HEALTH CARE REFORM OPTIONS

COST CONTAINMENT

A. Spending restraint via tax code changes

1. Tax cap: impute as income all amounts for employer-financed care above some cut-off

   Modification: As an effort to bring worker attention to wages foregone because of health insurance, report on W2, but do not impute.

   Revenue effect:

   Cap at $1,000 single/$2,000 family: $12 billion
   Cap at $2,000 single/$4,000 family: $2 billion

2. Tax cap: limits to employer deductibility

   Deductibility would be limited to some percentage of average insurance plan costs, creating new incentives for a competitive market by creating a new appreciation for the relative cost of plans.

3. Tax cap: extent of employer deductibility tied to 'right thinking.'

   To encourage movement towards managed care, a differential could be created between the deductibility of non-managed care health plans and managed care plans.

B. Create new tools for spending efficiencies

Behavioral responses are limited by the bluntness of current instruments that relate more to financing arrangements than more efficient care. Available responses include: drop coverage or classes of covered services; increase co-payments and deductibles; or go with a "managed care" plan (either an HMO or PPO) that sees most of its impact realized through pre-admission screening.

- o New tools must be developed through standard evaluation and statistical techniques to determine:
  - which providers are most efficient (that is, which cardiologist manages heart attack cases in the way that leads to the lowest costs); and
  - which services are necessary and which are unnecessary.

C. Medical liability reform

Could use federal programs like Medicaid as leverage for tort reform:

- o The "low option" would make procedural reforms designed to increase the threshold for litigation (requiring that some physician file an affidavit saying there is grounds for a case when the case is filed) to changing the calculus of probably victory (uniform standards for who is a medical "expert.")
- o The "high option" would move medical liability to a workmen's compensation like scheme of administratively determined liability and awards.

D. Use federal programs to leverage other cost containment reform efforts.

- o Share Medicare's monopsony purchasing power with private sector or locally-devised payment plans; allow the designers of the all-payor system to impose the Medicare rates on providers for all insured services.

- o Create statutory opportunity for state or metropolitan all-payor systems using aggregate expenditure targets for total costs to include Medicare in their systems.

ACCESS ENHANCEMENT

A. New program

Use revenue generated from tax cap to organize public sponsors; limit activity of public sponsor to what can be supported by tax cap revenues. Possibility: children under age 18.

B. Tax credit for low income persons for purchase of health plans

As with the New Program (see A), the credit's fiscal impact could be limited by making the credit available only for children's policies.

C. Expand public programs

- o Expand Medicaid eligibility
- o Medicaid buy-in
- o Community Health Centers

D. Incentives for small employers

Promote small employers banding together to form groups large enough to escape individual rating by insurers:

- Allow insurers to require providers to accept Medicare payment rates;
- Provide seed money through an SBA grant program for start up costs and/or marketing free technical assistance to small businesses and business groups (i.e., Chambers of Commerce;)
- Immunize small businesses against antitrust actions if they make participation available on a non-discriminatory basis;
- Clarify tax status of these new multi-employer trusts; and
- Provide ERISA-like protection from state mandated benefit laws.

E. Incentives/penalties related to provision of insurance by employers.

- Flat out mandating benefits.
- Striking out at free-riders on the present system through a "play or pay" set of carrots and sticks.
    - Set the stick high enough to finance publicly-sponsored insurance (a Medicaid "buy-out) for all who work for employers who do not provide insurance.
    - Create a small stick by increasing unemployment insurance amounts for employers not providing health insurance under the theory that their workers are more likely to wind up on Medicaid (especially after last year's Family Support Act mandated the "unemployed parent" benefit for intact households) if unemployed.

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"some basis" to the case when the case is filed) to changing the calculus of probably victory (uniform standards for who is a medical "expert.")

- o The "high option" imposes would move medical liability to a workmen's compensation like scheme of administratively determined liability and awards.

D. Use federal programs to leverage state and local reform efforts.

- o Allow opportunity for state or metropolitan all-payor systems using aggregate expenditure targets for total costs.

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HEALTH CARE OPTIONS

ISSUE: The conventional wisdom presents **cost** and **access** as the principal American health care issues.

The classic statistics of cost are two depicting growth and relative share of GNP.

GROWTH: Health care currently represents 11.7% of GNP in the US. The current rate of growth, about 5% in real per capita spending per year, would lead to 15% of GNP shortly past the year 2000.

RELATIVE SHARE: The United States leads the world's economies in the share devoted to health care. Comparing the US to its major trading partners, the EC countries as a whole devote 7.1% of GDP to health expenditures and Japan 6.8%. Second to the United States is Canada, where health expenditures account for 8.6% of GDP. Despite higher proportions of health expenditures, the United States does not outperform other industrialized countries in any of the major measures of morbidity and mortality. Indeed, the United States lags behind nineteen industrialized countries in rates of infant mortality.

Access to health care is most often represented in terms of a single statistic: the number of Americans without health insurance. That number currently stands at 31 million, down from a high of 37 million at the bottom of the last recession.

OPTIONS: Simply stated, the options available to our society are:

1. Do nothing, and create no further federal intervention to deflect the growth trend line or the number outside the ranks of the insured;
2. Incremental change building on the current division of labor and responsibility: public programs for the non-working poor; employer-provided insurance for workers; and respect for the autonomy of the individual service provider (doctors and hospitals);
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The Congress has demonstrated a proclivity for seeing the issues independently, more often eating the desert (expanding access) than the vegetables (containing costs.)

This paper explores a range of steps under option 2.

COST CONTAINMENT

The incidence of health care costs is regressive. The insured, insulated from the real cost of health care, are economically better off than the uninsured. Federal fiscal effort benefits portions of the poor and the rich: $39 billion for Medicaid in FY 90 and $32 billion in tax expenditures for health insurance, of which Americans in families with more than $50,000 account for approximately $20 billion.

A tax cap lessens the regressivity of health care costs, provides relief from demand induced price pressure by those perceiving health care as a near-free good, and creates pressure for participants in the health care game to get about doing what needs to be done.

1. Tax cap: impute as income all amounts for employer-financed care above some cut-off.

   Probable revenue effect:

Set cap at		
$1,000 single/$2,000 family	$1,500 single/$3,000 family	$2,000 single/$4,000 family
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Creating workable definitions is difficult; the easiest would be to recognize federally qualified or state-licensed HMOs as managed care and not try to invent definitions for new categories.

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   Deductibility would be limited to some percentage of average insurance plan costs, creating new incentives for a competitive market by creating a new appreciation for the relative cost of plans.

3. Tax cap: extent of employer deductibility tied to 'right thinking.'

   To encourage movement towards managed care, a differential could be created between the deductibility of non-managed care health plans and managed care plans.

B. Create new tools for spending efficiencies

Behavioral responses are limited by the bluntness of current instruments that relate more to financing arrangements than more efficient care. Available responses include: drop coverage or classes of covered services; increase co-payments and deductibles; or go with a "managed care" plan (either an HMO or PPO) that sees most of its impact realized through pre-admission screening.

- o New tools must be developed through standard evaluation and statistical techniques to determine:
  - which providers are most efficient (that is, which cardiologist manages heart attack cases in the way that leads to the lowest costs); and
  - which services are necessary and which are unnecessary.

C. Medical liability reform

Could use federal programs like Medicaid as leverage for tort reform:

- o The "low option" would make procedural reforms designed to increase the threshold for litigation (requiring that some physician file an affidavit saying there is grounds for a case when the case is filed) to changing the calculus of probably victory (uniform standards for who is a medical "expert.")
- o The "high option" would move medical liability to a workmen's compensation like scheme of administratively determined liability and awards.

CBO February 1989

ENT-15 TAX EMPLOYER-PAID HEALTH INSURANCE

Addition to CBO Baseline	Annual Added Revenues (In billions of dollars) 1990	1991	1992	1993	1994	Cumulative Five-Year Addition
Tax Some Employer-Paid Health Insurance						
Income Tax	3.1	5.6	7.5	10.0	13.4	39.6
Payroll Tax[a]	1.6	3.0	3.9	5.3	7.1	20.9
Total	4.7	8.6	11.4	15.3	20.5	60.5
Tax Employer-Paid Health Insurance, but Allow a Credit for Some Employer and Employee Contributions						
Income Tax	8.5	3.3	4.2	5.3	7.6	28.9
Payroll Tax[a]	10.3	16.7	18.2	19.8	22.1	87.1
Total	18.8	20.0	22.4	25.1	29.7	116.0

a. Net of reduced income tax revenues.

Employees do not pay taxes on income received in the form of employer-paid health care coverage. This exclusion will reduce 1990 income tax revenues and Social Security payroll tax revenues by a total of about $46 billion.

Tax Some Employer-Paid Health Insurance. One proposal to limit the exclusion would be to treat as taxable income for employees any employer contributions (including those in cafeteria plans and flexible spending accounts) that exceed $250 a month for family coverage and $100 a month for individual coverage (in 1990 dollars), with these amounts indexed to reflect future increases in the general level of prices. This proposal, which would affect about 50 percent of individual tax filing units, would raise income tax revenues by about $40 billion and payroll tax revenues by about $21 billion over the 1990-1994 period. Including employer-paid health care coverage in the Social Security wage base, however, would lead to increased outlays on benefit payments that would offset most of the added payroll tax revenues from this option over the long run. This proposal would also raise the state income tax liabilities of individuals in those states with

tax bases linked to the federal tax base, unless those states took offsetting actions.

An advantage of this approach is that it would eliminate the tax incentive to purchase additional coverage beyond the ceiling. Without such coverage, there would be stronger incentives to economize in the medical marketplace, thereby reducing upward pressure on medical care prices. Over the long run, indexing the ceilings would limit their erosion by inflation. Finally, the Congress has already limited the exclusion for employer-paid group term life insurance in a similar way (see REV-13).

One disadvantage of limiting the tax subsidy is the difficulty of determining just when extensive coverage becomes excessive. Moreover, a uniform ceiling would have uneven effects, since a given employer's contribution purchases different levels of coverage depending on such factors as geographic location and the demographic characteristics of the firm's workforce. Finally, the indexing provision of this proposal would lead to declining subsidies for employer-paid health insurance over time, if health insurance costs continue to rise faster than the general level of prices. This effect is of concern to people who argue that these subsidies to private-sector benefits help avoid the need for public provision of similar benefits.

Tax Employer-Paid Health Insurance, but Allow a Credit for Some Employer and Employee Contributions. Another option would be to treat all employer-paid health insurance premiums as taxable but offer an individual income tax credit of 20 percent for health insurance premiums up to the amounts described above for family and individual coverage. The credits would be available to taxpayers regardless of whether the coverage was paid for or sponsored by an employer. At this credit percentage and with these premium ceilings, the proposal would increase income tax revenues by about $29 billion and payroll tax revenues by about $87 billion over the 1990-1994 period. As under the first option, however, increases in Social Security outlays would offset most of the added payroll tax revenues in the long run. This proposal would substantially raise the state income tax liabilities of individuals in states with tax bases linked to the federal tax base, unless these states took offsetting actions.

In addition to eliminating the tax incentive to purchase health insurance above the limits, as under the first option, this one would have the added advantage of making the subsidy available to all taxpayers having health insurance, without regard to their employment status. Moreover, the subsidy per dollar of the eligible health insurance coverage purchased would not be higher for taxpayers with higher incomes.

A drawback of this option is that the benefits of the tax credit would not be available to low-income individuals and families who have no liability under the federal personal income tax, unless the credit were made refundable. Such a refund, however, would substantially reduce the net revenue gain discussed above. Moreover, as with the first option, opponents of this one have several concerns: it would be difficult to determine at what level health insurance coverage becomes excessive, the effects would vary among geographic areas, and the subsidy for health insurance would be likely to decline over time.

HEALTH CARE REFORM OPTIONS

COST CONTAINMENT

A. Spending restraint via tax code changes

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Could use federal programs like Medicaid as leverage for tort reform:

- o The "low option" would make procedural reforms designed to increase the threshold for litigation (requiring that some physician file an affidavit saying there is grounds for a case when the case is filed) to changing the calculus of probably victory (uniform standards for who is a medical "expert.")
- o The "high option" would move medical liability to a workmen's compensation like scheme of administratively determined liability and awards.

D. Use federal programs to leverage other cost containment reform efforts.

- o Share Medicare's monopsony purchasing power with private sector or locally-devised payment plans; allow the designers of the all-payor system to impose the Medicare rates on providers for all insured services.

- o Create statutory opportunity for state or metropolitan all-payor systems using aggregate expenditure targets for total costs to include Medicare in their systems.

ACCESS ENHANCEMENT

A. New program

Use revenue generated from tax cap to subsidize purchase of private health plans.

B. Tax credit for low income persons for purchase of health plans

C. Expand public programs

- o Expand Medicaid eligibility
- o Medicaid buy-in
- o Community Health Centers

D. Incentives for small employers

Promote small employers banding together to form groups large enough to escape individual rating by insurers:

- Allow insurers to require providers to accept Medicare payment rates;
- Provide seed money through an SBA grant program for start up costs and/or marketing free technical assistance to small businesses and business groups (i.e., Chambers of Commerce;)
- Immunize small businesses against antitrust actions if they make participation available on a non-discriminatory basis;
- Clarify tax status of these new multi-employer trusts; and
- Provide ERISA-like protection from state mandated benefit laws.

E. Incentives/penalties related to provision of insurance by employers.

- Flat out mandating benefits.
- Striking out at free-riders on the present system through a "play or pay" set of carrots and sticks.
  - Set the stick high enough to finance publicly-sponsored insurance (a Medicaid "buy-out) for all who work for employers who do not provide insurance.
  - Create a small stick by increasing unemployment insurance amounts for employers not providing health insurance under the theory that their workers are more likely to wind up on Medicaid (especially after last year's Family Support Act mandated the "unemployed parent" benefit for intact households) if unemployed.

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DESERT

ACCESS ENHANCEMENT

A. **New program**: Fulfilling the President's "Medicaid buy-in" commitment through the private sector

Use revenue generated from tax cap to organize public sponsors; limit activity of public sponsor to what can be supported by tax cap revenues. Possibility: children under age 18.

Issue: How can "public sponsor" be a hybrid of state risk pools, private insurance, and Medicaid without the worst features of all (insurance bought only by those anticipating expenses, complex eligibility determination)

Possible features:

- Public sponsor seeks bids from qualified private insurers.
- Qualified private insurers must be HMOs. Alternate definitions?
- Benefits package specified in federal law; state minimum benefits law pre-empted.
- All under income level of _____ eligible to purchase health insurance from public sponsor.
- Premium varies with income.
- Businesses currently offering employee-only coverage eligibile for public-sponsor subsidy to extend coverage to dependents; employer at risk for amounts incremental to cost of public sponsor's package.

B. **Tax credit for low income persons for purchase of health plans**

As with the New Program (see A), the credit's fiscal impact could be limited by making the credit available only for children's policies.

C. **Expand public programs**

- o Expand Medicaid eligibility
- o Medicaid buy-in
- o Direct delivery of care
  Community Health Centers

D. **Incentives for small employers**

PROBLEM: Forms of competition on basis of risk.

Promote small employers banding together to form groups large enough to escape individual rating by insurers:

- Allow insurers to require providers to accept Medicare payment rates;
- Provide seed money through an SBA grant program for start up costs and/or marketing free technical assistance to small businesses and business groups (i.e., Chambers of Commerce;)

- Immunize small businesses against antitrust actions if they make participation available on a non-discriminatory basis;
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  - Set the stick high enough to finance publicly-sponsored insurance (a Medicaid "buy-out) for all who work for employers who do not provide insurance.

  - Create a small stick by increasing unemployment insurance amounts for employers not providing health insurance under the theory that their workers are more likely to wind up on Medicaid (especially after last year's Family Support Act mandated the "unemployed parent" benefit for intact households) if unemployed.

Friday afternoon version

HEALTH CARE REFORM OPTIONS

VEGETABLES

COST CONTAINMENT

A. Spending restraint via tax code changes

1. Tax cap: impute as income all amounts for employer-financed care above some cut-off

   Modification: As an effort to bring worker attention to wages foregone because of health insurance, report on W2, but do not impute.

   Revenue effect, FY 90:

   Cap at $1,000 single/$2,000 family: $12 billion
   Cap at $2,000 single/$4,000 family: $2 billion

2. Tax cap: limits to employer deductibility

   Deductibility would be limited to some percentage of average insurance plan costs, creating new incentives for a competitive market by creating a new appreciation for the relative cost of plans.

   Available Treasury estimate:

   Cap/limit benefits to $350/$140 month for family/single coverage

   FY 90: $.6 billion FY 91 $1.4 billion FY 92 $2.4 billion FY 93 $3.9 billion

3. Tax cap: extent of employer deductibility tied to 'right thinking.'

   To encourage movement towards managed care, a differential could be created between the deductibility of non-managed care health plans and managed care plans.

(HMOs are the only proven form of managed care.)

B. Create new tools for spending efficiencies

Behavioral responses are limited by the bluntness of current instruments that relate more to financing arrangements than more efficient care. Available responses include: drop coverage or classes of covered services; increase co-payments and deductibles; or go with a "managed care" plan (either an HMO or PPO) that sees most of its impact realized through pre-admission screening.

- o New tools must be developed through standard evaluation and statistical techniques to determine:
  - which providers are most efficient (that is, which cardiologist manages

heart attack cases in the way that leads to the lowest costs); and

- which services are necessary and which are unnecessary.

E Cautionary: pressure parties than solutions come on - like.

X **C. Medical liability reform**

DESERT ~~Could~~ use federal programs like Medicaid as leverage for tort reform. or take the plunge

- o The "low option" would make procedural reforms designed to increase the threshold for litigation (requiring that some physician file an affidavit saying there is grounds for a case when the case is filed) to changing the calculus of probably victory (uniform standards for who is a medical "expert.")

- o The "high option" would move medical liability to a workmen's compensation like scheme of administratively determined liability and awards.

B **D. Use federal programs to leverage other cost containment reform efforts.**

- o Share Medicare's monopsony purchasing power with private sector or locally-devised payment plans; allow the designers of the all-payor system to impose the Medicare rates on providers for all insured services.

- o Create statutory opportunity for state or metropolitan all-payor systems using aggregate expenditure targets for total costs to include Medicare in their systems.

C E. Use federal programs to promote managed care.

- Medicare. - PPO, annual enrollment in PPO.
- FEHB. Moved to defined - contribution (elim cost - increment feedback.)
- Medicaid. Follow CHAMPUS model - sub for bidders

Health Care Reform

Cost-Control

1. Establish state-level all-payer expenditure targets for hospital and physician services; limit increase in targets to population growth plus inflation.

2. Tax employee on premium contributions by employer in excess of a cap, set initially at 80% of average premium costs, indexed by inflation.

3. Fund research to support "buy right" strategy -- developmewnt of cost and quality measures to permit purchasers of care to identify "efficient" (low cost, high quality) providers.

Sweeteners

1. Use tax cap revenues to pay for a new refundable tax credit for purchase of health insurance by the low income.

2. Malpractice reform.

3. Provide federal seed money to establish multi-employer trusts to help small employers buy health insurance.

Rationale

1. Controlling health care costs is too difficult for private health plans. Only a few cost control tools are available, and these are relatively limited in scope or effectiveness.

   All-payer expenditure targets are needed as a temporary measure to counter powerful forces driving up health care spending.

   Private health plans have only a few , relatively limited tools to control health care costs.

2. Expenditure targets are not satisfactory as a long-term solution because they do not differentiate between efficient and inefficient providers.

The expenditure target should be implemented in a way that encourages private plans to develop better ways to control costs.

Federal support is needed to statistical profiling methods that can be used to identify high value (low cost, high quality) providers.

3. Interest group politics will stymie any serious cost control proposal unless powerful sweeteners are added.

To secure support from House and Senate Democrats, expanded access for the uninsured is needed.

To limit opposition from physician groups, malpractice reform is needed.

4. Health insurance is either too costly or unavailable for many small employers.

Unless this problem is addressed, the number of Americans without health insurance will continue to grow.

Group purchasing arrangements for health insurance can make health insurance more affordable for small employers.

Providing seed money for these arrangements would be a low cost Federal response to the problem of the uninsured, with significant potential.

HEALTH CARE OPTIONS

ISSUE: The conventional wisdom presents **cost** and **access** as the principal American health care issues.

The classic statistics of cost are two depicting growth and relative share of GNP.

GROWTH: Health care currently represents 11.7% of GNP in the US. The current rate of growth, about 5% in real per capita spending per year, would lead to 15% of GNP shortly past the year 2000.

RELATIVE SHARE: The United States leads the world's economies in the share devoted to health care. Comparing the US to its major trading partners, the EC countries as a whole devote 7.1% of GDP to health expenditures and Japan 6.8%. Second to the United States is Canada, where health expenditures account for 8.6% of GDP. Despite higher proportions of health expenditures, the United States does not outperform other industrialized countries in any of the major measures of morbidity and mortality. Indeed, the United States lags behind nineteen industrialized countries in rates of infant mortality.

Access to health care is most often represented in terms of a single statistic: the number of Americans without health insurance. That number currently stands at 31 million, down from a high of 37 million at the bottom of the last recession.

OPTIONS: Simply stated, the options available to our society are:

1. Do nothing, and create no further federal intervention to deflect the growth trend line or the number outside the ranks of the insured;
2. Incremental change building on the current division of labor and responsibility: public programs for the non-working poor; employer-provided insurance for workers; and respect for the autonomy of the individual service provider (doctors and hospitals);
3. Take the plunge and adopt one of the radical schemes: require employers to provide insurance covering workers and dependents; place all employers under a "play or pay" obligation to provide insurance or pay a payroll tax to pay for publicly provided insurance; or socialize the provision of health care.

The Congress has demonstrated a proclivity for seeing the issues independently, more often eating the desert (expanding access) than the vegetables (containing costs.)

This paper explores a range of steps under option 2.

COST CONTAINMENT

The incidence of health care costs is regressive. The insured, insulated from the real cost of health care, are economically better off than the uninsured. Federal fiscal effort benefits portions of the poor and the rich: $39 billion for Medicaid in FY 90 and $32 billion in tax expenditures for health insurance, of which Americans in families with more than $50,000 account for approximately $20 billion.

A tax cap lessens the regressivity of health care costs, provides relief from demand induced price pressure by those perceiving health care as a near-free good, and creates pressure for participants in the health care game to get about doing what needs to be done.

1. Tax cap: impute as income all amounts for employer-financed care above some cut-off.

   Probable revenue effect:

Set cap at		
$1,000 single/$2,000 family	$1,500 single/$3,000 family	$2,000 single/$4,000 family
$12 billion	$6 billion	$2.2 billion

2. Tax cap: limits to employer deductibility

   Deductibility would be limited to some percentage of average insurance plan costs, creating new incentives for a competitive market by creating a new appreciation for the relative cost of plans.

   While less pure tax policy than placing the incidence of the tax on individuals, the incidence would be coincident with the ability to change the structure and design of health insurance plans.

3. Tax cap: extent of employer deductibility tied to 'right thinking.'

   To encourage movement towards managed care, a differential could be created between the deductibility of non-managed care health plans and managed care plans.

Creating workable definitions is difficult; the easiest would be to recognize federally qualified or state-licensed HMOs as managed care and not try to invent definitions for new categories.

Behavioral responses are limited by the bluntness of current instruments that relate more to financing arrangements than more efficient care. Available responses include: drop coverage or classes of covered services; increase co-payments and deductibles; or go with a "managed care" plan (either an HMO or PPO) that sees most of its impact realized through pre-admission screening.

- o "Enlightened" managed care focuses more on whether an operation should take place in a hospital or on an outpatient basis rather than whether the procedure should take place at all.

- o New tools must be developed through standard evaluation and statistical techniques to determine:

  - which providers are most efficient (that is, which cardiologist manages heart attack cases in the way that leads to the lowest costs); and

  - which services are necessary and which are unnecessary.

Medical liability

Physicians often begin their presentation of the health care situation with, "Well, if we only did something about malpractice ..." Physicians state that many tests and procedures take place because physicians want to reduce their risk of being sued.

Real action in this category means overcoming traditional federal reticence to become involved in an area that historically has been solely the province of state law.

- o The AMA has offered two sets of reform proposals.

  The "low option" makes only procedural reforms designed to increase the threshold for litigation (requiring that some physician file an affidavit saying there is "some basis" to the case when the case is filed) to changing the calculus of probably victory (uniform standards for who is a medical "expert.")

The "high option" imposes would move medical liability to a workmen's compensation like scheme of administratively determined liability and awards.

Use federal programs to leverage state and local reform efforts.

Opportunity for state or metropolitan all-payor systems

Current law allows Medicare to participate in state-level all-payor systems. In these systems (New Jersey is the only state at this time), Medicare pays according to locally determined rules. States can obtain such waivers as long as the alternate system costs no more than regular Medicare payment rules.

The concept could be expanded to allow state or locally-set expenditure targets to cover both physician and hospital payments by all major payors (Medicare, Medicaid, and private insurance.)

Share Medicare's monopsony purchasing power with state and local payment plans.

The federal government could strengthen local efforts to negotiate with providers over price by allowing the designers of the all-payor system to impose the Medicare rates to pay for privately-insured care. (Hospitals and physicians would be required to accept the Medicare rate from the all-payor system as a condition of receiving payment from Medicare.)

ACCESS

Tax credit for low income persons.

The federal government devotes none of its fiscal effort for health care to those with no tax liability or itemizable expenses below the standard deduction and not eligible for Medicare or Medicaid. (32% of the uninsured live in families with income below the poverty level.)

A tax credit for health insurance appeared in the Senate-passed child care bill as the brainchild of Senator Bentsen. Bentsen seems to think that health care for children is more important than child care (33% of the uninsured are under age 18).

Expanding public programs.

Medicaid eligibility

Expanding Medicaid eligibility has been the Congress' priority, largely through the never ending work of Rep. Waxman and occasional Democratic efforts to make "children" a focal issue on the party's agenda.

The Bush campaign committed to matching the Democrats' generosity, promising to aim for a national eligibility standard for pregnant women and infants of 185% of the poverty level and also of making improvements in eligibility for children over age one.

At 185% of poverty Medicaid eligibility begins to interact with state income distributions to make it something more than a program for the poor; in Alabama, for example, Medicaid would cover 54% of all pregnancies.

Medicaid buy-in/buy-out

Vice President Bush, in his second debate with Michael Dukakis, suggested a Medicaid buy-in as a means to improving access to care. A similar option would be to finance "buying out" of Medicaid into private insurance plans or HMOs.

An initiative in this area could begin with a few million dollars to finance a series of demonstrations of this previously untried concept.

Community Health Centers

Community Health Centers (CHCs) is a Great Society program that never bloomed as its creators hope nor has it wilted and died. Funded at $463 million in FY 90 (pre-sequester), CHCs operate clinics in the poorest neighborhoods and areas of the country. Secretary Sullivan asked for some $50 million add-on in his FY 91 budget request. Unlike the Medicaid enhancements, CHC increments do not automatically grow in the outyears.

Incentives for small employers.

Small employers and start up firms account for many of the 24.2 million workers without employer-sponsored or provided group insurance.

Accessible steps to decrease the cost (both monetary and to management resources) include:

Promote small employers banding together to form groups large enough to escape individual rating by insurers:

- Allow insurers to require providers to accept Medicare payment rates;
- Provide seed money through an SBA grant program for start up costs and/or marketing free technical assistance to small businesses and business groups (i.e., Chambers of Commerce;)
- Immunize small businesses against antitrust actions if they make participation available on a non-discriminatory basis;
- Clarify tax status of these new multi-employer trusts; and
- Provide ERISA-like protection from state mandated benefit laws.

Incentives/penalties related to provision of insurance by employers.

Options include:

- Flat out mandating benefits.

- Striking out at free-riders on the present system through a "play or pay" set of carrots and sticks.

    - Set the stick high enough to finance publicly-sponsored insurance (a Medicaid "buy-out) for all who work for employers who do not provide insurance.

- Create a small stick by increasing unemployment insurance amounts for employers not providing health insurance under the theory that their employees are more likely to wind up on Medicaid (especially after last year's Family Support Act mandated the "unemployed parent" benefit for intact households.)

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CBO: Steve Long 226-2653 FAX (415) 725-1668
Carlinyn Langwell - high enough to make it a good deal for healthy 80% - natl ave cost of health insurance

ACCESS ENHANCEMENT

A. New program

- ~~must~~ raise enough to (ē free riders) to finance.

Use revenue generated from tax cap to subsidize purchase of private health plans.

B. Tax credit for low income persons for purchase of health plans

C. Expand public programs

PUBLIC SPONSORS
- finite capitation amounts
- maybe do it for some people
> FAMILIES WITH CHILDREN.

- o Expand Medicaid eligibility
- o Medicaid buy-in
- o Community Health Centers

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- Clarify tax status of these new multi-employer trusts; and
- Provide ERISA-like protection from state mandated benefit laws.

E. Incentives/penalties related to provision of insurance by employers.

- Flat out mandating benefits. (à la Ted Kennedy.)
- Striking out at free-riders on the present system through a "play or pay" set of carrots and sticks.
  - Set the stick high enough to finance publicly-sponsored insurance (a Medicaid "buy-out) for all who work for employers who do not provide insurance.
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- Qualified private insurers must be HMOs. Alternate definitions?
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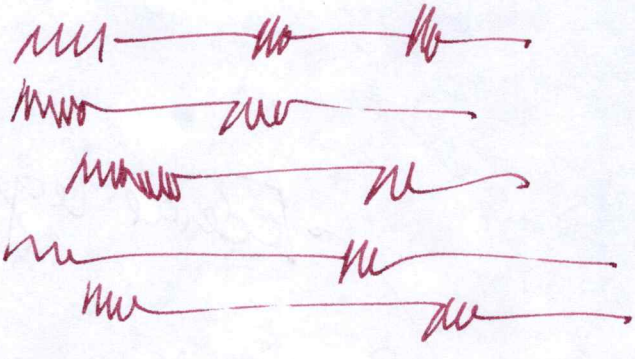
- All under income level of _____ eligible to purchase health insurance from public sponsor.
- Premium varies with income.
- Businesses currently offering employee-only coverage eligibile for public-sponsor subsidy to extend coverage to dependents; employer at risk for amounts incremental to cost of public sponsor's package.

B. **Tax credit for low income persons for purchase of health plans**

As with the New Program (see A), the credit's fiscal impact could be limited by making the credit available only for children's policies.

C. **Expand public programs**



- o Expand Medicaid eligibility
- o Medicaid buy-in
- o Community Health Centers

D. **Incentives for small employers**

Promote small employers banding together to form groups large enough to escape individual rating by insurers:

- Allow insurers to require providers to accept Medicare payment rates;
- Provide seed money through an SBA grant program for start up costs and/or marketing free technical assistance to small businesses and business groups (i.e., Chambers of Commerce;)

Who's that.

Options include

- Federal legislation to
  - facilitate establishment of state risk pools
  - provide federal seed money for METS & group purchasing arrangements for small employers
  - to increase market power.

REFORM

HEALTH CARE OPTIONS

COST CONTAINMENT

Spending restraint via tax code changes

A. ~~Tax cap permutations~~

1. Tax cap: impute as income all amounts for employer-financed care above some cut-off.

   Modification: As an effort to bring worker attention to wages foregone because of health insurance, report on W2, but do not impute.

2. Tax cap: limits to employer deductibility

   Deductibility would be limited to some percentage of average insurance plan costs, creating new incentives for a competitive market by creating a new appreciation for the relative cost of plans.

3. Tax cap: extent of employer deductibility tied to 'right thinking.'

   To encourage movement towards managed care, a differential could be created between the deductibility of non-managed care health plans and managed care plans.

B. Create new tools for spending efficiencies

Behavioral responses are limited by the bluntness of current instruments that relate more to financing arrangements than more efficient care. Available responses include: drop coverage or classes of covered services; increase co-payments and deductibles; or go with a "managed care" plan (either an HMO or PPO) that sees most of its impact realized through pre-admission screening.

- New tools must be developed through standard evaluation and statistical techniques to determine:
  - which providers are most efficient (that is, which cardiologist manages heart attack cases in the way that leads to the lowest costs); and
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C. Medical liability reform

Could use federal programs like Medicaid as ~~incentive~~ leverage for tort reform

~~The AMA has offered two sets of reform proposals.~~

- The "low option" would make ~~only~~ procedural reforms designed to increase the threshold for litigation (requiring that some physician file an affidavit saying there is

"some basis" to the case when the case is filed) to changing the calculus of probably victory (uniform standards for who is a medical "expert.")

- o The "high option" ~~imposes~~ would move medical liability to a workmen's compensation like scheme of administratively determined liability and awards.

D. Use federal programs to leverage ~~state and local~~ other cost containment reform efforts.

- o Allow opportunity for state or metropolitan all-payor systems using aggregate expenditure targets for total costs.
- o Share Medicare's monopsony purchasing power with private sector or state and local payment plans; allow ~~the designers of the all-payor~~ them system to impose the Medicare rates on providers for all insured services.

Page 2

ACCESS Enhancement

A. Tax credit for low income persons toward purchase of health plans

B. Expand public programs.

- o Expand Medicaid eligibility
- o Medicaid buy-in/buy-out
- o Community Health Centers

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D. Incentives/penalties related to provision of insurance by employers.

- Flat out mandating benefits.

- Striking out at free-riders on the present system through a "play or pay" set of carrots and sticks.

  - Set the stick high enough to finance publicly-sponsored insurance (a Medicaid "buy-out) for all who work for employers who do not provide insurance.

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This paper explores a range of steps under option 2.

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The incidence of health care costs is regressive. The insured, insulated from the real cost of health care, are economically better off than the uninsured. Federal fiscal effort benefits portions of the poor and the rich: $39 billion for Medicaid in FY 90 and $32 billion in tax expenditures for health insurance, of which Americans in families with more than $50,000 account for approximately $20 billion.

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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.

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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

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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.

HEALTH CARE REFORM OPTIONS

COST CONTAINMENT

A. Spending restraint via tax code changes

1. Tax cap: impute as income all amounts for employer-financed care above some cut-off

   Modification: As an effort to bring worker attention to wages foregone because of health insurance, report on W2, but do not impute.

2. Tax cap: limits to employer deductibility

   Deductibility would be limited to some percentage of average insurance plan costs, creating new incentives for a competitive market by creating a new appreciation for the relative cost of plans.

3. Tax cap: extent of employer deductibility tied to 'right thinking.'

   To encourage movement towards managed care, a differential could be created between the deductibility of non-managed care health plans and managed care plans.

B. Create new tools for spending efficiencies

Behavioral responses are limited by the bluntness of current instruments that relate more to financing arrangements than more efficient care. Available responses include: drop coverage or classes of covered services; increase co-payments and deductibles; or go with a "managed care" plan (either an HMO or PPO) that sees most of its impact realized through pre-admission screening.

- o New tools must be developed through standard evaluation and statistical techniques to determine:
  - which providers are most efficient (that is, which cardiologist manages heart attack cases in the way that leads to the lowest costs); and
  - which services are necessary and which are unnecessary.

C. Medical liability reform

Could use federal programs like Medicaid as leverage for tort reform:

- o The "low option" would make procedural reforms designed to increase the threshold for litigation (requiring that some physician file an affidavit saying there is grounds for a case when the case is filed) to changing the calculus of probably victory (uniform standards for who is a medical "expert.")
- o The "high option" would move medical liability to a workmen's compensation like scheme of administratively determined liability and awards.

D. Use federal programs to leverage other cost containment reform efforts.

- o Share Medicare's monopsony purchasing power with private sector or locally-devised payment plans; allow the designers of the all-payor system to impose the Medicare rates on providers for all insured services.

- o Create statutory opportunity for state or metropolitan all-payor systems using aggregate expenditure targets for total costs to include Medicare in their systems.

ACCESS ENHANCEMENT

A. New program

Use revenue generated from tax cap to subsidize purchase of private health plans.

B. Tax credit for low income persons for purchase of health plans

C. Expand public programs

- o Expand Medicaid eligibility
- o Medicaid buy-in
- o Community Health Centers

D. Incentives for small employers

Promote small employers banding together to form groups large enough to escape individual rating by insurers:

- Allow insurers to require providers to accept Medicare payment rates;
- Provide seed money through an SBA grant program for start up costs and/or marketing free technical assistance to small businesses and business groups (i.e., Chambers of Commerce;)
- Immunize small businesses against antitrust actions if they make participation available on a non-discriminatory basis;
- Clarify tax status of these new multi-employer trusts; and
- Provide ERISA-like protection from state mandated benefit laws.

E. Incentives/penalties related to provision of insurance by employers.

- Flat out mandating benefits.
- Striking out at free-riders on the present system through a "play or pay" set of carrots and sticks.
  - Set the stick high enough to finance publicly-sponsored insurance (a Medicaid "buy-out) for all who work for employers who do not provide insurance.
  - Create a small stick by increasing unemployment insurance amounts for employers not providing health insurance under the theory that their workers are more likely to wind up on Medicaid (especially after last year's Family Support Act mandated the "unemployed parent" benefit for intact households) if unemployed.

* tax cap.
  dimensions of choice.
  pricing if any.

Saturday version

HEALTH CARE REFORM OPTIONS

BACKGROUND FACTS

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  - $2,051 per capita in the US v. $1130 for the EC and $915 in Japan.

- US health spending is growing at twice the rate of the economy as a whole, and will reach 15% of GNP by the year 2000.
  - 20 cents of every new dollar added to GNP goes to health care.

- Higher spending in the US has not led to better health outcomes.

- The EC and Japan have universal health plan coverage. In contrast, 31 million Americans do not have health insurance.

COST CONTAINMENT

A. Spending restraint via tax code changes

1. Tax cap on employees: Treat as employee income health plan contributions by employer above the cap

   Revenue effect, FY 90, of taxing contributions above:

   $1,000 single/$2,000 family per annum: $12 billion
   $2,000 single/$4,000 family per annum: $2 billion

   (Average plan cost is $1500 for single, $3300 for family plan.)

2. Tax cap on employers: eliminate deductibility of employer contributions above the cap

   Cap deductible employer contribution at $140/$350 month ($1680/$4100) for single/family coverage

FY 90	FY 91	FY 92	FY 93
$.6 billion	$1.4 billion	$2.4 billion	$3.9 billion

3. Link tax treatment to structure of health plan

   Provide differential tax treatment to encourage more efficient health plans (e.g., HMOs, which have demonstrated the ability to provide care more efficiently.)

B. Use federal programs to leverage other cost containment reform efforts.

- o Allow private health plans to pay for hospital and physician services using Medicare payment rates.
- o Provide option for state-level all-payor expenditure targets for hospital and physician services.

C. Use federal programs to promote managed care

- o Medicare. New preferred provider organization (PPO) option for beneficiaries. Coordinated open enrollment process for PPOs and HMOs. Lower Medicare Part B premium for beneficiaries selecting HMO coverage.
- o Federal Employees Health Benefits Plan (FEHBP). Move federal employees' health plan from share of plan cost to defined-contribution plan.

D. Fund development of new tools to facilitate prudent purchasing of health care

Private health plans currently have available only a few tools (e.g., pre-admission review) to manage cost and quality. Moreover, these are of limited scope and impact.

Focus of research effort would be to develop methods to permit purchasers of care to identify efficient providers (low cost, high quality) and to identify unnecessary or substandard care. This is a classic public good.

E. Medical liability reform

Use federal health care programs as leverage for tort reform, or pre-empt state law.

- o A "low option" would make procedural reforms without changing basic tort law.

- o A "high option" would make basic changes in tort law.

ACCESS ENHANCEMENT

A. **New program:** Fulfilling the President's "Medicaid buy–in" commitment through the private sector

Use revenue generated from tax cap to organize public sponsors; limit eligible population to what can be supported by tax cap revenues. Possibility: children under age 18.

- State agency ("public sponsor") seeks bids from qualified private insurers.
- Public sponsor makes health plans available to low income individuals; premium varies with income.

B. **Tax credit for low income persons for purchase of health plans**

As with the New Program (see A, above), the credit's fiscal impact could be limited by making the credit available only for children's policies.

C. **Expand public programs**

- o Expand Medicaid eligibility
- o Medicaid buy–in
- o Direct service delivery (e.g., Community Health Centers)

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

Options and incentives include:

- Allow plans insuring small employers to use Medicare rates to pay doctors and hospitals.
- Provide federal seed money and technical assistance for health insurance group purchasing arrangements for small employers.
- Federal legislation to facilitate establishment of state risk pools.

E. **Incentives/penalties related to provision of insurance by employers.**

- o Mandate health benefits (e.g., Kennedy bill)
- o "Play or pay" system, whereby employers not providing health insurance are subject to a payroll tax to finance vouchers for those without employer–provided health insurance.

file: a:\nov\outline

Saturday version

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Monday,
December 4

HEALTH CARE REFORM
- Rev memo w/WLR at 11

MEM FOR RBP: Head Start
FY 91 pot ideas
CSBG

Misl

Dinner/JHart

CALL

WCB:

Eliz Kepley 393-2100
Tressler 639-5942
John Danneher
Pete Lunnie
DDS
P Jarvis
Wodatch Small bus pc
Jost
Eisccccheid 245-7027

WLR

FEHBP
Larry Oday 223-6611 ASCs
Next step on health care ref
Hmls experts mtng/SSA idea
ES: Dis - fish or cut bait
Seafood inspection

M McG: Tauke staff call/elevators
Brad: Initiative tracking for FY 91
NIH

STAFF MEETING:

ES: K Yale/Fnk paper
Implementation - anything more?
IM TF report
Wodatch: status of SBA document

Mrs. Mead: FEHBP

HEALTH CARE REFORM -- ISSUES AND OPTIONS

Background

- The United States leads the world's economies in the share of GNP devoted to health care.
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  - $2,051 per capita in the US; $1130 in the EC; $915 in Japan.
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- 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.
- 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 and 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").

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+ 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. Also, the tax code causes employees to prefer additional health benefits to more wages.

+ 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.

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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 legislature is struggling to make it work fiscally and politically.

- 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.

- Many are calling for tougher **controls on total outlay**, as were just enacted for Medicare payments to doctors, but for private payers as well.

- Professor Alain Enthoven, of Stanford, is pushing a **consumer-choice** health plan. It would provide for universal insurance coverage, either through employer coverage of the 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.

- 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.

- In cost containment, the main approaches are price/volume outlay control and **competition between alternative plans, primarily 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 is a problem.

  - Better assessment of health care quality and effectiveness is also essential, as well as improved techniques for actually "managing" health care.

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   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.

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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. 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 $300 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 and 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.

2. **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.

3. **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.

Options for Access Enhancement

1. 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.

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

   This is analogous to the 1989 Bush child care proposal.

3. **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.

4. 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. Allow plans insuring small firms to use the generally lower Medicare rates to pay doctors and hospitals, and mandate that providers accept these rates.

b. Provide federal seed money and technical assistance for health insurance group purchasing arrangements for small firms, so that they can increase their market clout.

c. Pre-empt state mandated benefit laws for insurance purchased through multi-employer trusts, to allow for less costly plans to be offered.

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 -- ISSUES AND OPTIONS

Background

- 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.
- 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.
- 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.
- 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. spell out
    - 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.

Tax also makes plan "richer"

+ 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. — how?

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.

only on mandates. Many going to 185%

- 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.

What does this mean?

- 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.**

private?

- 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~~ In cost containment, ~~front, the argument is between~~ main approaches are price/volume control and competition between managed care plans.**

alternati plans, particularly

  - 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.

vague

  - 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

Make clear that this is in the '91 budget

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.

What are these? Introduce acronym

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.

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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.

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   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.

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Options for Access Enhancement

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   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.

   Needs to be explained

   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~~ private 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.

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   a. **Medicaid** -- continue the pattern of the past several years, with expansion of eligibility up the income scale, with mandates on the States.

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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.)

Bill,
This is not the option as intended.
Make clear that a tax umbella is provided - not revenue sharing, as this is written.
Options for tax umbrella would be
- sin taxes
- payroll tax (less good)
- it can also be linked to the tax cap - I think - but

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:

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- 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.

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new page

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- commissions - Stockman
  - Pepper

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BACKGROUND

- o We lead the world in share of GNP devoted to helath care.
  - %
  - $
- o Health care growing at twice the rate of the economy.
  - Government at all levels buys 40% of all health care; continued growth of health care faster than revenues means either fewer dollars for other governmental purposes or higher taxes.
- o Yet we have nothing to show for higher spending.
  - Life expectancy/infant mortality.

HEALTH CARE REFORM OPTIONS

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 pools to equalize burden among hospitals.
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; index 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.	Provide federal seed money for technical assistance for small employer group in purchasing, as under option 1. Allow opt-out from benefits mandated by state state law for health plans purchased through small employer groups. Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates. Cushion lower payment rates through malpractice relief. Encourage states to establish indigent care pools to equalize burden among hospitals.

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

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

Same steps as under option 2a; 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 states to set statewide expen-

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.

editure targets to include not only hospital, but also doctor payments with overruns to be recovered through reductions in future prices.

Option 5: Tax cap financing access; limited incentives for small business

(1)Tax cap and (2)federal program leadership, as under option 3.

(3) Expand current law allowing states to set statewide expen- to include not only hospital, but also doctor payments with overruns to be covered through reductions in future prices.

(1) Federal seed money and technical assistance for small employer group purchasing, as under option 1.

(2) Allow opt-out from target benefits mandated by state for health plans purchased through small employer groups, as under option 2.

(3) Encourage states to establish indigent care pools to equalize burden among hospitals.

(4) 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.

HEALTH CARE REFORM OPTIONS

Cost Containment	Access
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Option 2b: Tax code incentives with no immediate revenue effect	
Tax cap set at a level that generates revenue immediately; HMO cap set higher than cap for indemnity plans.	Same steps as under option 2a; incremental revenue goes to deficit reduction.

HEALTH CARE REFORM OPTION PACKAGES

Cost Containment

Access

Current commitments

Limit costs from medical liability through procedural or tort reform (DPC developing options.)

Fund development of statistical and other tools to distinguish between more efficient and less efficient providers of health care and to target medical care for review of appropriateness.

Medicaid:

- Reconciliation bill requires states to cover all pregnant women and children in families with incomes of up to 133% of the poverty level.

OPTIONS FOR ADDITIONAL ACTION

Option 1: Minimum Additional Cost

Use federal programs to promote managed care:

- Medicare: Allow PPOs 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 small employer purchasing groups.

Allow opt-out...

Encourage States to set up indigent care pools...

(Florida plan)

Cost Containment **Access**

Option 2: Tax code incentives with no immediate revenue effect

Implement a cap on the amount of employer-provided health insurance that is excluded from taxable income, with few individuals initially over the cap; the cap phases-in gradually by indexing the cap to an index that increases less rapidly than premiums.

and/or

Provide a favored status for HMOs via a higher cap for HMOs.

pull out separate

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

Provide federal seed money for technical assistance for small employer purchasing groups, as under option 1.

Allow small firms organized under option 1 to require hospitals and doctors to accept Medicare payment rates.

Allow opt-out from (+ limited liability)
~~Pre-empt~~ state mandated benefits for health plans purchased through small employer groups.

~~(+ Core mandates benefits)~~

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

Tax cap set at a level that generates revenue immediately.

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

Federal seed money and technical assistance, for small employer purchasing groups, as under option 1.

Allow small firms organized under option 1 to require hospitals and doctors to accept Medicare payment rates, as under option 2.

Pre-empt state mandated benefits for plans purchased through small employer groups, as under option 2.

vouchers for

Use revenue from tax cap to subsidize purchase of private health plan coverage through group purchasing arrangements open both to small businesses and individuals

OR

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

or Voucher

Cost Containment **Access**

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

Tax cap option, as under option 3.

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

Allow states to determine aggregate expenditure targets for hospital and doctor costs and recover overruns through reductions in future price increases.

- Note: current law for hospitals

Federal seed money and technical assistance for small employer purchasing groups, as under option 1.

Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates, as under option 2.

Pre-empt state mandated benefits for health plans purchased through small employer groups, as under option 2.

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

Add - 1. tax cap 5 new program

2. Kleinberg proposal — allow States to use revenue like UI program

make minimalist option that is doable

optional option

tax cap

diff for HMO

option for State ETs

opt. out from state mandated benefits

HEALTH CARE REFORM OPTION PACKAGES

Cost Containment	Access
Current commitments	
Limit costs from medical liability through procedural or tort reform (DPC developing options.) Fund development of statistical and other tools to distinguish between more efficient and less efficient providers of health care and to target medical care for review of appropriateness.	Medicaid: - Reconciliation bill requires states to cover all pregnant women and children in families with incomes of up to 133% of the poverty level.

OPTIONS FOR ADDITIONAL ACTION

Option 1: Minimum Additional Cost

Use federal programs to promote managed care:

- Medicare: Allow PPOs 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 small employer purchasing groups.

Allow opt-out...

Encourage States to set up indigent care pools...

Florida plan

Cost Containment	Access

Option 2: Tax code incentives with no immediate revenue effect

Implement a cap on the amount of employer-provided health insurance that is excluded from taxable income, with few individuals initially over the cap; the cap phases-in gradually by indexing the cap to an index that increases less rapidly than premiums.

and/or

Provide a favored status for HMOs via a higher cap for HMOs.

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

Provide federal seed money for technical assistance for small employer purchasing groups, as under option 1.

Allow small firms organized under option 1 to require hospitals and doctors to accept Medicare payment rates.

Pre-empt state mandated benefits for health plans purchased through small employer groups.

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

Tax cap set at a level that generates revenue immediately.

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

Federal seed money and technical assistance, for small employer purchasing groups, as under option 1.

Allow small firms organized under option 1 to require hospitals and doctors to accept Medicare payment rates, as under option 2.

Pre-empt state mandated benefits for plans purchased through small employer groups, as under option 2.

Use revenue from tax cap to subsidize purchase of private health plan coverage through group purchasing arrangements open both to small businesses and individuals

OR

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

Cost Containment **Access**

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

Tax cap option, as under option 3.

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

Allow states to determine aggregate expenditure targets for hospital and doctor costs and recover overruns through reductions in future price increases.

- Note: current law for hospitals

in addition to currently provided for hospitals.

Federal seed money and technical assistance for small employer purchasing groups, as under option 1.

Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates, as under option 2.

Pre-empt state mandated benefits for health plans purchased through small employer groups, as under option 2.

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

5: 1) Tax cap that generates rev.

2) Hmo diff

everything for 4 except allow hosp to require 'care rates

Add - 1. tax caps & new program

2. Kleinberg proposal — allow States to use revenue like UI program

make minimalist option that is doable

optional option

tax caps

diff for HMO

option for State ETs

opt-out from state mandated benefits

Health Care Reform Options

Cost Containment

Already underway

Limit costs from medical liability through procedural or tort reform (~~DPC developing options.~~)

Fund ~~[illegible]~~ment of
Develop~~ statistical~~ and other tools to distinguish more efficient from less efficient providers of health care.

OPTIONS FOR ADDITIONAL ACTION:

Option 1: No ~~incremental revenue~~

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.

No immediate incre rev; but tax code incentives

Option 2: Start to cap employer-provided health insurance

Implement a tax cap through:

- Including in income all amounts over the cap amount ($300 per family per month, $140 for single coverage leaves 15% of all insured over cap; raises $1.4 billion to start) ~~or~~, and
- Provide HMO preference: ~~Provide a~~ higher cap for HMOs ~~[or limit non-HMO deductibility to 95% of plan cost.]~~

Use federal programs, as outlined under option 1

...: tax cap ...at hits ...tually no ...e to start, ...t idea that ...ads to ...ode over ...ime if ...alth care ↑ ...eeds ...ses in ...neral. AND ...ve ...'s cap ...cription ...option 3

Access

Medicaid:

- Reconciliation bill requires states to cover all pregnant women and children up to 133% of poverty.

Minimal Additional Cost

Provide federal seed money and technical assistance for health insurance group purchasing by small firms; ~~pre-empt state laws~~ mandating minimum benefits for these group purchasing arrangements.

Federal seed money, technical assistance, and pre-emption for small employers, as under option 1.

Allow small ~~firms~~ employee groups organizing under option 1 to require hospitals and doctors to accept Medicare payment rates.

Option 3: Set tax cap to finance improving access

Tax cap

15% hit or
30% hit cap ??

Federal seed money, technical assistance, and pre-emption for small employers, as under option 1.

Allow small firms to use Medicare payment rates, as under option 2.

NEW PROGRAM: Subsidies purchase of private health plans coverage through group purchasing arrangements open to small businesses and individuals.

Use federal programs, as outlined under option 1.

Tax cap financing accountability plus requirement for employer participation

Option 4: ~~Require employer participation in health care~~

Tax cap option, as above

Use federal programs, as under option 1.

Encouragement of small firms, as above.

Organize group purchasing organizations for small firms and individuals, as under option 3.

Allow states to determine aggregate expenditure targets for hospital and doctor costs and recover overruns through reduced increases in amounts paid.

Require all firms to provide health benefits plans to their employees OR pay a payroll tax. Use revenues from payroll tax to expand tax credit as under option 3.

Use revenues from tax cap to fund low-income refundable tax credit to assist purchase of health insurance from small employer group or federally qualified HMO

Health Care Reform Options

Cost Containment

Access

Already underway

Limit costs from medical liability through procedural or tort reform (DPC developing options.)

Develop statistical and other tools to distinguish more efficient from less efficient providers of health care.

Medicaid:

- Reconciliation bill requires states to cover all pregnant women and children up to 133% of poverty.

OPTIONS FOR ADDITIONAL ACTION:

Option 1: No ~~incremental revenue~~ Min addl 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.

Option 2: 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; index 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.

Provide federal seed money for technical assistance for small employer group in in purchasing, as under option 1.

Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates.

Pre-empt state mandated benefits for plans purchased through small employer group purchasing arrangements.

Cost containment

Access

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

Tax cap set at a level generates revenue immediately.

Use federal programs to promote managed care,

Federal seed money and that technical assistance, for small employer group purchasing, as under option 1.

Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates, as under option 2.

Pre-empt state mandated benefits for plans purchased through small employer group purchasing arrangements, as under option 2.

~~NEW PROGRAM:~~ Subsidize purchase of private health plans coverage through group purchasing arrange-ments open to small businesses and individuals.

Ref Tax or Credit

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

Tax cap option, as under option 3.

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

Allow states to determine aggregate expenditure targets for hospital and doctor costs and recover overruns through reductions in future price increases.

Federal seed money and technical assistance for small employers, as under option 1.

Allow small firms Medicare rates ...

Pre-empt ....

~~NEW PROGRAM~~: ...

Require all firms to provide health benefits plans OR pay a payroll tax to finance subsidies through the new program.

Health Care Reform Options

Cost Containment	Access
Already underway	
Limit costs from medical liability through procedural or tort reform (DPC developing options.) Develop statistical and other tools to distinguish more efficient from less efficient providers of health care.	Medicaid: - Reconciliation bill requires states to cover all pregnant women and children up to 133% of poverty.
Option 1: No incremental revenue	
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 and technical assistance for health insurance group purchasing by small firms; [pre-empt state laws mandating minimum benefits for these group purchasing arrangements.]
Option 2: Tax code incentives with no immediate revenue effect	
Implement a tax cap on the amount of employer-provided health insurance that is not included in taxable income; set the cap at a level that initially effects a negligible number of people; index the cap to an index that increases more slowly than the historical increase in health insurance costs; effectively phasing in the cap. Provide a favored status for HMOs via a higher cap for HMOs. Use federal programs, as outlined under option 1	Federal seed money, technical assistance, and pre-emption for small employers, as under option 1. Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates.

Option 3: Set tax cap to finance improving access

Tax cap set at a level to generate revenue immediately.
under

to favor MC

Use federal programs, as outlined under option 1.

Federal seed money, technical assistance, and pre-emption for small employers, as

option 1.

Allow small firms to use Medicare payment rates, as under option 2.

NEW PROGRAM: Subsidize purchase of private health plans coverage through group purchasing arrangements open to small businesses and individuals.

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

Tax cap option, as above

Use federal programs, as under option 1.

Allow states to determine aggregate expenditure targets for hospital and doctor costs and recover overruns through reduced increases in amounts paid.

Encouragement of small firms, as above.

Organize group purchasing organizations for small firms and individuals, as under option 3.

Require all firms to provide health benefits plans OR pay a payroll tax to finance subsidies through the new program, outlined under option 3.

Health Care Reform Options

Cost Containment

Access

Already underway

Limit costs from medical liability through procedural or tort reform (DPC developing options.)

Develop statistical and other tools to distinguish more efficient from less efficient providers of health care.

Medicaid:
- Reconciliation bill requires states to cover all pregnant women and children up to 133% of poverty.

OPTIONS FOR ADDITIONAL ACTION:

Option 1: No incremental revenue

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 and technical assistance for health insurance group purchasing by small firms; [pre-empt state laws mandating minimum benefits for these group purchasing arrangements.]

No immediate incre rev; but tax code incentives

Option 2: Start to cap employer-provided health insurance

Implement a tax cap through:

- Including in income all amounts over the cap amount ($300 per family per month, $140 for single coverage leaves 15% of all insured over cap; raises $1.4 billion to start) or,

- HMO preference: Provide a higher cap for HMOs [or limit non-HMO deductibility to 95% of plan cost.]

Use federal programs, as outlined under option 1

Federal seed money, technical assistance, and pre-emption for small employers, as under option 1.

Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates.

or: tax cap that hits virtually no one to start, but one that tends to erode over time if health care ↑ exceeds prices in general. AND move this cap description to option 3

Option 3: Set tax cap to finance improving access

Tax cap

15% hit or
30% hit cap??

Federal seed money, technical assistance, and pre-emption for small employers, as under option 1.

Allow small firms to use Medicare payment rates, as under option 2.

NEW PROGRAM: Subsidize purchase of private health plans coverage through group purchasing arrangements open to small businesses and individuals.

Use federal programs, as outlined under option 1.

Tax cap financing access improvement plus requirement for employer participation

Option 4: ~~Require employer participation in health care~~

Tax cap option, as above

Encouragement of small firms, as above.

Use federal programs, as under option 1.

Organize group purchasing organizations for small firms and individuals, as under option 3.

Allow states to determine aggregate expenditure targets for hospital and doctor costs and recover overruns through reduced increases in amounts paid.

Require all firms to provide health benefits plans to their employees OR pay a payroll tax.

HEALTH CARE REFORM OPTION PACKAGES

Cost Containment | **Access**

Current commitments

Limit costs from medical liability through procedural or tort reform (DPC developing options.)

Fund development of statistical and other tools to distinguish between more efficient and less efficient providers of health care and to target medical care for review of appropriateness.

Medicaid:

- Reconciliation bill requires states to cover all pregnant women and children in families with incomes of up to 133% of the poverty level.

OPTIONS FOR ADDITIONAL ACTION

Option 1: Minimum Additional Cost

Use federal programs to promote managed care:

- Medicare: Allow PPOs 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. paying a fixed, per employee amount

Provide federal seed money and technical assistance for small employer purchasing groups.

Cost Containment	Access
Option 2: Tax code incentives with no immediate revenue effect	
Implement a cap on the amount of employer-provided health insurance that is excluded from taxable income, with few individuals initially over the cap; the cap phases-in gradually by indexing the cap to an index that increases less rapidly than premiums. and/or Provide a favored status for HMOs via a higher cap for HMOs. Use federal programs to promote managed care, as under option 1.	Provide federal seed money for technical assistance for small employer purchasing groups, as under option 1. Allow small firms organized under option 1 to require hospitals and doctors to accept Medicare payment rates. Pre-empt state mandated benefits for health plans purchased through small employer groups.
Option 3: Set tax cap to create immediate revenue effect; revenue finances improving access	
Tax cap set at a level that generates revenue immediately. Use federal programs to promote managed care, as under option 1.	Federal seed money and technical assistance, for small employer purchasing groups, as under option 1. Allow small firms organized under option 1 to require hospitals and doctors to accept Medicare payment rates, as under option 2. Pre-empt state mandated benefits for plans purchased through small employer groups, as under option 2. Use revenue from tax cap to subsidize purchase of private health plan coverage through group purchasing arrangements open both to small businesses and individuals OR Use revenue from tax cap to finance a refundable tax credit for purchase of health plans by low-income persons.

Cost Containment	Access
Option 4: Tax cap financing access improvement plus requirement for employer involvement in health insurance	
Tax cap option, as under option 3.	Federal seed money and technical assistance for small employer purchasing groups, as under option 1.
Use federal programs to promote managed care, as under option 1.	Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates, as under option 2.
Allow states to determine aggregate expenditure targets for hospital and doctor costs and recover overruns through reductions in future price increases.	Pre-empt state mandated benefits for health plans purchased through small employer groups, as under option 2.
	Require all firms to provide health benefits plans OR pay a payroll tax that, with tax cap revenues, would subsidize purchase of health plans for those without employer-provided benefits.

HEALTH CARE REFORM OPTIONS

Cost Containment	Access
Current commitments	
Limit costs from medical liability through procedural or tort reform (DPC developing options.)	Medicaid:
Fund development of statistical and other tools to distinguish tools to distinguish between more efficient and less efficient providers of health care and to target medical care for review of appropriateness.	- Reconciliation bill requires states to cover all pregnant women and children in families with incomes of up to 133% of the poverty level.

OPTIONS FOR ADDITIONAL ACTION

Option 1: Minimum Additional Cost

Use federal programs to promote managed care:

- Medicare: Allow PPOs 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 employer purchasing groups.

Small

Cost Containment	Access
Option 2: Tax code incentives with no immediate revenue effect	
Implement a cap on the amount of employer-provided health insurance that is not included taxable income with few individuals initially over the cap; the cap phases-in gradually by indexing the cap to an index that increases less rapidly than premiums. effectively phasing in the cap; and/or Provide a favored status for HMOs via a higher cap for HMOs. Use federal programs to promote managed care, as under option 1.	Provide federal seed money for technical assistance for ~~small~~ employer group ~~in~~ purchasing, ~~as~~ under option 1. Allow small firms organized under option 1 to require hospitals and doctors to accept Medicare payment rates. Pre-empt state mandated benefits for health plans purchased through small employer groups.
Option 3: Set tax cap to create immediate revenue effect; revenue finances improving access	
Tax cap set at a level that generates revenue immediately. Use federal programs to promote managed care, as under option 1.	Federal seed money and that technical assistance, for small employer groups, as under option 1. purchasing Allow small firms organized under option 1 to require hospitals and doctors to accept Medicare payment rates, as under option 2. Pre-empt state mandated benefits for plans purchased through small as employer groups ~~organized~~ under option 1. Use revenue from tax cap to subsidize purchase of private health plan coverage through group purchasing arrangements open both to small businesses and individuals OR Use revenue from tax cap to finance a refundable tax credit for purchase of health plans by low-income persons.

HEALTH CARE REFORM OPTIONS

Cost Containment | **Access**

Already underway

Limit costs from medical liability through procedural or tort reform (DPC developing options.)

Fund development of statistical and other tools to distinguish tools to distinguish ~~more~~ between efficient ~~from less~~ and efficient providers of health care and to target medical care for review.

Medicaid:

- Reconciliation bill requires states to cover all pregnant women and children in families with incomes of up to 133% of the poverty level.

OPTIONS FOR ADDITIONAL ACTION

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.

Option 2: 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; index 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.

Provide federal seed money for technical assistance for small employer group purchasing, as under option 1.

Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates.

Pre-empt state mandated benefits for plans purchased through small employer group purchasing arrangements.

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

Tax cap set at a level generates revenue immediately.

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

Federal seed money and that technical assistance, for small employer groups purchasing, as under option 1.

Allow small firms organizing under option 1 to require hospitals and doctors to accept Medicare payment rates, as under option 2.

Pre-empt state mandated benefits for plans purchased through small employer group purchasing arrangements, as under option 2.

Use revenue from tax cap to subsidize purchase of private health plan coverage through group purchasing arrangements open both to small businesses and individuals OR

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

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

Tax cap option, as under option 3.

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

Allow states to determine aggregate expenditure targets for hospital and doctor costs and recover overruns through reductions in future price increases.

Federal seed money and technical assistance for small employers, as under option 1.

Allow ~~small firms organizing under option 1~~ to require hospitals and doctors to accept Medicare payment rates, as under option 2.

Pre-empt state mandated benefits for plans purchased through small employer group~~s purchasing arrangements~~, as under option 2.

Require all firms to provide health benefits plans OR pay a payroll tax that, with tax cap revenues, would subsidize purchase of health plans.

HEALTH CARE REFORM OPTIONS

BACKGROUND FACTS

- 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 v. $1130 for the EC and $915 in Japan.

- US health spending is growing at twice the rate of the economy as a whole, and will reach 15% of GNP by the year 2000.
  - 20 cents of every new dollar added to GNP goes to health care.

- Higher spending in the US has not led to comparatively better health outcomes.

- The EC and Japan have universal health plan coverage. In contrast, 31 million Americans do not have health insurance.

COST CONTAINMENT

A. Spending restraint via tax code incentives

1. Tax cap on employees: Treat as employee income health plan contributions by employer above the cap

Full-year revenue effect of taxing contributions above:

per month cost for family/cost for individual coverage; cap indexed to CPI/U
revenue in billions

	$200/$80	% insured over cap	$250/$100	% insured over cap	$350/$140	% insured over cap
1990	6.0	40%	3.5	30%	.6	7%
1991	10.8	47%	6.5	34%	1.4	13%
1992	14.0	52%	8.9	38%	2.4	16%
1993	18.4	58%	12.2	40%	3.9	19%
1994	24.5	60%	16.6	43%	6.2	23%

Treasury estimate; November 1988

2. Tax cap on employers: eliminate deductibility of employer contributions above the cap

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.

3. Link tax treatment to structure of health plan

Provide differential tax treatment to encourage more efficient health plans (e.g., HMOs, which have demonstrated the ability to provide care more efficiently.)

B. Use federal programs to leverage other cost containment reform efforts.

- o Allow private health plans to pay for hospital and physician services using Medicare payment rates.
- o Provide option for state-level all-payor expenditure targets for hospital and physician services.

C. Use federal programs to promote managed care

- o Medicare. New preferred provider organization (PPO) option for beneficiaries. Coordinated open enrollment process for PPOs and HMOs. Lower Medicare Part B premium for beneficiaries selecting HMO coverage.

- o Federal Employees Health Benefits Plan (FEHBP). Move federal employees' health plan from share of plan cost to defined-contribution plan.

D. Fund development of new tools to facilitate prudent purchasing of health care

Private health plans currently have available only a few tools (e.g., pre-admission review) to manage cost and quality. Moreover, these are of limited scope and impact.

Focus of research effort would be to develop methods to permit purchasers of care to identify efficient providers (low cost, high quality) and to identify unnecessary or substandard care. This is a classic public good.

E. Medical liability reform

Use federal health care programs as leverage for tort reform, or pre-empt state law.

- o A "low option" would make procedural reforms without changing basic tort law.

- o A "high option" would make changes in tort law.

ACCESS ENHANCEMENT

A. New program: Fulfilling the President's "Medicaid buy-in" commitment through the private sector

Use revenue generated from tax cap to organize public sponsors; limit eligible population to what can be supported by tax cap revenues. Possibility: children under age 18.

- State agency ("public sponsor") seeks bids from qualified private insurers.
- Public sponsor makes health plans available to low income individuals; premium varies with income.

B. Tax credit for low income persons for purchase of health plans

As with the New Program (see A, above), the credit's fiscal impact could be limited by making the credit available only for children's policies.

C. Expand public programs

- o Expand Medicaid eligibility
- o Medicaid buy-in
- o Direct service delivery (e.g., Community Health Centers)

D. Improve access to health insurance for small employers

Options and incentives include:

- Allow plans insuring small employers to use Medicare rates to pay doctors and hospitals.
- Provide federal seed money and technical assistance for health insurance group purchasing arrangements for small employers.
- Federal legislation to facilitate establishment of state risk pools.

E. Incentives/penalties related to provision of insurance by employers.

- o Mandate health benefits (e.g., Kennedy bill)
- o "Play or pay" system, whereby employers not providing health insurance are subject to a payroll tax to finance vouchers for those without employer-provided health insurance.

11/20

HEALTH CARE REFORM ISSUES & OPTIONS

BACKGROUND FACTS

- 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 v. $1130 for the EC and $915 in Japan.

- US health spending is growing at twice the rate of the economy as a whole, and will reach 15% of GNP by the year 2000.
  - 20 cents of every new dollar added to GNP goes to health care.

- Higher spending in the US has not led to comparatively better health outcomes.

- The EC and Japan have universal health plan coverage. In contrast, 31 million Americans have no health insurance at any time during a year.

COST CONTAINMENT

A. Promote spending restraint via tax code incentives

The tax code excludes employer contributions to health plans from employee income. After the Tax Reform Act of 1986, health plans are the only unlimited fringe benefit.

At the same time, for those without employer provided health plans, the tax code excludes only amounts above 7.5% of income. For those with incomes so low that they have no tax liability, the tax code is irrelevant.

The tax code leads to irony: generous subsidies to higher income persons produces price insensitive individuals who drive up prices that are felt most by people who do not do not have insurance.

Options for reigning in the subsidy include:

1. Tax cap on employees: Treat as employee income health plan contributions by employer above the cap

   Setting the cap at twice the cost of the average health plan would increase revenue by $.6 billion in the first full year and $3.9 billion in the fourth year.

   Setting the cap at one and a half times the average cap would increase revenue by $3.5 billion in the first full year and $12.2 billion in the fourth year.

2. Tax cap on employers: eliminate deductibility of employer contributions above the cap

   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.

3. Link tax treatment to structure of health plan

   Provide differential tax treatment to encourage more efficient health plans (e.g., HMOs, which have demonstrated the ability to provide care more efficiently.)

B. Use federal programs to leverage other cost containment reform efforts.

- o Allow private health plans to pay for hospital and physician services using Medicare payment rates. to accept as payment in full for certain plans
- o Provide option for state-level all-payor expenditure targets for hospital and physician services.

C. Use federal programs to promote managed care

- Medicare. Allow preferred provider organizations (PPOs) serving the private market to enroll Medicare beneficiaries. Coordinated open enrollment process for PPOs and HMOs. Lower Medicare Part B premium for beneficiaries selecting HMO coverage.

- Federal Employees Health Benefits Plan (FEHBP). Change calculation of the federal government's payment from share of plan cost to defined-contribution amount.

ACCESS ENHANCEMENT

A. Establish New program: Subsidized purchase of private health plan coverage.

Use revenue generated from tax cap to organize new entities called "public sponsors": limit eligible population to what can be supported by tax cap revenues. Possibility: children under age 18.

- State agency ("public sponsor") seeks bids from qualified private health plans.
- Public sponsor makes health plans available to low income individuals; premium varies with to income.
- New program seeks to accomplish same goal as "Medicaid buy-in": coverage for poor and near poor who are not now Medicaid-eligible.

B. Allow tax credit for low income persons for purchase of health plans

As with the New Program (see A, above), the credit's fiscal impact could be limited by making the credit available only for children's policies.

C. Expand public programs

- o Medicaid eligibility expansion
- o Medicaid "buy-in"
- o Direct service delivery (e.g., Community Health Centers)

D. Improve access to health insurance for small employers

Deals with problem of lack of insurance for employees of small times, and their families.

- Allow plans insuring small employers to use Medicare rates to pay doctors and hospitals.
- Provide federal seed money and technical assistance for health insurance group purchasing arrangements for small employers.
- Pre-empt state mandated benefit laws for insurance purchased through multi-employer trusts.

E. Create incentives/penalties related to provision of insurance by employers.

Deals further with problem of uninsured members and families.

- o Mandate health benefits (e.g., Kennedy bill)

- 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 OPTIONS

BACKGROUND FACTS

- 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 v. $1130 for the EC and $915 in Japan.

- US health spending is growing at twice the rate of the economy as a whole, and will reach 15% of GNP by the year 2000.
  - 20 cents of every new dollar added to GNP goes to health care.

- Higher spending in the US has not led to comparatively better health outcomes.

- The EC and Japan have universal health plan coverage. In contrast, 31 million Americans do not have health insurance.

31 - not covered - for year

COST CONTAINMENT

A. Spending restraint via tax code incentives

1. Tax cap on employees: Treat as employee income health plan contributions by employer above the cap

Full-year revenue effect of taxing contributions above:

per month cost for family/cost for individual coverage; cap indexed to CPI/U
revenue in billions

	$200/$80	% insured over cap	$250/$100	% insured over cap	$350/$140	% insured over cap
1990	6.0	40%	3.5	30%	.6	7%
1991	10.8	47%	6.5	34%	1.4	13%
1992	14.0	52%	8.9	38%	2.4	16%
1993	18.4	58%	12.2	40%	3.9	19%
1994	24.5	60%	16.6	43%	6.2	23%

Treasury estimate; November 1988

2. Tax cap on employers: eliminate deductibility of employer contributions above the cap

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.

3. Link tax treatment to structure of health plan

Provide differential tax treatment to encourage more efficient health plans (e.g., HMOs, which have demonstrated the ability to provide care more efficiently.)

B. Use federal programs to leverage other cost containment reform efforts.

- Allow private health plans to pay for hospital and physician services using Medicare payment rates.
- Provide option for state-level all-payor expenditure targets for hospital and physician services.

C. Use federal programs to promote managed care

- o Medicare. New preferred provider organization (PPO) option for beneficiaries. Coordinated open enrollment process for PPOs and HMOs. Lower Medicare Part B premium for beneficiaries selecting HMO coverage.

- o Federal Employees Health Benefits Plan (FEHBP). Move federal employees' health plan from share of plan cost to defined-contribution plan.

D. Fund development of new tools to facilitate prudent purchasing of health care

Private health plans currently have available only a few tools (e.g., pre-admission review) to manage cost and quality. Moreover, these are of limited scope and impact.

Focus of research effort would be to develop methods to permit purchasers of care to identify efficient providers (low cost, high quality) and to identify unnecessary or substandard care. This is a classic public good.

E. Medical liability reform

Use federal health care programs as leverage for tort reform, or pre-empt state law.

- o A "low option" would make procedural reforms without changing basic tort law.

- o A "high option" would make changes in tort law.

ACCESS ENHANCEMENT

A. New program: Fulfilling the President's "Medicaid buy-in" commitment through the private sector

Use revenue generated from tax cap to organize public sponsors; limit eligible population to what can be supported by tax cap revenues. Possibility: children under age 18.

- State agency ("public sponsor") seeks bids from qualified private insurers.
- Public sponsor makes health plans available to low income individuals; premium varies with income.

B. Tax credit for low income persons for purchase of health plans

As with the New Program (see A, above), the credit's fiscal impact could be limited by making the credit available only for children's policies.

C. Expand public programs

- o Expand Medicaid eligibility
- o Medicaid buy-in
- o Direct service delivery (e.g., Community Health Centers)

D. Improve access to health insurance for small employers

Options and incentives include:

- Allow plans insuring small employers to use Medicare rates to pay doctors and hospitals.
- Provide federal seed money and technical assistance for health insurance group purchasing arrangements for small employers.
- Federal legislation to facilitate establishment of state risk pools.

E. Incentives/penalties related to provision of insurance by employers.

- o Mandate health benefits (e.g., Kennedy bill)
- o "Play or pay" system, whereby employers not providing health insurance are subject to a payroll tax to finance vouchers for those without employer-provided health insurance.

Options Packages

1. a. Use fed prog to promote managed care
   - Medicare – PPO/HMO
   - FEHBP – defined contribution

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

2. a. Tax cap – at level that does not immediately generate substantial revenue

   b. or More favorable tax treatment for HMOs

   c. Use fed prog to promote managed care

   d. Allow certain private health plans to pay Medicare rates –

   e. Allow small firms access to Medicare rates

   e Fed seed money & tech assistance

   f. pre-empt state mandated benefit laws to allow for less costly plans

3. a. Tax cap – at level that does raise substantial revenue

b. Use fed prog to promote managed care

c. Allow small firms plans to pay Medicare rates

d. Fed seed money & tech assist

e. Pre-empt state mandated benefit laws to allow for less costly plans

f. Establish new program: Subsidize purchase of private health plan coverage; using revenue generated by tax cap.

4. a. Tax cap – at level that raises even more revenue

b. Use fed prog to promote managed care

c. Allow small firm plans to pay med rates

d. Fed seed money & tech assist

e. Provide an option for States – ETs –

f. New program: Subsidize plans

g. mandate health benefits or "play or pay" system

12.1 Darman, Dickerscheid, Porter, Rogers, Kuttner, Ken Gideon (Treas)
Kleinberg, Lieberman, Huber, Bandeian, Glandemans, Holen, Schrieber

Dan EXPOP – politically would it sell? Usually option is what can be done as minimum

Gideon Cap is "slow drift down"

Darman Could they phase – à la catastrophic – ↑ limit up + later start for outgo than income?

Holen Sure.

Darman Is there an option – just TAX?
Put in Kleinberg's option.
- state UC typ
- umbrella
- state can use it (or lose it)

Gideon Medicare payment rates PLUS limited liability coverage

Darman Mandated benefits
[terminology → better to use "require many benefits."]
Prefers not to require
↳ OPT OUT from ~~mandated~~ required benefits
less required by State law.
What not allow opt out under this plan?
Debate: Need for subsidy – EXPLICIT – cash
IMPLICIT – hospital ~~rates~~ taxes less
Add: Encourage State to have uncomp care reform plans
[- call ~~SBA~~
→ survey of small businesses + health care – employer role]
Don't understand market imperfections well enough to understand why they don't get more favorable rate
Pvt: educating what is going wrong. Do what we can to help fix information gap – low cost / high return.
Vouchers unable in pools.

Rick not covered – because of profit ▷ don't want to

Do you need option 4?
▷ Dann - ~~Ko~~ Not c̄ pervasive voucher.

Nat'l Health Ins - OK as long as it has internal consistency.

Pay or play - worse than nationalizing
< Not sure it makes sense to have state by state caps

ETs - note that current law allows for hospitals.

Selfridge - world is less and less self and family coverage - market is much more complex than this

Dar My aspiration - acquaint him c̄ issues/options at budget time - pointed in a direction we're comfortable c̄
- Can't escape saying something about this.

Medicare incentives don't deal c̄
- 31 million problem
- LTC problem.

No problem c̄ getting Treasury report out.

WK Jan - 1. nothing til next yr.
2. we're studying - "stay tuned"

RJD Pref for HMOs
.. OK - pt in paper is OK

Build mix and match
— Make minimalist one that we can do.

Describe one as plus: Voucher + tax cap + pref for HMOs + pool mechanisms