characterized as a revenue neutral change within the Tax Code to promote equity.)
- * Or, cap could be structured as "tax umbrella" with new revenues flowing directly to the States. (Similar to UI tax.)
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OPTION 1: "WAIT AND SEE"

- * Propose no new initiative at this time.
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- * Propose limited initiative in State of the Union Address:
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 - Proposal would be described as a health reform to control costs and improve competitiveness.

HEALTH CARE REFORM -- ISSUES AND OPTIONS

Background

- o The United States leads the world's economies in the share of GNP devoted to health care.
 - 11.2% of GNP in the US; 7.1% in the EC; 6.8% in Japan.
 - \$2,051 per capita in the US; \$1130 in the EC; \$915 in Japan.
- o US health spending is growing at twice the rate of the economy as a whole, and is projected to reach 15% of GNP by the year 2000.
 - 20 cents of every new dollar added to GNP goes to health care.
- o Yet Americans are less healthy than citizens of other Western nations.
 - The US average life expectancy is shorter and the US infant mortality rate is higher.
 - For the inner-city black poor, things are much worse.
- o The US health care system has two major problems:
 - One problem is that many Americans do not have health insurance. The EC and Japan have universal health plan coverage -- but 31 million Americans have none at any time during a year.
 - + Of this 31 million, three-quarters are employed workers (who work for small firms that do not offer health benefits) and their families; and
 - + One third are low income, below the national poverty level.
 - The second problem is the skyrocketing cost of American health care. It would be hard to design a better way of inflating spending.

- + Big employers often cover every dollar of an employee's costs, giving no incentive to keep costs down.
- + Where employees have a choice of health plans, the exemption from income tax (worth more than \$40 billion per year) lessens the incentive to pick cheaper plans.
- + Under the dominant fee-for-service payment system, hospitals and doctors have a direct incentive to provide additional costly services, whether needed or not.
- + Overutilization also results from "defensive medicine" stemming from fear of malpractice lawsuits.

Ideas for the Future

The pattern is clear:

- o If the current trends continue, health care will be 15% of America's GNP by the turn of the century.
- o International competitiveness could suffer.
- o Medicare will go bankrupt, unless taxes are increased.
- o By 2005, Medicare spending could be the biggest item in the federal budget.

There are several ideas for what to do:

- o Once again, some are proposing national health insurance, including many Democrats, organized labor, and now even a few big business leaders.
- o Others, including Senator Kennedy, want to deal with the uninsured by mandating employers to provide health benefits. Massachusetts has tried to do this, but its plan is in trouble.
- o Some favor expanded public coverage, such as the expansion of Medicaid eligibility for poor pregnant women and their children this year. But public

budgets are already stretched, and the Governors have asked for a moratorium.

- o Many are calling for tougher price and volume controls, as were just enacted for Medicare payments to doctors, but for other payers as well.
- o Professor Alain Enthoven, of Stanford, is pushing a consumer-choice health plan. It would provide for universal insurance coverage, either through employers or "public sponsors" set up in each state to guarantee coverage of the self-employed and those not now insured. These sponsors would also push for choice among rival managed care plans, as a better route to cost containment than price controls.
- o The Heritage Foundation has proposed curbing or eliminating the tax subsidy for employer-provided insurance, while giving individuals who purchase their own plans a refundable tax credit. It also would require individuals to have catastrophic insurance coverage, with public subsidy to those who cannot afford it.
- o On the cost containment front, the argument is between price/volume control and competition between managed care plans.
 - For managed care, including HMOs and PPOs (preferred provider organizations) to expand, the tax subsidy that encourages unfettered fee-for-service medicine must be dealt with.
 - Better assessment of health care quality and effectiveness is also essential, as well as improved techniques for actually "managing" health care.

Options for Cost Containment

1. Use federal programs to promote managed care
 - a. Medicare: Allow PPOs serving the private market to enroll Medicare beneficiaries. Have Medicare operate a coordinated open enrollment process for PPOs and HMOs. Set a lower Medicare premium for beneficiaries selecting HMOs, giving Medicare beneficiaries an incentive to choose HMOs.

- b. **Federal Employees Health Benefits Plan:** Change calculation of the federal government's payment from a percentage share of plan cost to a defined-contribution amount. This would give federal employees an incentive to seek lower cost plans, generally HMOs.

2. **Promote spending restraint via tax code incentives**

The tax code does not consider employer contributions to health plans as employee income. After tax reform in 1986, health benefits are the only unlimited fringe benefit.

- a. **Tax cap on employees:** Treat as employee income health plan contributions by employer above the cap. This limit on the tax subsidy of health benefits would cause employees to seek more cost-efficient health plans -- such as HMOs and insurance with higher deductibles and copayments.

Setting the cap at \$350 for a family and \$140 for an individual employee (and indexing by CPI(u)) will produce \$1.4 billion new revenue in 1991 and will effect 15% of subscribers; this grows to \$9.6 billion and 26% in 1995.

Setting the cap at \$250 for a family and \$100 for an individual employee (similarly indexed) will produce \$5.2 billion new revenue in 1991 and will effect 36% of subscribers; this grows to \$22.6 billion and 44% in 1995.

Source: Office of Tax Analysis 11/22/89.

- b. **Tax cap on employers:** Eliminate deductibility of employer contributions above the cap. This limit would cause employers to seek more cost-efficient health plans.

Treasury has not estimated the revenue effect of this alternative. Non-profits and state/local governments would not be subject to the cap unless an excise tax was imposed.

- c. **Link tax treatment to structure of health plan:** Provide differential tax treatment to encourage more efficient health plans (for example, HMOs). This would give direct incentives for more cost-efficient health plans.

3. **Use federal programs to leverage private sector cost containment reform efforts**
 - a. Allow certain private health plans to pay for hospital and physician services using the generally lower Medicare payment rates; mandate that providers accept these rates.
 - b. Provide an option for States to implement state-level all-payor expenditure targets for hospital and physician services.

Options for Access Enhancement

1. **Improve access to health insurance for small employers**

Deals with the problem of lack of insurance for employees of small firms and their families.

 - a. Provide federal seed money and technical assistance for health insurance group purchasing arrangements for small firms, so that they can increase their market clout.
 - b. Pre-empt state mandated benefit laws for insurance purchased through multi-employer trusts, to allow for less costly plans to be offered.
 - c. Allow plans insuring small firms to use the generally lower Medicare rates to pay doctors and hospitals, and mandate that providers accept these rates.
2. **Establish a new program: Subsidize purchase of private health plan coverage.**

This could be done using revenue generated from the tax cap described above, or with other revenue, such as from "sin taxes."

A State agency, or "public sponsor," would seek bids from qualified private health plans. These plans would be made available to low income individuals, with the premium varying with income.

3. Give a refundable tax credit for low income persons for purchase of health plans.

This is analogous to the 1989 Bush child care proposal.

4. Expand public programs

- a. Medicaid -- continue the pattern of the past several years, with expansion of eligibility up the income scale, with mandates on the States.
- b. Medicaid "Buy-in" -- construct a new program, based on Medicaid.
- c. Direct Services -- expand community health centers, etc.

5. Create incentives/penalties for insurance offered by employers

Deals further with the problem of uninsured workers and their families.

- a. Mandate health benefits -- as in the Kennedy bill.
- b. Mandate "play or pay" system -- whereby employers must provide worker health insurance ("play"), or they are subject to a payroll tax to finance vouchers for those without employer-provided health insurance ("pay").

HEALTH CARE REFORM OPTION PACKAGES

Cost Containment

Access

Option 1: Minimum additional cost

Use federal programs to promote managed care:

- Medicare: Allow PPOs serving the private market to enroll Medicare beneficiaries; set lower premium for beneficiaries enrolling in HMOs.
- Federal Employees Health Benefits Plan: Show leadership to the private sector by moving to a defined contribution plan.

Provide federal seed money and technical assistance for health insurance group purchasing by small firms.

Allow opt-out from benefits mandated by state law for health plans purchased through small employer groups.

Encourage states to establish indigent care programs to finance care for uninsured.

Option 2a: Tax code incentives with no immediate revenue effect

Implement a tax cap on the amount of employer-provided health insurance that is not included taxable income; set the cap at a level that effects a negligible number of people; tie the cap to an index that increases more slowly than the historical increase in health insurance costs, effectively phasing in the cap;

and/or

Provide a favored status for HMOs via a higher cap for purchase of coverage through HMOs.

Use federal programs to promote managed care, as under option 1.

Access-building efforts under option 1, plus:

Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates. Cushion lower payment rates through malpractice relief.

Option 2b: Set tax cap to create immediate revenue for
deficit reduction

Tax cap set at a level that generates revenue immediately; HMO cap set higher than cap for indemnity plans.

Use federal programs to promote managed care, as under option 1.

Access-building efforts under option 2a, plus: incremental revenue goes to deficit reduction.

Option 3a: Set tax cap to create immediate revenue effect;
revenue finances improving access

Tax cap set at a level that generates revenue immediately; HMO cap set higher than cap for indemnity plans.

Use federal programs to promote managed care, as under option 1.

Access-building efforts under options 1 and 2 plus:

Use revenue from tax cap to subsidize vouchers for private health plan coverage for the uninsured.

OR

Use revenue from tax cap to finance a refundable tax credit for purchase of health plans by low-income persons.

Option 3b: Set tax cap to create immediate revenue effect;
revenue finances state-level programs.

Tax cap set at a level that generates revenue immediately with revenue flowing to the States.

Use federal programs to promote managed care, as under option 1.

Access-building efforts under options 1 and 2 plus:

Allow states to use tax cap revenues for access-building approaches fashioned at the state level. (States can do as they please -- Medicaid expansions, vouchers, public sponsor OR States do as under UI: fashion an insurance program, leaving only benefit design issues to the state.)

Option 4: Tax cap financing access improvement plus requirement
for employer involvement in health insurance

Tax cap and federal program
leadership, as under option 3.

Expand current law allowing
state to set statewide
expenditure targets to include
not only hospital, but also
doctor payments, with overruns
to be recovered in future
prices.

Access-building efforts under
options 1 and 2 plus:

Require all firms to provide
health benefits plans OR pay a
payroll tax that, with tax cap
revenues, would subsidize
vouchers of health plans for
those without employer-
provided benefits.

Option 5: Tax cap financing access, plus other initiatives

Use federal programs to promote managed care:

- Medicare: Allow PPOs serving the private market to enroll Medicare beneficiaries; set lower premium for beneficiaries enrolling in HMOs.
- Federal Employees Health Benefits Plan: Show leadership to the private sector by moving to a defined contribution plan.

Tax cap set at a level that generates revenue immediately; HMO cap set higher than cap for indemnity plans.

Provide federal seed money and technical assistance for health insurance group purchasing by small firms.

Allow opt-out from benefits mandated by state law for health plans purchased through small employer groups.

Encourage states to establish indigent care programs to finance care for uninsured.

Use revenue from tax cap to subsidize vouchers for private health plan coverage for the uninsured.

OR

Use revenue from tax cap to finance a refundable tax credit for purchase of health plans for low-income persons.

WHY HEALTH CARE REFORM?

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 - Higher costs in the U. S. have not resulted in better outcomes.
- * Higher costs can compromise competitiveness and consume resources needed for investments in the future.
 - Many U.S. corporations are calling for government action.
- * 31 million Americans have no health insurance.
 - Needed care may be deferred leading to illness or disability.
 - Problem may worsen as cost spiral forces employers to cut back on health benefits.

POLICY TOOLS AVAILABLE FOR HEALTH CARE REFORM

- * Draft FY91 Budget: Continued Medicare spending restraint and promotion of managed care in Medicare and Medicaid.

ADDITIONAL OPTIONS INCLUDE:

- * Research initiative to develop tools and data needed to better manage costs and quality of care.
- * Grants or other assistance to State and private sector initiatives.
- * Allow health plans to opt-out of State laws that increase health care costs.
- * Incentives and disincentives through the Tax Code.
- * Direct regulation of the health care system.

CURRENT TAX POLICY ISSUES

Current Policy

- * Health insurance fringe benefits are 100% tax free for employees.
- * Health benefits are 100% deductible for incorporated firms, but only 25% deductible for unincorporated firms and the self-employed.

Concerns

- * Excessive tax subsidy for employee health benefits:
 - Weakens market forces and hinders competition among health plans that could control costs;
 - Encourages employees to demand wasteful first dollar coverage that results in overutilization.
- * Workers with employment-based health insurance (generally middle to upper income) receive substantial tax benefit at the expense of those without such insurance (generally lower income).
- * Less generous treatment of unincorporated firms and the self-employed is unfair and discourages provision of health benefits by small firms.

POSSIBLE OBJECTIVES FOR TAX CAP

1. Promote health care competition and prudent purchasing by helping to correct market distortions that result from excessive tax subsidies.
2. Encourage employers and employees to select efficient health plans.
3. Promote the reorganization of the Nation's health care system by favoring "managed care" (either HMOs or broader definition).
4. Greater tax equity for workers without employment-based health insurance and for unincorporated firms and the self-employed.
5. Generate revenues for expanded access to health care or for deficit reduction.

DESIGN ISSUES FOR TAX CAP

1. Incidence of cap: limit on exclusion for employee vs. limit on deduction for employer.
 - Better economic rationale for cap on employees vs. politics of taxing workers.
2. Initial level of cap and subsequent increase.
 - Gradual phase-in (set cap high, but increase slowly) vs. immediate impact (lower cap, with increase).
 - Phase in could reduce opposition, but cap would have little impact on strengthening market forces over the next five years.
 - May need to maintain substantial tax subsidy in the out years to ensure widespread employment-based health insurance.
3. Geographic or other adjustments to ensure equity. (A serious issue because of wide geographic variations in premium costs.)
4. Nature of preference (if any) for "managed care".

NON-TAX OPTIONS FOR COST CONTROL

1. Major Federal effort to develop tools needed to better manage health care cost and quality.
2. Allow opt-out of State laws requiring that health plans cover costly but non-essential health care services.
 - Current opt-out is limited to employers that self-insure;
 - Opt-out could be extended to small employers and others.
3. Major Federal effort to reform medical malpractice liability to reduce costs and access problems.
4. Extensive Federal of State regulation of health care system.

GENERAL ISSUES REGARDING ACCESS

- * Role and responsibilities of Federal and State governments, employers and individuals need clarification and definition.
- * High cost is the biggest obstacle to expanding health care coverage.
- * Revenues from a tax cap could fund expansion of access, but universal coverage would require a major tax increase or employer mandate.
- * Using tax cap revenues to fund access is probably needed to undercut political opposition to cap from unions and others.
- * But, proposing a new Federal access initiative may encourage unrealistic expectations and give added momentum to mandated benefits and other initiatives the Administration would oppose.

OPTIONS FOR IMPROVED ACCESS

Minimal Cost Options

1. Provide seed money and technical help to "voluntary buyer groups" open to small employers and other for purchase of health insurance.
2. Allow opt-out from State laws mandating that health plans cover costly but non-essential health care service.
3. Encourage States to enact indigent care programs.

Substantial Cost Options

1. Expand Medicaid, possibly with low income "buy in".
2. Subsidize vouchers for private health plan coverage for the uninsured.
3. Establish refundable tax credit to help low income individuals purchase health insurance.
4. Provide "tax umbrella" to States for their own new health programs.

TAX CAP PROS AND CONS

Arguments For Cap

- * A tax cap helps the private sector with the rapid increase in health costs by giving employees a reason to seek cost restraint.
- * Reagan Administration proposed a tax cap.
- * If coupled with a health insurance tax credit, net revenues would not be raised. (Could be characterized as a revenue neutral change within the tax code to promote equity.)
- * Or, cap could be structured as "tax umbrella" with new revenues flowing directly to the States. (Similar to UI tax.)
- * Finally, cap could be set at a high level so that minimal revenues would be raised at least initially.

Arguments Against Cap

- * Any change from strict "no new taxes" could open the flood gates.
- * The public may not accept the distinctions noted above.

PROBABLE REACTION TO TAX CAP

Likely Support

- * Many corporations.
- * Many leaders in the health care industry.
- * Some in insurance industry.
- * Media (if proposal deals both with cost and access).

Likely Opposition

- * Unions (opposition could be undercut, if all revenues from cap are used for low income access).
- * Some in insurance industry.
- * Dentist, mental health professionals, and other providers of services that might be dropped from health plans with tax cap.

Likely Criticisms

- * Doesn't go far enough in providing access and won't directly control costs.
- * Will force employers and employees to drop "needed" services.
- * Uniform cap is unfair to areas of the country or groups with high health costs.

OPTION 1: PRESENT FY 1991 BUDGET, THEN WAIT AND SEE

- * Propose no major initiative at this time.
- * Draft FY 1991 Budget includes:
 - Further cost restraint in Medicare for hospitals and doctors.
 - Promotion of managed care:
 - o PPOs in Medicare;
 - o Medicaid incentives.
 - Targeted access improvement, especially for problem of infant mortality.
- * Examine options for reducing medical malpractice cost and access problems.
- * Wait for Pepper and Steelman commissions reports in 1990.

OPTION 2: TEST THE WATER

- * Propose limited initiative in early 1990:
 - Tax cap with level set so as to raise minimal revenues initially.
 - Include preference for "managed care".
 - Research initiative to develop better tools to help private sector better manage cost and quality of care.
 - Include some or all of the following minimal cost access measures:
 - Seed money and technical assistance for small employer "voluntary buyer groups";
 - Allow opt-out from State laws mandating that health plans cover costly but non-essential health care services.
 - Encourage States to enact indigent care programs.

OPTION 3: BROAD BLUEPRINT

- * Propose broad initiative in early 1990; specifics to be provided subsequently. Include all elements of Option 2, with the following changes:
 - Set tax cap at lower level to raise substantial revenues in FY 91 (approximately \$5 billion) and to provide a more immediate impact on incentives and choice of health plans.
 - Include preference for "managed care".
 - Use tax cap revenues to fund new access program to health 5 to 10 million low income Americans either by a
 - Subsidizing vouchers for private health plans,
 - Establishing a refundable tax credit for purchase of health insurance, or
 - Funding state programs through a UI-type "tax umbrella".
 - Expand health benefit deduction for unincorporated firms and the self employed to encourage small firms to provide insurance.

OPTION 4: FOCUS ON DEFICIT REDUCTION AND INTERNATIONAL COMPETITIVENESS

- * Same as Option 3, but with less emphasis on access.
 - Tax cap would be set to generate substantial revenues with a sizeable fraction going to deficit reduction.
 - Proposal would be described as a health reform to control health care costs and improve competitiveness.

REMARKS

Attached is a draft set of briefing materials on health care reform prepared by HIMD staff at my request.

These materials could assist in the meeting with the President this Thursday.

The materials incorporate the content of the papers developed by Bill Roper (also attached). They have been formatted in a way that may be helpful in explaining the issues at the meeting.

The options are structured in a way to present the key issues that could be considered by the President at this time.

If the materials appear to be useful, please comment by close of business on Tuesday to expand, modify, or clarify the points made.

WHY HEALTH CARE REFORM?

- * Health care costs in the U.S. are very high and increasing rapidly.
 - 11.2% of U.S. GNP vs. 7.1% in the EC and 6.8% in Japan.
 - Health spending is growing twice as fast as the economy as a whole and will reach 15% of GNP by the year 2000.
 - Higher costs in the U.S. have not resulted in better outcomes.
- * Higher costs can compromise competitiveness and consume resources needed for investments in the future.
 - Many U.S. corporations are calling for government action.
- * 31 million Americans have no health insurance.
 - Needed care may be deferred leading to illness or disability.
 - Problem may worsen as cost spiral forces employers to cut back on health benefits.

POSSIBLE OBJECTIVES FOR HEALTH CARE REFORM

- * Assist private sector in controlling health costs.
- * Promote competition among health plans by correcting distortions caused by government policies.
- * Improve equity of current tax policy.
- * Make progress in improving access.

POLICY TOOLS AVAILABLE FOR REFORM INITIATIVE

- * Incentives and disincentives through the Tax Code.
- * Direct regulation of the health care system.
- * Preemption of State laws that increase health care costs.
- * Grants or other assistance to State and private sector initiatives.
- * Research initiative to develop tools and data needed to better manage costs and quality of care.

CURRENT TAX POLICY

Current Policy

- * Health insurance fringe benefits are 100% tax free for employees.
- * Health benefits are 100% deductible for incorporated firms, but only 25% deductible for unincorporated firms and the self-employed.

Concerns

- * Excessive tax subsidy for employee health benefits:
 - Weakens market forces and hinders competition among health plans that could control costs;
 - Encourages employees to demand wasteful first dollar coverage that results in overutilization.
- * Workers with employment-based health insurance (generally middle to upper income) receive substantial tax benefit at the expense of those without such insurance (generally lower income).
- * Less generous treatment of unincorporated firms and the self-employed is unfair and discourages provision of health benefits by small firms.

POSSIBLE OBJECTIVES FOR TAX CAP

1. Promote health care competition and control costs by correcting market distortions that result from excessive tax subsidies.
2. Encourage employers and employees to select efficient health plans.
3. Promote the reorganization of the Nation's health care system by favoring "managed care" (either HMOs or broader definition).
4. Greater tax equity for workers without employment-based health insurance and for unincorporated firms and the self-employed.
5. Generate revenues for deficit reduction or expanded access to health care.

DESIGN ISSUES FOR TAX CAP

1. Incidence of cap: limit on exclusion for employee vs. limit on deduction for employer.
 - Better economic rationale for cap on employees vs. politics of taxing workers.
2. Initial level of cap and subsequent increase.
 - Gradual phase-in (set cap high, but increase slowly) vs. immediate impact (lower cap, with moderate increase).
 - Phase-in could reduce opposition, but cap would have little impact on strengthening market forces over the next five years.
 - May need to maintain substantial tax subsidy in the out-years to ensure widespread employment-based health insurance.
3. Geographic or other adjustments to ensure equity. (A serious issue because of wide geographic variations in premium costs.)
4. Nature of preference (if any) for "managed care".

NON-TAX OPTIONS FOR COST CONTROL

1. Major Federal effort to develop tools needed to better manage health care cost and quality.
2. Preempt State laws requiring that health plans cover costly but non-essential health care services.
 - Current preemption is limited to employers that self-insure;
 - Preemption could be extended to small employers and others.
3. Extensive Federal or State regulation of health care system.

GENERAL ISSUES REGARDING ACCESS

- * Role and responsibilities of Federal and State governments, employers and individuals need clarification and definition.
- * High cost is the biggest obstacle to expanding insurance coverage (31 million Americans are uninsured, premiums cost \$1,500 a year.)
- * Revenues from a tax cap could fund modest expansion of access, but universal coverage would require a major tax increase or employer mandate.
- * Using tax cap revenues to fund access may be needed to undercut political opposition to cap from unions and others.
- * But, proposing a new Federal access initiative may encourage unrealistic expectations and give added momentum to mandated benefits and other initiatives the Administration would oppose.

OPTIONS FOR IMPROVED ACCESS

Minimal Cost Options

1. Provide seed money and technical help to "voluntary buyer groups" open to small employers and others for purchase of health insurance.
2. Encourage States to enact hospital indigent care pools.
3. Encourage States to establish assigned risk pools to help individuals and small employers buy insurance at affordable rates.

Substantial Cost Options

1. Expand Medicaid, possibly with low income "buy-in".
2. Provide grants to States for new programs.
3. Establish refundable tax credit to help low income individuals purchase health insurance.

All options need further analysis before final recommendation.

TAX CAP AND "NO NEW TAXES PLEDGE"

Arguments For Cap

- * Short of direct regulation, a tax cap is the only means of helping private sector with the rapid increase in health costs.
- * Reagan Administration proposed a tax cap.
- * If coupled with a health insurance tax credit, no new revenues would be raised. (Could be characterized as a revenue neutral change within the Tax Code to promote equity.)
- * Or, cap could be structured as "tax umbrella" with new revenues flowing directly to the States. (Similar to UI tax.)
- * Finally, cap could be set at a high level so that minimal revenues would be raised at least initially.

Arguments Against Cap

- * Any change from strict "no new taxes" line could open the flood gates.
- * The public may not "buy" any of the distinctions noted above.

PROBABLE REACTION TO TAX CAP

Likely Support

- * Some corporations.
- * Many leaders in the health care industry.
- * Media (if proposal deals both with cost and access).

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- * Unions (opposition could be undercut, if all revenues from cap are used for low income access).
- * Insurance industry.
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- * Doesn't go far enough in providing access and won't control costs.
- * Will force employers and employees to drop "needed" services.
- * Uniform cap is unfair to areas of the country with high health costs.

OPTION 1: "WAIT AND SEE"

- * Propose no new initiative at this time.
- * Wait for Pepper and Steelman commission reports this spring.

OPTION 2: "TEST THE WATERS"

- * Propose limited initiative in State of the Union Address:
 - Tax cap with level set so as to raise minimal revenues initially.
 - Include preference for "managed care".
 - Research initiative to develop better tools to help private sector better manage cost and quality of care.
 - Include some or all of the following minimal cost access measures:
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 - Encourage States to enact assigned risk pools help small employers and others buy insurance at affordable rates.

OPTION 3: "BROAD BLUEPRINT"

- * Propose broad initiative in State of the Union Address; specifics to be provided subsequently. Include all elements of Option 2, with the following changes:
 - Set tax cap at lower level to raise substantial revenues in FY 91 (approximately \$5 billion) and to provide a more immediate impact on incentives and choice of health plans.
 - Include preference for "managed care".
 - Use tax cap revenues to fund new access program to help 5 to 10 million low income Americans either by a
 - Establishing a refundable tax credit for purchase of health insurance, or
 - Funding state programs through a UI-type "tax umbrella".
 - Expand health benefit deduction for unincorporated firms and the self employed to encourage small firms to provide insurance.

OPTION 4: "FOCUS ON INTERNATIONAL COMPETITIVENESS AND DEFICIT REDUCTION"

- * Same as Option 3, but with less emphasis on access.
 - Tax cap would be set to generate substantial revenues with a sizeable fraction going to deficit reduction.
 - Proposal would be described as a health reform to control costs and improve competitiveness.

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2. Allow opt-out of State laws requiring that health plans cover costly but non-essential health care services.
 - Current opt-out is limited to employers that self-insure;
 - Opt-out could be extended to small employers and others.
3. Major Federal effort to reform medical malpractice liability to reduce costs and access problems.
4. Extensive Federal of State regulation of health care system.

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- * Workers with employment-based health insurance (generally middle to upper income) receive substantial tax benefit at the expense of those without such insurance (generally lower income).
- * Less generous treatment of unincorporated firms and the self-employed is unfair and discourages provision of health benefits by small firms.

TAX CAP -- HOW IT WOULD WORK

Premium contributions by employer above cap level would be:

- * Reported as taxable income on the employee's 1040 form.
- * Included in the employee's Social Security wage base increasing the payroll tax paid by employer and employee.

Example:

Assume cap at \$1200 a year, employer pays \$1500 in premiums,

Employer can deduct \$1500 fully as a business expense.

Employee must report \$300 as taxable income on the 1040.

Social Security wage base would increase by \$300.

Alternatively, cap could be structured as a limit on employer's business deduction: amounts above cap could not be. Has less justification on economic grounds and would result in some distortions, but avoids the appearance of imposing a tax on workers

OPTIONS FOR IMPROVED ACCESS

Minimal Cost Options

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2. Allow opt-out from State laws mandating that health plans cover costly but non-essential health care service.
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 - o Medicaid incentives.
 - Targeted access improvement, especially for problem of infant mortality.
- * Examine options for reducing medical malpractice cost and access problems.
- * Wait for Pepper and Steelman commissions reports in 1990.

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 - Include preference for "managed care".
 - Research initiative to develop better tools to help private sector better manage cost and quality of care.
 - Include some or all of the following minimal cost access measures:
 - Seed money and technical assistance for small employer "voluntary buyer groups";
 - Allow opt-out from State laws mandating that health plans cover costly but non-essential health care services.
 - Encourage States to enact indigent care programs.

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 - Include preference for "managed care".
 - Use tax cap revenues to fund new access program to help 5 to 10 million low income Americans either by a
 - Subsidizing vouchers for private health plans,
 - Establishing a refundable tax credit for purchase of health insurance, or
 - Funding state programs through a UI-type "tax umbrella".
 - Alternatively, could use a sizeable portion of tax cap revenue for deficit reduction.