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001. memo	To Pam Cicetti from Jonathan P. Gill re: Campaign Technology Strategy (1 page)	05/04/95	Personal Misfile

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2013-0359-S
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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

cc Melanne –
We need to do
R to this ASAP
On my desk

PHOTOCOPY
HRC HANDWRITING

Health Insurance for A

By Elizabeth McCaughey

Health insurance is a kitchen table topic. People without insurance are scared that one serious illness could wipe out their savings and even their homes. Families with insurance see premiums getting unaffordable but also worry that the Clinton bill would mean rationing, restricted choices and red tape.

Here is a proposal to offer health insurance to all families who want it no matter how little they can pay. It would not add a single dollar to the federal budget. So far none of the health bills in Congress does everything proposed here:

Affordable Insurance

The first step toward universal coverage is to enable people to buy affordable, no-frills policies to cover only the devastating bills that mount up if they become seriously ill. In many states, this is not possible. Legislators have pushed the price of individual and small-group policies out of reach of low- and middle-income workers by requiring that policies include costly benefits such as treatment for drug abuse (19 states) and alcoholism (29 states), and the services of chiropractors (45 states), acupuncturists (three states), naturopaths (two states), and even, in Minnesota, marriage counseling and hairpieces.

The 1980s—the first decade ever to see an increase in the percentage of the population that is uninsured—was also the decade in which state lawmakers doubled the number of benefits that customers are compelled to buy, whether or not they want them and can afford them. Many cannot.

Individuals buying their own policies have been hit hardest. In the '80s, the number of people insured under individual policies plunged to 29 million from 41 million. The cause was rising premiums.

Keeping insurance affordable is key. Almost all uninsured adults are either between jobs or working at low-wage jobs. Three-quarters are covered again within a year, usually through work. What they need in the meantime is low-cost protection, not a gold-plated policy loaded with extras they can't afford.

Even for those who can afford a gold-plated policy, less insurance is better. A no-frills, high-deductible policy encourages people to avoid needless duplication of tests and other waste. People used to pay out of pocket for half of their medical expenses; now they pay for less than a quarter that way.

Paying out of pocket also saves money by eliminating the administrative costs of insurance. When you prepay an insurance company for routine medical care, you are paying what the doctor's fee will be plus what it will cost the insurer to process your claim, a cost that can add 30% to a small medical bill. Paying your doctor directly for routine services reduces costs without any reduction in quality.

The Clinton bill would make everyone buy a government-designed "benefits package" loaded with requirements. Many states have made that mistake; national health reform should not repeat it.

Fair Pricing

Fair pricing is also key. Almost half of uninsured adults are under 30. The average 25-year-old man needs about $560 of health care a year; the average 55-year-old man needs $2,345. Young people should be charged low premiums that reflect their generally low medical needs.

That doesn't mean that middle-aged people without the means to pay higher premiums should be left to sink or swim. But providing targeted subsidies for people who cannot afford their premiums is far preferable to artificially lowering the premiums of all middle-aged people by compelling the young to pay more—a system called "community rating" or one-price-for-all insurance. When you charge young and old the same rate, the young see that insurance is a bad buy and opt out.

The failure of community pricing is obvious in New York state. Last April, lawmakers required insurers to adopt community pricing for all individual and small-group policies. In the next 10 months, community pricing pushed up the average premium for a 30-year-old man 81%; group rates for small businesses with relatively young workers shot up 113%. A two-adult family in New York City now pays, on average, $84 a month more for health coverage. The community pricing law has failed to produce any increase in the number of insured New Yorkers. Instead, it has made insurance less affordable for young and low-income workers.

The Clinton bill would make the whole country adopt community pricing. Most of the other health bills in Congress allow insurers to vary premiums by age (t not by medical history), chargin young less.

Help for Low Earners

The way to make insurance univers affordable is to offer a federal subsidy people who don't have the money to p premiums. The Congressional Budget C fice reports that it is possible to provic such a subsidy, without adding a singl dollar to the federal budget, by convertin the present tax exclusion for employer-provided health benefits into a refundable tax credit targeted to families and individuals least able to afford coverage on their own. The CBO says that in contrast to this revenue-neutral approach, the Clinton bill would increase the federal deficit by $70 billion during the first six years.

The first step toward universal coverage is to enable people to buy affordable, no-frills policies to cover only the bills that mount up if they become seriously ill.

If you get your health coverage through your job, you currently don't pay income tax or Social Security tax on the value of that policy. On the other hand, if you go out and buy your own insurance, you pay for it with after-tax earnings. This is unfair: Some people get insurance with pre-tax dollars, which makes insurance seem cheap; others must pay taxes on all their compensation and then buy insurance with after-tax dollars. If employees were required to pay tax on the health policies they earn at work, federal tax revenues would increase by $74 billion.

That $74 billion is enough to provide subsidies to people who need help buying coverage. Imagine that to qualify for a tax credit, you must staple proof of insurance to your April 15 filing. You would be eligible whether you got your coverage at work or bought it on your own. In general, the amount of your subsidy would be based on your household income, not on how much your policy costs. The type of policy would be your choice. For people who owe taxes, the subsidy would be a reduction (credit) against their tax liability. Low-income earners would get a check from the government.

It would be possible, the CBO concludes, to provide the poorest working families with a 100% subsidy for their health insurance costs—up to $1,775 for an individual, $3,750 for a head of household, and $4,425 for a family with two working adults. That's enough for a no-frills, serious-illness policy.

Under the CBO model, the family with income between $20,000 and $29,999 would pay an average of $410 less after the changes, while a family earning between $40,000 and $49,999 would pay about $180 more. The tax burden would be shifted somewhat to the highest income groups, because the tax exclusion was worth the most to them and they are not eligible for the credit. But even high-income families generally would be hit with a smaller increase under the CBO model than under the Clinton scheme, which would impose steep mandatory "premiums" to cover the health care costs of the poor and probably other taxes to offset predicted deficits.

The CBO model—replacing the tax exclusion with a tax credit—would also encourage employees with coverage at work to insist on reasonably priced insurance. If every dollar of health benefits means a dollar less of cash wages, some employees will want to swap their gold-plated plans for no-frills, high-deductible insurance and higher take-home pay. Millions "would suddenly wake up to the real cost of health insurance," says health policy expert Grace Marie Arnett.

Fortunately, the tax change would have no impact on what it costs a business to employ workers, because both cash wages and health benefits would continue to be deductible expenses for employers. Unlike President Clinton's bill, which the Employment Policies Institute estimates would destroy 780,000 to 870,000 mostly low-wage jobs, the proposal made here would cost no jobs.

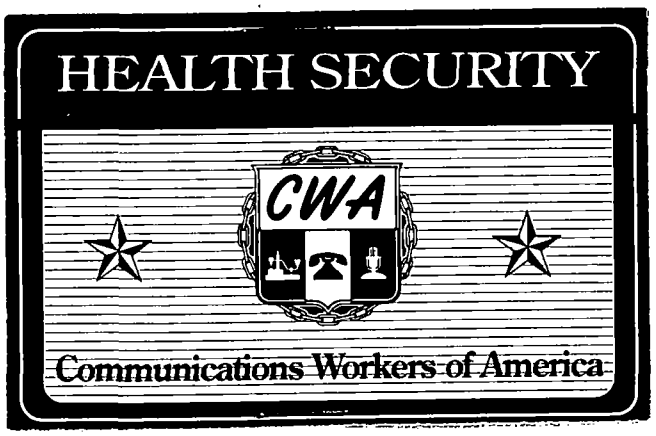
Tort Reform

This three-point proposal achieves an important goal: health insurance for anyone who wants it regardless of ability to pay. Families will not have to risk losing their homes and savings because they cannot afford steep premiums.

The health bill Congress passes also should include tort reform so that doctors no longer will be forced to practice wasteful, defensive medicine; and insurance reform so that people can change insurers without losing protection for their pre-existing conditions. But the defining principle of Congress's 1994 health bill should be affordable insurance for those who want it, with subsidies for families who need help paying for it.

Ms. McCaughey is a fellow at the Manhattan Institute.

THE WALL STREET JOURNAL, THURSDAY, APRIL 28, 1994

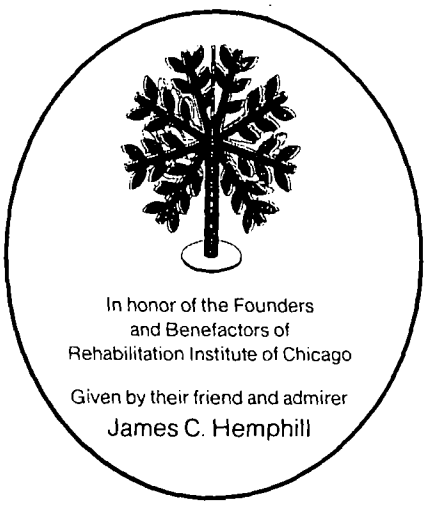


HOW REFORM WORKS

- Universal coverage by a date certain
- All employers must contribute their fair share
- Comprehensive benefits
- Affordable for all
- Real cost controls
- High quality care
- State single payer option

Pam
Put on my desk

THE NINTH ANNUAL



James C. HEMPHILL LECTURE

October 16, 1990

Newton Minow -
Lamy Wells

THE POLICY PROCESS

ADMINISTRATION POLICY STAFF HAVE BEEN MEETING WITH STAFF AND SOME MEMBERS FROM ALL FIVE MAJOR COMMITTEES AND THE LEADERSHIP IN BOTH HOUSES TO RESPOND TO REQUESTS ABOUT MODIFICATIONS IN THE HEALTH SECURITY ACT.

SO FAR, THEY ARE RESPONSIVE TO OUR ADVICE AND THE MODIFICATIONS THEY ARE CONSIDERING ARE WELL WITHIN OUR END GAME SCENARIOS.

THERE ARE FOUR AREAS OF MAJOR FOCUS:

- FINANCING
- THE ALLIANCES
- PREMIUM CAPS
- THE EMPLOYER/EMPLOYEE MANDATE

END GAME - SCENARIO I

IF WE CAN SUSTAIN THE PUBLIC DEBATE, AND NEGOTIATE WELL, UNDER THE MOST OPTIMISTIC SCENARIO, WE WILL WIND UP WITH THE FOLLOWING TYPE OF COMPROMISE:

- UNIVERSAL COVERAGE PASSED IN THIS BILL ON QUR TIMETABLE WITH AN EMPLOYER/INDIVIDUAL MANDATE AND LARGER SUBSIDIES OR A SLOWER PHASE-IN FOR SMALLER COMPANIES.

- PREMIUM CAPS WHICH ARE SOMEWHAT LESS RIGID THAN THE ONES WE PROPOSE.

- HEALTH ALLIANCES FOR COMPANIES OF 500-1,000 OR UNDER (WHERE THE ONE PERCENT ASSESSMENT GAINED FROM ADDITIONAL CORPORATE ALLIANCES WOULD PAY FOR THE EXTRA SMALL FIRM SUBSIDIES).

- SMALLER MEDICARE AND MEDICAID SAVINGS.

- A SLOWER PHASE-IN OF LONG-TERM CARE AND THE PRESCRIPTION DRUG BENEFIT TO COMPENSATE FOR THE LOWER MEDICARE AND MEDICAID SAVINGS AND A TIE-IN BETWEEN THE SAVINGS AND THE SPENDING ON THESE PROGRAMS.

- A FEW HUNDRED MINOR MODIFICATIONS.

END GAME - SCENARIO II

IF WE ARE ONLY MARGINALLY SUCCESSFUL IN THE PUBLIC DEBATE AND SECURE A LESSER BILL WHICH STILL FULFILLS THE PRESIDENT'S PRINCIPLES, IT MIGHT LOOK LIKE THE FOLLOWING:

- UNIVERSAL COVERAGE ON A SLOWER TIMETABLE -- BY 2000, WITH AN EMPLOYER AND INDIVIDUAL MANDATE WITH THE EMPLOYER SHARE REDUCED (WORST CASE, AS LOW AS 50 PERCENT), POSSIBLY LIMITED TO THE LOW COST INSTEAD OF THE AVERAGE COST PLAN, POSSIBLY WITH A SLOWER PHASING-IN OF THE FULL BENEFITS OR WITH ENHANCED SMALL COMPANY DISCOUNTS.

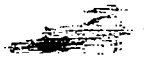
- LESS STRINGENT PREMIUM CAPS WHICH TRIGGER IF COMPETITION DOES NOT PRODUCE A CERTAIN LEVEL OF SAVINGS BY A CERTAIN TIME.

- A SLIMMED DOWN LONG-TERM CARE PACKAGE WHICH PHASES IN MUCH SLOWER AND A MORE SLOWLY PHASED-IN PRESCRIPTION DRUG BENEFIT, AND A TIE-IN BETWEEN THE SAVINGS AND THE SPENDING ON THESE PROGRAMS.

- LOWER MEDICARE AND MEDICAID CUTS.

- A SMALLER TOBACCO TAX.

END GAME - SCENARIO II (CONTINUED)



- SMALL ALLIANCES -- 100 OR UNDER, POSSIBLY VOLUNTARY, WITH STATES ALLOWED TO GO HIGHER AND A NATIONAL RISK POOL TO REINSURE CASES ABOVE $25 OR $50 THOUSAND PER YEAR.

- REDUCTION OF THE ONE PERCENT CORPORATE ASSESSMENT.

- A FEW HUNDRED MINOR MODIFICATIONS.

FINANCING
CBO DEFICIT ESTIMATES

CBO ESTIMATES OF TOTAL NATIONAL HEALTH SPENDING UNDER THE HEALTH SECURITY ACT ARE VERY SIMILAR TO OURS.

THEY BELIEVE, HOWEVER, THAT STATE AND LOCAL GOVERNMENT AND BUSINESSES WILL SAVE MORE AND THE FEDERAL GOVERNMENT WILL SPEND MORE THAN WE PROJECTED.

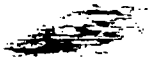
THE FOLLOWING CHART SHOWS CHANGES IN THE HEALTH SECURITY ACT WHICH ARE EASILY MADE, WHICH HAVE SUPPORT AMONG FRIENDLY COMMITTEE AND LEADERSHIP STAFF AND WHICH RESTORE SIGNIFICANT DEFICIT REDUCTION TO THE ACT.

POTENTIAL SAVINGS FROM THE HEALTH SECURITY ACT

	5 YEAR DEFICIT	10 YEAR DEFICIT
CBO scoring of HSA	74	126
Lowering alliance size* (community rating pool) to 1,000; provide subsidies to all firms; assess those above 1,000 at 1%	-30	-70
Targeting employer subsidies to low-wage individuals with a 12% cap	-52	-164
Increase cost sharing in benefits package	-29	-78
Phase-in long-term care more slowly	-31	-43
Total savings from HSA	-142	-355
Deficit reduction	-68	-233

*Approximate

STATE & LOCAL GOVERNMENT SAVINGS



UNDER THE CBO SCORING OF THE HEALTH SECURITY ACT, STATE & LOCAL GOVERNMENTS REALIZE DRAMATIC SAVINGS ON HEALTH CARE EXPENDITURES.

CONGRESSIONAL COMMITTEES ARE LIKELY TO TRY TO CAPTURE SOME OF THOSE SAVINGS FOR THE FEDERAL DEFICIT AS WELL.

THE SAVINGS COME MAINLY THROUGH LESS SPENDING FOR GOVERNMENT RUN HOSPITALS, CLINICS AND HEALTH PROGRAMS ONCE UNIVERSAL COVERAGE AND THE MEDICARE PRESCRIPTION DRUG BENEFIT ARE ACHIEVED.

POTENTIAL ADDED COSTS TO THE HEALTH SECURITY ACT

INCREASED SUBSIDIES FOR SMALL BUSINESSES OR A SMALL BUSINESS CARVE OUT OR SLOWER PHASE-IN OF PAYMENTS BY SMALL BUSINESSES

INCREASE ACADEMIC HEALTH CENTER SET ASIDES

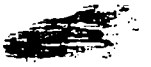
LOWER MEDICARE CUTS

TOBACCO TAX DEAL

CHRONIC CARE CHILDREN BENEFITS

LOOSENING OF GROWTH RATES UNDER PREMIUM CAPS

ENDING DISCRIMINATION
AND ENHANCING CONSUMER CHOICE



TODAY, PEOPLE PAY WILDLY DIFFERENT AMOUNTS FOR THE SAME INSURANCE COVERAGE BASED ON HEALTH STATUS, GENDER, AGE, WHETHER THEY WORK FOR A SMALL OR LARGE COMPANY OR ARE SELF EMPLOYED, WHETHER A CO-WORKER HAS A SERIOUS ILLNESS, ETC.

HEALTH INSURANCE COMPANIES COMPETE PRIMARILY BY TRYING TO INSURE ONLY PEOPLE WHO ARE LIKELY TO STAY HEALTHY AND THEREFORE, NOT NEED SERVICES.

INCREASINGLY, INSURERS MARKET TO COMPANIES WHO "LOCK" THEIR EMPLOYEES INTO ONE HEALTH PLAN. THE INSURERS SAVE MONEY BY SHAVING BENEFITS, INSTITUTING TIGHT UTILIZATION REVIEWS, CONTRACTING WITH LOWER COST PROVIDERS, ETC.

CONSUMERS HAVE NO CHOICE.

ENDING DISCRIMINATION AND ENHANCING CONSUMER CHOICE

THE HEALTH SECURITY ACT ADDRESSES THESE PROBLEMS IN THE FOLLOWING WAYS:

- CREATES ONE PRICE FOR ALL CONSUMERS IN THE ALLIANCE, REGARDLESS OF HEALTH STATUS AND OTHER DEMOGRAPHICS

- ALLOWS CONSUMERS A WIDE CHOICE OF HEALTH PLANS, EVEN IF THEY WORK FOR SMALL COMPANIES OR ARE UNEMPLOYED

- PROVIDES INFORMATION TO CONSUMERS AND ENSURE FAIR MARKETING BY HEALTH PLANS

- STREAMLINES ADMINISTRATION OF ENROLLMENTS, FUNDS FLOW AND SUBSIDIES

- BLENDS PREMIUMS TO FACILITATE RISK ADJUSTMENT AND REINSURANCE.

IN THE HEALTH SECURITY ACT, MANDATORY ALLIANCES PERFORM THESE FUNCTIONS.

ENDING DISCRIMINATION AND ENHANCING CONSUMER CHOICE

THESE GOALS CAN BE ACHIEVED THROUGH OTHER MECHANISMS SUCH AS VOLUNTARY ALLIANCES, BUT WILL REQUIRE ADDED REGULATION:

- FAIR MARKETING RULES AND OVERSIGHT ENFORCED BY STATE INSURANCE DEPARTMENT
- ENFORCEMENT OF COMMON PRICE BY STATE INSURANCE DEPARTMENT
- PUBLIC POINT OF ENROLLMENT PROVIDED BY STATE AUTHORITY WHICH GIVES INFORMATION TO CONSUMERS
- CLEARINGHOUSE FOR COLLECTIONS CREATED BY STATE OR INSURANCE CONSORTIUM
- SUBSIDY ADMINISTRATION BY STATES OR HHS OR IRS
- RISK ADJUSTMENT AND REINSURANCE MECHANISMS CARRIED OUT BY A CONSORTIUM OF INSURERS
- SOLVENCY REGULATION BY STATES OR TREASURY
- RULES TO ENSURE CONSUMER CHOICE ENFORCED BY STATE INSURANCE DEPARTMENTS OR HHS

FINANCING LEVERS
COST CONTAINMENT

THE HEALTH SECURITY ACT HAS TWO IMPORTANT COST CONTAINMENT GOALS:

- TO CAPTURE WINDFALL SAVINGS FROM HEALTH REFORM FOR CONSUMERS AND BUSINESSES RATHER THAN ALLOWING A HEALTH INDUSTRY BONANZA.

- TO SLOW THE RATE OF GROWTH OF HEALTH CARE COSTS LONG TERM.

FINANCING LEVERS

CAPTURING THE WINDFALL FROM HEALTH REFORM FOR CONSUMERS AND BUSINESSES

PROVIDING UNIVERSAL COVERAGE TO ALL AMERICANS AND INTEGRATING MEDICAID BENEFICIARIES INTO THE PRIVATE HEALTH CARE SYSTEM COULD RESULT IN A HUGE WINDFALL TO HEALTH CARE INSURERS AND PROVIDERS AT THE EXPENSE OF CONSUMERS AND BUSINESSES.

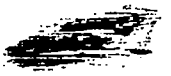
TODAY, WHEN UNINSURED PEOPLE USE THE HEALTH CARE SYSTEM, THEY PAY ONLY 21% OF THEIR HEALTH CARE COSTS. THE REST OF THEIR COST IS SHIFTED TO THOSE WITH PRIVATE INSURANCE, SOME $25 BILLION PER YEAR, OR 8% OF TOTAL PRIVATE PREMIUMS.

TODAY, MEDICAID PAYS, ON AVERAGE, 17.8% LESS FOR HEALTH CARE SERVICES THAN PRIVATE PAYERS. THE FULL COST OF THEIR SERVICES IS SHIFTED TO PRIVATE PAYERS.

UNDER REFORM, ALL AMERICANS WILL HAVE PRIVATE INSURANCE AND MEDICAID WILL BE FOLDED INTO THE PRIVATE HEALTH CARE SYSTEM. THE HEALTH INDUSTRY COULD REALIZE FULL PAYMENT FOR EVERYONE.

WILL THEY PASS THESE EXTRA PAYMENTS ON TO PRIVATE CONSUMERS AND BUSINESSES WHO HAVE BEEN OVERPAYING OR WILL THEY KEEP THE EXTRA PAYMENTS AS WINDFALL PROFITS?

FINANCING LEVERS
COST CONTAINMENT
CAPTURING WINDFALL PROFITS



THE HEALTH SECURITY ACT DOES NOT RELY ON THE LARGESS OF HEALTH INSURERS AND PROVIDERS TO PASS SAVINGS BACK TO CONSUMERS AND BUSINESSES.

THE HSA BUILDS THESE SAVINGS INTO THE BASELINE PREMIUM AND GUARANTEES THAT THEY WILL OCCUR BY CAPPING THAT BASELINE PREMIUM.

- THE SAVINGS FROM THE UNINSURED NOW ABLE TO PAY THEIR BILLS (UNCOMPENSATED CARE SAVINGS) ARE SHIFTED BACK TO PRIVATE PREMIUMS.

- THE MEDICAID PAYMENT SAVINGS ARE USED TO FUND THE FEDERAL SUBSIDY POOL FOR LOW-INCOME PEOPLE AND SMALL BUSINESSES.

THESE CONSTRAINTS PREVENT WINDFALLS FROM BEING TAKEN BY INSURERS AND PROVIDERS AND INSTEAD GIVE THE BENEFITS TO CONSUMERS AND BUSINESSES.

COMPETITION ALONE MIGHT PREVENT THE HEALTH INDUSTRY FROM TAKING THIS ENTIRE WINDFALL, BUT IF COMPETITION DOES NOT WORK FULLY OR IN A TIMELY ENOUGH FASHION, THE CONSEQUENCES COULD BE SEVERE.

FINANCING LEVERS
COST CONTAINMENT
CAPTURING WINDFALL PROFITS

IF ALL OF THE WINDFALL WENT TO THE HEALTH INDUSTRY INSTEAD OF TO CONSUMERS AND BUSINESSES, THE COST OF HEALTH REFORM WOULD RISE DRAMATICALLY. PREMIUMS FOR BUSINESSES AND HOUSEHOLDS WOULD RISE AS WOULD GOVERNMENT SUBSIDIES.

INCREASED COST RELATIVE TO HSA

$ BILLIONS

	All uncompensated care savings and increased payments for uninsured go to health industry	All Medicaid cost increases go to health industry	TOTAL
	5-YEAR	5-YEAR	5-YEAR
Government Spending	79	120	213
Household Spending	51	78	132
Business Spending	75	114	199
TOTAL	205	312	544

FINANCING LEVERS

THE DYNAMIC IN THE PREMIUM CAPS

THE COMPETITIVE FORCES AND PREMIUM CAPS IN THE HEALTH SECURITY ACT REDUCE THE RATE OF HEALTH CARE SPENDING GROWTH FROM 8.5% TO 7.7% DURING THE NEXT FIVE YEARS WHILE PROVIDING COMPREHENSIVE BENEFITS TO ALL AMERICANS.

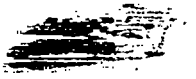
SOME HAVE ARGUED FOR ELIMINATING OR LOOSENING CONSTRAINTS, RELYING MORE HEAVILY ON MARKET FORCES TO CONTROL THE RATE OF INCREASE.

ONCE THE BASELINE IS SET, PROPOSALS TO LOOSEN THE GROWTH RATES SET IN THE HEALTH SECURITY ACT HAVE THE FOLLOWING EFFECTS ON FEDERAL COSTS.

RAISING PREMIUM CAP
COST RELATIVE TO HSA
$ BILLIONS

	5-YEAR COST	10-YEAR COST
Constrained premium, HSA growth plus 1% every year	27	NA
Constrained premium, HSA growth plus 1% in 1999 and 2000	6	NA

GUARANTEED PRIVATE INSURANCE
CONGRESSIONAL MODIFICATIONS UNDER DISCUSSION



THE FOLLOWING MODIFICATIONS TO THE EMPLOYER/INDIVIDUAL MANDATE ARE UNDER DISCUSSION IN CONGRESS.

- KEEPING 80/20 MANDATE BUT PHASING IN SMALL BUSINESS MORE GRADUALLY, STARTING WITH 50/50 AND MOVING TO 80/20.

- KEEPING HSA STRUCTURE BUT TAKING SMALL BUSINESS DOWN TO A 1 OR 2% OF PAYROLL CAP INSTEAD OF 3.5%.

- LOWERING THE 80/20, PERHAPS ULTIMATELY TO 50/50.

- EXEMPTING FIRMS BELOW 10 FROM THE EMPLOYER MANDATE BUT ASSESSING A SMALL PAYROLL TAX FOR THOSE FIRMS WHO DO NOT PROVIDE INSURANCE.

- ESTABLISHING A SMALL FIRM CARVE OUT AT 10 OR POSSIBLY 25 EMPLOYEES.

ALL OF THESE ARE DOABLE, FROM A POLICY POINT OF VIEW, BUT THE "CARVE OUT" IS EXPENSIVE. AT 10 OR UNDER WITH THE ALTERNATE PAYROLL TAX AS IN THE ENERGY & COMMERCE DRAFT, THE POLICY IS OKAY.

IF THE CARVE OUT GETS TOO MUCH BIGGER, IT BECOMES PROBLEMATIC.

EMPLOYER PAYMENTS AS A PERCENT OF TOTAL PREMIUMS AFTER DISCOUNTS IN THE HEALTH SECURITY ACT

UNDER THE HEALTH SECURITY ACT, FIRMS PAY ON AVERAGE, 67% OF PREMIUMS.

FIRM SIZE & TYPE	FIRMS THAT DO NOT CURRENTLY INSURE (%)	ALL FIRMS (%)
AVERAGE SALARY		
<25-<12K	13	
12-15K	20	
15-18K	29	
18-21K	41	
21-24K	53	
>24K	60	
25-99	53	62
100-1,000	63	71
1,000-5,000	72	79
AVERAGE	48	67

NUMBER OF FIRMS, WORKERS AND SIZE OF PAYROLL BY FIRM SIZE

%

	<10	<100	<500	>500
ALL FIRMS	78	98	99.7	0.3
ALL EMPLOYEES	12	39	54	46
ALL PAYROLL	11	35	48	52

FINANCING LEVERS

THE STRUCTURE OF THE EMPLOYER RESPONSIBILITY

ELIMINATING EMPLOYER REQUIREMENT

ELIMINATING THE EMPLOYER REQUIREMENT FOR THE SMALLEST BUSINESSES:

- INCREASES PREMIUMS FOR LARGER EMPLOYERS AS THEY NOW ASSUME THE FULL COST OF INSURANCE FOR FAMILIES WITH A WORKER IN EXEMPT FIRMS.

- INCREASES OVERALL SUBSIDY REQUIREMENTS IF INDIVIDUALS IN EXEMPT FIRMS ARE HELD TO THE 3.9% INCOME PROTECTION AS IN THE HEALTH SECURITY ACT.

- INCREASES THE RISK ALREADY PRESENT IN THE HEALTH SECURITY ACT FOR LARGE FIRMS TO BENEFIT FROM THE EXEMPTION BY OUTSOURCING.

- INCREASES THE ADMINISTRATIVE BURDENS.

- CREATES A CLIFF EFFECT ON HIRING DECISIONS.

THE EASY DEALS

WHAT COULD GO WRONG?

1. PHONY UNIVERSAL COVERAGE -- ACCESS WHICH IS UNAFFORDABLE OR WHICH IS CONTINGENT IS NOT UNIVERSAL COVERAGE.

2. TRIGGER WHICH DOESN'T CAPTURE WINDFALL -- ENHANCED COVERAGE AND BENEFITS WITHOUT SUFFICIENT COST CONTAINMENT COULD BUST THE BUDGET.

3. LIMITED COMMUNITY RATING -- "SWISS CHEESE-LIKE" COMMUNITY RATING LAWS WHICH ALLOW INSURERS TO CONTINUE TO COMPETE ON RISK SELECTION.

4. EMPLOYER CHOICE -- EMPLOYER CHOICE COULD TAKE AWAY CONSUMER CHOICE OF DOCTOR AND HEALTH PLAN, ANGERING PEOPLE AS THEY ARE FORCED INTO PLANS BY THEIR EMPLOYER AND ANGERING PROVIDERS WHO ARE INCREASINGLY DOMINATED BY INSURERS.

5. WATERED DOWN BENEFITS -- PEOPLE WILL PERCEIVE THEIR CURRENT BENEFITS WILL BE CUT.

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Put on my desk

Working together to reduce the violence in our society and to promote the safety and well-being of our children.

Bombardment of news can make you cynical

JENNIFER JAMES
Seattle Times columnist

A recent study of television and newspaper habits concluded that people who watch a lot or read a lot of news live in a meaner world than people who do not consume as much "news."

News junkies have a tendency to become cynics or pessimists and their attitude bears little relationship to the real dangers of the world they live in.

The multiplication of news sources and the expansion to bad news from everywhere, rather than just the regional bad news we used to get, never gives us a break. Try tuning it out for a week. You will be amazed at how your world begins to improve and your free-floating anxiety lessens. Don't secede, just rest. Anxiety, even if it is manufactured anxiety, makes us cranky.

DEAR MS. JAMES: I'm sitting here reading your year-end column — your essay on the "evolution" of homo sapiens. You say we need to redefine our intelligence to include caring for others, caring for our planet and otherwise loving one another as God commanded. I need to ask, "Where do we start?"

Do we start with television and the violence, profanity and meanness in various forms that spews out into our homes daily? Do we send a message to Hollywood saying, "Look we're fed up with sex and violence!" Do we condemn the drivel that goes on in Congress, where decent laws are voted down in the name of politics?

Do we send out mixed messages to our young and then sit back and shake our heads? Please write a column and give us some suggestions, addresses, etc., so that we can begin to turn this around.

— Marie

Try tuning it out for a week. You will be amazed at how your world begins to improve and your free-floating anxiety lessens. Don't secede, just rest.

DEAR MARIE: It is the American way to fight for what you believe in, so do all of the things you have suggested. Turn off the television when it violates your values and write to the sponsors telling them you will boycott their products.

That is what civil-rights activists did in the 1950s and it broke the back of racism.

Skip your local television news shows and find out what is happening through CNN, PBS, NPR, Discovery, A & E or whichever networks you think offer something other than mayhem and meanness. Let the sponsors know what you will accept or reject.

Write to your newspaper and complain when you encounter misleading headlines, gratuitous violence, invasion of privacy or what you perceive to be hype, injustice or unfairness. Do the same with Hollywood and other entertainment sources that you do with television.

Let politicians know you will not tolerate the acceptance of side deals from lobbyists, the useless name-calling, the mindless conflict and simplistic thinking that they engage in. Don't tune in out of curiosity to talk shows that offer negative energy. When such shows lie about and insult the nation's leaders, young people assume it is an acceptable way to debate issues.

Join groups such as Mothers Against Violence In America (206-343-0676 or 1-800-987-7697). It would be wonderful if their membership some day equaled that of the NRA. Tell your school that you want a curriculum for the future with more emphasis on thinking skills and cooperative relationships than competitive contact sports.

Insist your schools have zero tolerance for racism, sexism and any form of physical or psychological harassment, not covert acceptance. When it happens every adult in the school has to be prepared to take quick, clear action. Social coercion is a powerful tool for changing mores. Some schools have organized "shark" patrols of students to keep their peers civil much as traffic patrols once kept them in the crosswalk.

Parents must back up teachers and administrators on virtually everything including dress codes. We are giving our children a double message by allowing violence and disrespect in our media, our community, our politics and by our support of student rights when they are contrary to the common good. We give our children a double message when we encourage disrespect, violence or harassment for one cause while deploring it for a cause we do support.

One of the reasons some citizens stopped demanding civil behavior in the 1960s and became more concerned with civil liberties was because such civility in the form of language and manners had long been associated with the upper classes who used it to humiliate and control. We must use civility to free each of us to live with respect and grace.

Jennifer James's column runs Sunday in the Scene section of The Seattle Times. Address letters to Jennifer James, c/o Scene, The Seattle Times, P.O. Box 70, Seattle, WA 98111.

Jennifer is an advisor we trust. Really support the Constitution

Today's Paper

PHOTOCOPY PRESERVATION

To Betsy

Hi! Good morning! Thought you'd like to read Jennifer James column - particularly where I'm circled!

I'm really upset with the GOP/2 dozen Dems who want to repeal the ban on assault weapons. Most of all, they don't care about children in America — they just want revenge and to get our President.

I'd like to write them and make sure the letter gets to her — will you help me do that?

I'm ready to go out! and build a powerful organization to oppose the NRA or others. There's more to gain to reduce violence ~~and~~ by going out to build a grassroots movement.

Talk to you soon!

Bob called in Friday! Pam

May 14, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: THE VICE PRESIDENT

SUBJECT: INSURANCE: INSIDE BUILD-UP AND DEFERRED ACQUISITION COST PLANS

This is to follow-up on our conversation about the possibility of our advancing additional tax measures that might be unpopular with insurers -- and later relenting. I mentioned to you "inside build-up" and "deferred acquisition costs."

"Inside build-up" refers to the accumulation of earnings (interests and dividends) on the premium payments on a life insurance policy. Under current federal tax laws, this income is not taxed at the time it is earned. Policyholders like inside build-up because it shelters income. It is also an important selling point for insurance companies and their agents.

"Deferred acquisition costs" refer to the costs associated with selling a new policy (such as the agent's commission). In the past, these costs were generally deductible in the year that the policy was sold. Under the Budget Agreement, however, insurers must amortize acquisition costs over the life of the insurance policy, thus reducing their annual yearly deductions.

The Reagan Administration proposed taxing inside build-up as part of the 1986 tax reform, but the idea died. The Bush Administration successfully proposed a requirement that deferred acquisition costs be amortized. It may be, however, that there would be additional ways in which to extend this rule and, so, further limit the deductibility of these costs.

Attached is a somewhat dated chart that reflects the Joint Tax Committee's estimates of the revenue effects of taxing inside build-up under different scenarios. I have also attached a table that shows the Joint Tax Committee's estimates of revenues from the deferred acquisition costs rules. (These estimates are apparently consistent with Treasury's figures.)

Attachments

Revenue Effect

[Fiscal years, billions of dollars]

Proposal	1988	1989	1990	1988–90
Life insurance policies; including single premium or investment-oriented policies:				
(1) Tax inside buildup on new life insurance policies	0.1	0.3	0.4	0.7
(2) Modify definition of investment-oriented insurance	0.1	0.1	0.2	0.4
(3) Treat surrenders on life insurance as income	(1)	(1)	0.1	0.1
(4) Tax inside buildup on deferred annuities	(1)	0.1	0.2	0.3
(5) $50,000 cap on tax-favored deferred annuities	(1)	(1)	(1)	0.1
(6) Loans from life insurance policies treated as distributions	0.2	0.3	0.3	0.7
(7) Below market loans	(1)	(1)	0.1	0.1
(8) Deduction for reserves limited to surrender value	(1)	0.1	0.1	0.2
(9) Deny reserve deductions for new life insurance and annuity contracts	0.2	0.3	0.4	0.9
(10) Treat life insurance reserves as preference items for minimum tax	(1)	0.1	0.1	0.2
(11) Require use of AFR for reserve deductions	0.1	0.1	0.1	0.2

[1] Gain of less than $50 million.

JTC ESTIMATE
TREASURY ESTIMATE IN 1990 ABOUT THE SAME

Item	Effective	1991	1992	1993	1994	1995	1991-95
7. Expand ozone-depleting chemicals excise tax	1/1/91	73	72	84	134	122	485
8. Extend Leaking Underground Storage Tank (LUST) Trust Fund excise tax (5 years)	12/1/90	94	122	124	126	128	593
9. Increase and extend Airport Trust Fund aviation excise taxes (5 years)	12/1/90	1,351	2,335	2,520	2,727	2,975	11,908
10. Increase harbor maintenance excise tax	1/1/91	314	342	369	395	422	1,842
11. Extend telephone excise tax and modify collection period (6)	1/1/91	1,643	2,578	2,757	2,946	3,145	13,069
12. Revise treatment of loss deductions and salvage values for insurance companies	1/1/90	204	83	90	98	106	581
13. Amortize insurance policy deferred acquisition expenses (DAC)	9/30/90	1,445	1,730	1,677	1,610	1,533	7,995
14. Adopt tax compliance provisions including certain provisions from H.R. 4308 and S. 2410	3/20/90	42	47	78	63	68	298
15. Adopt retiree health provision with reversion excise increase and asset cushion requirement	--	491	196	140	83	39	949
16. Increase by 2 percentage points the interest rate on corporate tax underpayments over $100,000 following notice from IRS	1/1/91	1,559	96	79	46	46	1,826
17. Certain corporate business tax provisions:							
a. Expand and clarify reporting and allocation rules for certain asset acquisitions	10/10/90	9	13	15	17	19	73
b. Require accrual of redemption premium for certain preferred stock	10/10/90	19	55	86	104	109	373
c. Expand application of CERT rules to subsidiary acquisitions	10/10/90	45	81	84	77	69	356
d. Require recognition of corporate-level gain in certain divisive corporate transactions (5-year limitation period)	10/10/90	9	25	38	49	60	181
e. Clarify treatment of debt exchanges	10/10/90	111	95	75	53	25	359
18. Extend IRS user fees (5 years) (6)	9/30/90	45	45	45	45	45	225
19. Extend Social Security (OASDHI) to State and local employees not participating in a public employee retirement system (7)	7/1/91	444	1,970	2,106	2,253	2,414	9,187
20. Extend FUTA 0.2% surtax (5 years)	1/1/91	787	1,106	1,137	1,167	1,199	5,396
21. Adopt payroll tax deposit stabilization	--	950	2,200	-3,150	--	--	---
22. Extend Hazardous Substance Superfund taxes (4 years) (8)	1/1/92	--	--	--	--	--	---
23. Increase Medicare (HI) wage cap to $125,000	1/1/91	1,848	5,709	6,058	6,439	6,827	26,881
24. Extend statute of limitations for collection from 6 years to 10 years	1/1/91	1	1	2	2	2	8

Draft Specifications of a Compromise Plan

1. *Employer Mandate*

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

2. *Purchasing Cooperatives [Alliances]*

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

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

3. *Subsidy Structure*

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

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

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

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

4. *Benefit Package*

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

5. *Calendar*

Full implementation of mandate by 2000 to 2003

6. *Cost Control*

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

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HEALTH CARE REFORM PROJECT

THE VOICE OF AMERICANS FOR CHANGE, NOW.

For Immediate Release
March 15, 1994

Contact: Mark Johnson
202-296-2777

New 'Harry and Louise' Ad Written for H.I.A.A.

WASHINGTON -- The Health Care Reform Project today faxed a script for a new 30-second Harry and Louise TV spot to Bill Gradison, chief lobbyist for the Health Insurance Association of America, who last week wrote President Clinton and offered to sponsor a positive ad endorsing most of the key elements and overall goals of the President's health reform plan.

In a cover note faxed to Gradison along with the script today, The Project said, "While we find your offer hard to believe -- after all, HIAA has already spent $14 million on negative ads criticizing the President's plan -- we are eager to see you prove your claims."

The Project said that if HIAA refuses to run the spot and back it up with a multimillion dollar buy, then "the duplicity of your strategy will be clear: You want the insurance industry to be seen as allies of reform so that you get a seat at the bargaining table, but the vast majority of your war chest will have been spent trying to derail reform."

The Project also rejected Gradison's complaint in his same March 10 letter to President Clinton that the Health Care Reform Project is running "inaccurate" ads criticizing the insurance industry. The Project noted that Gradison "failed to document or even allege a single specific misleading or inaccurate statement in any of our broadcast or print ads" and its ads were "100 percent accurate, including all references to the abusive practices of 'some insurance companies.'"

The Project also took exception to Sunday's HIAA ad in The Washington Post. "Every television ad you excerpted to demonstrate a pro-reform position was critical of the President's plan when taken in its entirety. If these negative ads are the best examples of HIAA's support for reform, then it is truly remarkable that you would accuse the Project of 'fanning the flames of division.'"

-30-

HEALTH CARE REFORM PROJECT

THE VOICE OF AMERICANS FOR CHANGE, NOW.

March 15, 1994

Mr. William Gradison
President
Health Insurance Association of America
1025 Connecticut Ave., N.W.
Washington, D.C. 20036

Dear Mr. Gradison:

In your March 10 letter to President Clinton, you accuse the Health Care Reform Project of running inaccurate ads, you claim that HIAA actually supports health care reform and you offer to run new HIAA spots endorsing many key elements and the overall goals of the President's plan.

While we find your offer hard to believe -- after all, HIAA has already spent $14 million on negative ads criticizing the President's plan -- we are eager to see you prove your claims. Thus, we have enclosed a script for a new Harry and Louise spot that is consistent with the positions you claim to support and the style of your advertising. If the health insurance industry is serious about its intent to support key elements of real health care reform, HIAA should produce the enclosed spot and back it up with the same level of advertising HIAA has already spent attacking the President's plan -- roughly $14 million.

If, on the other hand, HIAA won't put this spot on the air and back it up with a multimillion dollar buy, the duplicity of your strategy will be clear: You want the insurance industry to be seen as allies of reform so that you get a seat at the bargaining table, but the vast majority of your war chest will have been spent trying to derail reform.

That's not just our view. Many newspaper editorials and columnists also believe that HIAA has been hostile to the Clinton plan and to health reform in general:

"The real message [in the HIAA ads is] trust the insurance companies that got you into this mess in the first place."
(Clarence Page, Chicago Tribune, 2/13/94)

"Ads that badly and inaccurately reflect the effect on families of the national health plan proposed by President Clinton."
(Boston Globe, 11/3/93)

"Insidious message being bankrolled by the Health Insurance Association of America...to protect their profits."
(St. Petersburg Times, 11/3/93)

"Divisive demagoguery...A fear-mongering television ad...Deliberate distortions and outright lies."
(Minneapolis Star Tribune, 9/19/93)

In addition, a close examination of your Sunday Washington Post ad raises serious questions about HIAA's credibility on its claim of support for health care reform. Every television ad you excerpted to demonstrate a pro-reform position was critical of the President's plan when taken in its entirety. The September and October, 1993 ads criticized the price cap provision; the January and February, 1994 ads criticized the alliances. If these negative ads are the best examples of HIAA's support for reform, then it is truly remarkable that you would accuse the Project of "fanning the flames of division."

Finally, with regard to your claim that the Health Care Reform Project's ads are "misleading, inaccurate and inflammatory," we note that your letter fails to document or even allege a single specific misleading or inaccurate statement in any of our broadcast or print ads. We believe the ads are 100 percent accurate, including all references to the abusive practices of "some insurance companies." If you have a real complaint, please translate it into something specific.

We look forward to your next round of paid broadcast media endorsing health care reform and the President's goals.

Sincerely,

Robert A. Chlopak
General Consultant

HEALTH CARE REFORM PROJECT

THE VOICE OF AMERICANS FOR CHANGE, NOW.

Harry and Louise around the breakfast table. Louise is reading the newspaper. Harry has the Clinton health book in front of him.

Louise: You know, Harry, most people think insurance companies oppose health care reform.

Harry: I hope they didn't get that impression from us.

Louise: Actually, insurance companies support many of the specifics of President Clinton's plan... like guaranteeing everyone affordable insurance, comprehensive benefits, and requiring employers to provide coverage.

Harry: You're right, Louise. Those things are right here in the President's plan. Along with caps on insurance premiums, and an end to the practice of charging older people more than younger people.

Louise: We should get that message to Congress ...now...before it's too late.

For Immediate Release
November 3, 1993

HIAA

Health Insurance Association of America

Contact: Richard Coorsh
202/223-7787

NEWS RELEASE

"HIAA ADS ARE ACCURATE, WILL CONTINUE TO AIR;"
QUESTIONS REMAIN ON ALLIANCES, PRICE CONTROLS

Washington, D.C., November 3, 1993 -- "In the past two days we've been asked two questions over and over -- 'Are our ads accurate?' and, 'Will we continue to run them?'" said Bill Gradison, president of the Health Insurance Association of America (HIAA).

"Without hesitation, we answer, our ads are accurate. We couldn't, we wouldn't, and we won't run something that is inaccurate," continued Gradison. "They will continue to air."

Speaking at a press conference today in Washington, the former Ohio congressman said he was "puzzled at the harsh rhetoric that the Clinton Administration has directed at the health insurance industry in the last 48 hours, particularly since I recently received a personal letter from the President thanking us for our support of health care reform."

In the letter to Gradison, the President says that he is "pleased to hear of the interest of the health insurance industry in reforming our nation's health care system ... that we agree on many aspects of the reform our country needs, and I look forward to working with you toward these beneficial changes."

Gradison said he is glad President Clinton understood the health insurance industry's support for reform, which includes

- more -

elimination of all preexisting condition requirements and provides coverage for all Americans. He added that health insurers have even endorsed a key provision of President Clinton's bill: a mandate on employers as a means to ensure universal coverage.

"We believe the President's letter was a response to our numerous good faith efforts to seek dialogue with the Administration on this critical subject. Through our ads and other communications, we have raised some serious concerns about the plan that the Clinton Administration has offered. They are based chapter and verse on the President's own proposal as we have known it," said Gradison.

"We also believe it is clear the administration is listening to the questions raised by insurers and that it has responded. In several instances, changes have been made in the proposed health alliances to increase choice," continued Gradison.

"But overall, our analysis of the legislation offered by the Administration shows that although the rhetoric has changed, many details of the proposal have not," said Gradison. "Our ads raise good questions. And, they ask the public to approach health care reform with open eyes and a healthy degree of skepticism. There is a better way."

The Health Insurance Association of America (HIAA) is a Washington, D.C. based trade association of the nation's leading commercial insurance carriers.

# # #

HIAA

Health Insurance Association of America

November 3, 1993

Budget Development and Enforcement (Premium Caps) For Regional Health Alliances in President Clinton's Proposed Health Security Act

1. The National Health Board (NHB) determines a "national per capita baseline premium target" for 1994, 1995 and 1996 by adjusting and trending forward actual 1993 expenditures for items and services included in the national benefit package. (§6002)

> The legislation specifies in considerable detail the adjustments that are to be made to arrive at a fair representation of per capita spending for alliance-eligible individuals. Whether sufficient data exist to make these adjustments is another question entirely.

2a. By January 1, 1995, the NHB determines a "regional alliance per capita premium target" for 1996. (§6003(a))

> The alliance-specific targets are based on the "national per capita baseline premium target," adjusted to reflect regional differences in health care expenditures, percent of population un- and under-insured, and use of academic health centers.

2b. "Regional alliance per capita premium targets" for subsequent years are established by the NHB by March 1 of the previous year. (§6003(b))

After 1996, the new target equals the previous year's target times the "regional alliance inflation factor," also set by the NHB under §6001(a).

The "regional alliance inflation factor" equals a "general health care inflation factor" specified in the legislation (§6001(a)(3)), adjusted to take into account any material changes in the demographic and socio-economic characteristics of a particular alliance's population. (§6001(a)(2))

The factor may be reduced if the alliance exceeded its target in previous years. (§6001(d)) (See item 10, below.)

1025 Connecticut Avenue, N.W., Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

3. By April 1 each year, the regional alliance sends to prospective health plans NHB-specified information "necessary to enable a plan to estimate, based upon an accepted bid, the amounts payable" to the plan (i.e., actual revenue the plan will receive). (§1341(a))

> Alliances must disclose to prospective bidders the "regional alliance inflation factor" (§1341(a)(2)(D)), but may choose whether or not to disclose the actual per capita premium target (§6004(a)(1)(B)).

4. Bids from health plans for 1996 are due to the regional alliance on or before July 1, 1995. For subsequent years, bids are due August 1 of the previous year. In submitting bids, plans must agree to accept any premium reduction that may be imposed under §6011 (see item 7 below). (§6004(a))

5. If the state's plan permits it, alliances negotiate with health plans over premiums to be charged. After negotiations, health plans may submit new, lower bids. (§6004(a)(2))

   Alliances are generally required to "negotiate with any willing State-certified health plan to enter into a contract" (§1321(a)(1)) but are not required to offer a contract if the plan's "proposed premium exceeds 120 percent of the weighted-average premium within the alliance" (§1321(b)).

6. By September 1, the alliance submits health plans' final bids to the NHB, along with information necessary to enable the NHB to estimate probable enrollment in each plan. (§6004(b))

7. The NHB determines a "weighted average accepted bid" (WAAB) for each alliance (§6004(c)), and compares it with the per capita premium target for that alliance.

   If the WAAB exceeds an alliance's target, the NHB notifies the alliance on or before October 1. The NHB also notifies both the alliance and each "noncomplying plan" (i.e., plan whose final bid exceeds the target) of the "plan payment reduction" (i.e., the amount by which payment to the plan will be reduced below the plan's bid). (§6004(d))

> After the first year, whether a plan is "noncomplying" is determined by comparing the plan's bid, not with the alliance's target premium, but with a plan-specific "maximum complying bid," which equals the previous year's premium for that plan, less any plan payment reduction for that year, plus the dollar amount (not percentage) by which this year's alliance per capita premium target exceeds last year's target or WAAB, whichever is less. (§6011(d))

7. (con't)

Details of how the NHB will calculate the actual reduction for each noncomplying plan are specified in §6011(c). The reductions guarantee that the new WAAB for the alliance, after implementation of the reductions, will equal the target (unless actual plan enrollment differs from pre-year estimates). The regional alliances implement the reductions when paying health plans under §1351.

8. Each "noncomplying" health plan passes on the plan payment reduction to its providers, both participating and non-participating. The method for calculating the amount of the reduction is specified in the legislation and by the NHB and cannot be changed by the health plan. Providers must accept the reduction and cannot charge patients more because of it. (§6012)

9. The alliance publishes the final information about premiums for each of its health plans, and other required information, and holds an open enrollment period during which individuals (family heads) choose which plan they wish to enroll in. Enrollment is effective January 1.

10. Once the final enrollment in each health plan is known, the alliance reports this information to the NHB, which calculates the "actual weighted average accepted bid" for the alliance for that year and compares it to the alliance's per capita premium target. (§6001(d))

If the actual WAAB exceeds the alliance's target, the "regional alliance inflation factor" for that alliance for the two succeeding years is reduced to make up the overage. (§6001(d))

HIAA

November 3, 1993

Health Insurance Association of America

STATE HEALTH ALLIANCES HAVE BEEN VOLUNTARY, NOT MANDATORY

To date, six states have enacted some variation of a health alliance program. In each of the states, the programs have been voluntary. In other words, plans can be offered through an alliance or outside of an alliance. Not a single state has enacted a mandatory alliance. The six states, with cites to the voluntary nature of the programs are listed below. (To date, program experience is only available for California.)

1. California: In 1992 California created the Voluntary Alliance Uniting Employers Purchasing Program. (See Assembly Bill Number 1672, Article 4 §10730.)

   The California program began operating July 1, 1993. Based on three months of experience, 1,189 employer groups with 19,900 employees and dependents are participating in the program. Eighteen carriers are providing coverage through the program. The percent of participating employers which were previously uninsured is 22.8 percent. Approximately 79 percent of eligible employers have used agent/broker services in enrolling in an alliance plan.

2. Florida: By statute, "membership in an alliance is voluntary." (See Senate Bill Number 1914, §67 paragraph 408.702(5).)

3. North Carolina: The stated purpose of the North Carolina statute is to promote "the development of voluntary purchasing alliances". (See House Bill Number 729, Part III Article 66 §143-621).

4. Ohio: A voluntary alliance program was created in House Bill Number 478. The alliance legislation was enacted to "assist small employers to obtain coverage" and to "encourage" small employers to obtain their coverage through alliances. (See §1731.01(B) and §1732.02.)

5. Texas: The Texas statute states "two or more small employers may form a cooperative for the purchase of small employer health benefit plans." (See House Bill Number 2055, Art. 26.14(a).) The powers and duties of the cooperatives include arranging coverage for small employers who participate in the cooperative. (See HBN 2055, Art. 26.15(1).)

6. Washington state: "Every health insurance purchasing cooperative shall: ... admit all individual, employers, or other groups wishing to participate in the cooperative". (See §425.(3)(a) of Senate Bill Number 5304.)

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Regional Health Alliances: A Before-and-After Comparison

Feature	Working Group Draft*	Health Security Act
Alliance is mandatory for individuals and employers with fewer than 5,000 employees	Yes p. 14	Yes §1311 (e)
Alliance solicits bids from state-certified health plans	Yes p. 60	Yes §6004 (a)
Alliance negotiates with plans submitting bids	Yes p. 60	State Option §6004 (a)
Alliance must offer contract to every state-certified health plan except:	Yes p. 60	Yes §1321 (a)
May limit number of fee-for-service plans or exclude entirely	Yes p. 61	No
May exclude a plan whose premium would bust alliance's budget	Yes p. 61	No
May exclude a plan whose premium exceeds 120% of alliance average	Yes p. 60	Yes §1321 (b)
Instead of alliances, states may set up single-payer system	Yes p. 54	Yes §1221

* Page numbers are for the 9-7-93 Working Group Draft, the 239-page, 8 1/2" x 11" version, rather than the published book version.

A Budget by Any Other Name: A Before-and-After Comparison

Feature	Working Group Draft*	Health Security Act
Draft uses term "National Health Care Budget"	Yes p. 93	No
Act sets annual rate-of-increase limits for premiums	Yes p. 94	Yes §6001 (a)
National Health Board (NHB) sets per capita premium target for each regional alliance (RA)	Yes p. 95	Yes §6003
Health plans bid and negotiate with alliances, which report final bids to NHB	Yes p. 95	Yes §6004 (a,b)
Alliance's weighted average premium must not exceed target	Yes p. 95	Yes §6004 (c,d)
If exceeded, NHB/RA reduce payments to plan whose premiums are over target	Yes p. 96	Yes §6011
Plans, in turn, reduce payments to providers	Yes p. 96	Yes §6012

* Page numbers are for the 9-7-93 Working Group Draft, the 239-page, 8 1/2" x 11" version, rather than the published book version.

Ra ion' ng Hea : n Care

"Commercial and nonprofit H.M.O.'s both criticize Mr. Clinton's proposal calling for the Government to regulate premiums.

Dr. John M. Ludden, medical director of the Harvard Community Health Plan, which serves 547,000 people in New England, said, 'Premium caps will drive capital out of this business and will drive us straight to the rationing of health care.'"

—*The New York Times,* October 18, 1993

Heads of H.M.O.'s Have Concerns on Health Plan

By ROBERT PEAR
Special to The New York Times

WASHINGTON, Oct. 17 — Because President Clinton's health plan seeks to increase the number of Americans in health maintenance organizations, White House officials expected the directors of H.M.O.'s to be among the plan's most enthusiastic supporters.

But the people who run these organizations, while generally favoring the President's ideas, nevertheless express many concerns and doubts about the proposal.

The directors worry about Federal regulation of their premiums, about 50 different sets of state rules, about their ability to handle a surge in membership and the difficulty of bringing poor people into their networks. They doubt that Federal payments and subsidies will cover the costs they expect when they enroll Medicaid recipients, homeless people, drug addicts and people with chronic illnesses like AIDS.

And they worry about losing the expertise that employers have developed *over decades of purchasing health care* for their employees. They say such employers have given H.M.O.'s the impetus to be more efficient.

Staking Out Positions

Meeting in Washington last week, medical directors of the health maintenance organizations said they strongly supported Mr. Clinton's goals, including medical insurance for all Americans with an emphasis on preventive care. But, like other sectors of the health care industry, they want to shape the President's plan to address their concerns and are staking out positions for the struggles ahead.

Mr. Clinton's proposal would give all Americans a choice of joining an H.M.O. and would create financial incentives for people to do so. Under Mr. Clinton's plan, H.M.O.'s, which provide comprehensive medical care in return for a monthly payment, would need to be certified by the states where they were operating, and states could set widely differing criteria.

For H.M.O.'s operating in more than one state, as most do, "that would be a nightmare," said Dr. Lee N. Newcomer, medical director of the United Healthcare Corporation, whose H.M.O.'s serve 2.4 million people in 14 states, *including Illinois, Minnesota,* Ohio and Rhode Island.

Mr. Clinton is intent on preserving state power to regulate H.M.O.'s within *a Federal framework.*

Call for National Standards

But Dr. Don Nielsen, associate medical director of Kaiser Permanente, the nation's largest H.M.O., with 6 6 million members in 16 states, said, "We want a common set of national standards for certifying health plans and for reporting data in all 50 states."

Karen M. Ignagni, president of the Group Health Association of America, a trade group for H.M.O.'s, said, "It is not in the consumer's interest to have multiple conflicting standards." Instead, she said, "there has to be regulatory uniformity," with the Federal Government setting nationwide standards in categories like financial management, the quality of care and the reporting of data.

Membership in health maintenance organizations exploded in the last decade, to 41.4 million in 1992 from 10.8 million in 1982. Doctors who work at *these organizations worry about* whether they can expand much faster without harming the quality of care.

Dr. Jesse H. Jampol, medical director *of the Health Insurance Plan of* Greater New York, which has more than a million members, said it would be difficult, though not impossible, to *accommodate a surge in membership.*

'Adds to the Paperwork'

"We have 47 medical centers in New York City," Dr. Jampol said. "We don't want to dilute the quality of care by putting more people into a center than it was designed for. If we get 100,000 new patients in a year, we'll have to build another three or four centers at a cost of $8 million to $12 million apiece."

Mr. Clinton would require H.M.O. members to pay $10 for each visit to a doctor, and similar amounts for other services. Dr. Jampol's organization does not make such charges, nor does it want to.

"We are not eager to pocket little bits of money and set up a whole new system of billing and accounts," he said. "It adds to the paperwork and the bureaucracy."

Prof. Uwe E. Reinhardt, a health care economist at Princeton University, said *the H.M.O.'s of today provide a* model for the way health care will be delivered in the future. "Under the Clinton plan," he said, "there will be *more H.M.O.'s, and some of them will* be bigger. But their profit margins will be smaller because they will face fiercer competition."

Kathryn Langwell, a health economist at KPMG Peat Marwick, the accounting and consulting firm, said: "Today's health care reform initia*tives are favorable to H.M.O.'s.* They should be relatively happy, but their concerns are reasonable."

'Rationing of Health Care'

Commercial and nonprofit H.M.O.'s both criticize Mr. Clinton's proposal calling for the Government to regulate premiums.

Dr. John M. Ludden, medical director of the Harvard Community Health Plan, which serves 547,000 people in New England, said, "Premium caps will drive capital out of this business and will drive us straight to the rationing of health care."

Dr. Newcomer said: "Premium caps will make us get rid of care that has no proven value, and that's good. They may also force us to limit access to care that is effective and valuable but expensive, and that's not good."

As employers prod workers to join H.M.O.'s, doctors across the country are rushing to *affiliate with such net*works.

For years, the Government has been trying to increase the use of health maintenance *organizations by poor* people on Medicaid and elderly people on Medicare. But only 2 million of the 30 million Medicaid recipients and fewer *than 2.5 million of the 36 million* Medicare beneficiaries are in such organizations.

It is unclear whether these patterns *will change.* Dr. Howard L. Bailit, senior vice president of Aetna Health Plans, said: "Government has underfunded Medicaid for 20 years. I think *that's going to continue.* It will be a real serious problem for us." Aetna operates 26 H.M.O.'s with 1.2 million members.

Little Control for Employers

Middle-income consumers can be enrolled in large groups through their employers But Dr. Newcomer said H.M.O.'s needed a different strategy to recruit and serve poor people. "In parts of Chicago," he said, "we have door-knocking sales people to enroll Medicaid recipients one by one."

In addition, he said, large numbers of Medicaid recipients fail to keep their *medical appointments, and these pa*tients often need special help with transportation. "We have to find clinics on public bus lines and sometimes buy *bus tickets or pay cab fare," Dr. New*comer said

Dr. Ludden said the Harvard Community Health Plan had many patients who cannot speak English. The H.M.O. has interpreters in more than 25 languages. If millions of uninsured people get coverage under Mr. Clinton's plan, other H.M.O.'s will need to provide similar services, Dr. Ludden said.

Under the Clinton proposal, employers would have to pay health insurance premiums for their workers, but they would have little control over the cost of care. Insurance purchasing groups, known as regional health alliances, would collect the premiums from employers, negotiate with H.M.O.'s and buy coverage for millions of people.

The H.M.O. directors lamented the loss of the employers' expertise in this transaction. Dr. Ludden said: "Employers are a powerful voice for health *care consumers. They have really be*come sophisticated customers. They know what to ask for and how to ask for it. They set goals for us — clinical *goals, not just cost goals."*

Under Mr. Clinton's plan, employers with more than 5,000 workers could still serve as their own health insurers or buy coverage from insurance companies. But most employers would have little or no role in selecting insurers for their workers. That decision would be made by the alliance.

Darcy Padilla for The New York Times

"We want a common set of national standards for certifying health plans and for reporting data in all 50 states," said Dr. Don Nielsen, left, associate medical director of Kaiser Permanente in Oakland, Calif.

Seraphin Baer for The New York Times

Dr. John M. Ludden, medical director of the Harvard Community Health Plan, said, "Premium caps will drive capital out of this business and will drive us straight to the rationing of health care."

Criticism from expected allies of the Clinton health proposal.

The Political Debate About Health Care: Are We Losing Sight of Quality?

Potential Effects of Cost Reductions

The most likely effect of trying to reduce costs—in the face of rapidly increasing demand, an aging population, a highly labor-intensive health service industry, and a rising rate of technological innovation—is rationing. Aaron and Schwartz (*7*) have noted:

> Growth of medical costs will be contained on a sustained basis only if we are prepared to ration care to those who are insured and are able and willing to pay for services. . . . Concern for fundamental values such as age, visibility of an illness, and aggregate costs of treatment will inevitably shape our decisions on resource allocation. Physicians and other providers will increasingly experience tension between their historic commitment to doing all that is medically beneficial and the limitations imposed on them by increasingly stringent cost limits.

As such, rationing represents effects on both equity of access and quality of care, and it is already in place, not just in the National Health Service in Britain but also in Oregon (whose form of rationing applies only to its Medicaid population) and elsewhere. Indeed, there are reasons to believe that informal rationing is already occurring in a hundred different ways, and that the medical profession has often had "to disguise rationing decisions about the use of resources as clinical decisions about appropriate treatment (*8*)."

Two other readily foreseeable effects of cost reduction on access and quality are (i) a decrease in the amount of time physicians and surgeons can spend with patients, as well as a concomitant decrease in the number of real physician services per visit; and (ii) a corresponding increase in patient waiting time and in the number of visits required for appropriate medical care to take place. In Japan, for example, where physician fee controls have been stringent, "physician visits now last roughly 5 minutes, and the Japanese average 12 visits to the physician each year—roughly three times as many as Americans, whose average visit length is 15 to 20 minutes" (*9*).

In a larger sense, past experience shows that trying to contain costs can be expected not only to influence access to medical services as well as their quality in terms of appropriateness and timeliness, but could also affect health outcomes through effects on the core doctor-patient relationship. That is, if the meaningfulness of contacts were reduced; if patients should become exasperated by long waits; if their compliance with doctors' orders were to decrease; and if stressful tensions should be created between providers and patients on the question of who will receive what services, the effectiveness of doctor-patient interactions is likely to decline and patient outcomes along with them.

Other probable effects of cost reductions are decreases in staff. After diagnosis-related groups were implemented in 1984, for example, the number of workers on hospital payrolls was cut by about 3% nationally in 1985. This decline meant then (and would likely mean again) that hospital patients received less attention, call bells were answered less quickly, and nurses' caseloads crept or zoomed upward, depending on the depth of the cut.

However, cost reductions could also have some very beneficial effects on quality of care. But benefits would occur only in an environment in which attention to cost was intimately associated with concern for quality. Much progress has recently been made in the field of health outcomes research, which seeks to establish the most effective medical procedures and discourage the use of less effective ones, such as unnecessary or inappropriate surgery (*10*). Because of this work, it is plausible that quality could improve despite cost reductions, if the findings of outcomes research were used to drive the elimination of ineffective therapies; to develop more efficient standardization (in those areas where standardization is appropriate); to encourage watchful waiting instead of immediate action (again, where appropriate); and simply to constrain everyone—hospitals, doctors, insurers, and patients—to take fewer inappropriate risks.

Source: Eleanor Chelimsky, *Science,* Vol. 262, 22 October 1993, page 526

The Washington Times

★ WEDNESDAY, NOVEMBER 3, 1993 / PAGE A21

The first lady's invective against our ads is misplaced

By Bill Gradison

On December 2, 1992, the board of directors of the Health Insurance Association of America (HIAA) voted unanimously to support passage of federal legislation that would make universal health care coverage a reality. Within a day, ranking members of the soon-to-be-inaugurated Clinton administration, including Judith Feder and George Stephanopoulos, publicly acknowledged the importance of the industry's innovative new policies, and seemed unconditionally pleased that the industry and the incoming administration had far more in common on the subject of health reform than anyone might have previously thought.

In the months that followed, HIAA and the many companies for which it carries the banner of responsible reform have not wavered from the belief that every American should have affordable health insurance coverage that cannot be taken away under any circumstances. Yet, in recent weeks, several of the most visible and vocal members of the Clinton administration's health care reform team have attacked HIAA and its members, chiefly by characterizing us — and frankly, I find this incredible — as opposed to reform, as supporting the status quo, as favoring a system that permits "cherry picking" and the use of preexisting condition limitations to deny coverage. None of these assertions is true.

First Lady Hillary Rodham Clinton's factually groundless remarks about health insurers, delivered during the recent annual meeting of the American Academy of Pediatrics, are the latest manifestation of a communications strategy rife with distortion and inspired, at least in part, by dated poll results. I know this because when I met with senior White House policy advisor Ira Magaziner this past February, he candidly admitted that White House pollsters had already concluded that the administration's campaign to sell its health care plan would be enhanced by attacks on the insurance industry. Clearly, no one's position in the debate over health care reform is in any way enhanced by scattershot accusations that have no basis in fact. The cynicism that underlies such attacks is truly disturbing.

The focus of the first lady's diatribe against health insurers was a television advertisement sponsored by the Coalition for Health Insurance Choices and funded by HIAA. This ad (in fact, there have been two such ads, and we apologize for neither) focused on the question of personal choice — in particular, choice of health plan — under the Clinton administration's approach to reform.

After a working draft of the Clinton plan began to circulate last August, it was clear to everyone that the administration wanted to drastically limit the number of health care plans competing in the marketplace. The limiting mechanism in question was the monopolistic (or "exclusive") health alliance, which would allow only a few plans to market health insurance products in a given region and unilaterally exclude all others. We believed then, as we believe now, that alliances are a good idea, but they shouldn't be monopolistic, and they shouldn't under any circumstances have life-or-death power over health plans. Our two "choice" commercials reflected these beliefs. We wanted people to question the advisability of a system under which governmental entities decided which plans consumers would have access to.

Hillary Rodham Clinton's factually groundless remarks are the latest manifestation of a communications strategy rife with distortion.

It would seem that our ads were even more effective than we might have hoped. The administration blasted HIAA at every turn for producing them. Yet ranking White House officials have evidently taken the ads' simple but powerful messages to heart. And I say this because the Clinton administration recently made last-minute changes to its health care reform bill, changes that would oblige alliances to accept every health plan that meets minimum federal standards, with some limits. As soon as we had the actual legislation for the Clinton plan in our hands, and saw that the White House had backed away from the idea of limiting choice by limiting the number of plans that could compete in a given market, we stopped running our "choice" ads. They had clearly served their purpose.

Space limitations don't permit a point-by-point response to all of Mrs. Clinton's accusations against companies that market health insurance products, but one additional aspect of her speech cannot be left unaddressed. At one point, she slammed the use of utilization review as an insurance company-inspired conspiracy to keep doctors from doing their jobs. And yet later in her speech, she praised managed care, saying that "under a managed care system for Medicaid, I had mothers telling me [that] for the first time they had their own doctor. They had a telephone number they could call. They were able to get good information."

The first lady's ideologically contradictory stances puzzle me. I think it's reasonable to say that Mrs. Clinton knows what I and many others know about utilization review — that it's fundamental to managed care's effectiveness. Without it, what puts the brakes on unnecessary care, on the unnecessary costs from unwarranted tests and procedures? Needless to say, it isn't the insurance companies that derive profits from paying for unneeded care. Instead, it's the insurance companies that are called upon to pay for it.

Real reform of the health care system means that everyone — insurers included — must make sacrifices. And "everyone" includes even those groups whose political and professional inclinations have manifested themselves time and again, on Capitol Hill and in statehouses across the country, as opposed at every turn to managed care and to its quality-enhancing and cost-containing elements. Not the least of which is utilization review.

Contrary to Mrs. Clinton's rhetoric, the companies represented by HIAA support meaningful reform of the nation's health care system. We support universal, continuous coverage for all Americans under a package of comprehensive benefits, a package that does include — in spite of Mrs. Clinton's comments to the contrary — across-the-board preventive health care services. We oppose denial of coverage for preexisting conditions. We want everybody covered under the humane auspices of a new, reformed health care system, one that will ultimately put the health systems of all other industrialized countries to shame. We can do it. We should do it. But progress toward the health care goals that HIAA shares with the administration will only be promoted if political rhetoric is abandoned in favor of an attitude of mutual respect, built upon a shared commitment to work together constructively to make America's health care system the finest in the world.

Bill Gradison is president of the Health Insurance Association of America.

The E. J. Faulkner Lecture Series
University of Nebraska-Lincoln
November 5, 1993
Bill Gradison, President
Health Insurance Association of America

Now that the details of the President's health plan are public, it is possible to examine the specifics, make comparisons with other proposals, and analyze how the plan would work. Clearly, the goals are laudable, and the health insurance industry supports them -- including achieving universal coverage, ending exclusions for preexisting conditions, specifying a federally-defined benefit package, developing a uniform claims form, and emphasizing managed care.

Viewed broadly, our position and that of the Clinton Administration is that the nation should move away from the private insurance model (in which premium levels and indeed availability of insurance itself are related to risk) towards the social insurance model (where everyone is covered and premiums do not reflect health status). Put another way, the concept of individual equity requires one to treat the individual fairly and is a basic tenet of private insurance. Many of the envisioned reforms, however, are a means of bringing to the free market social equity, which is a basic tenet of social insurance, and requires everyone in society to be treated the same.

Achieving universal coverage, of course, requires imposition of mandates or the coverage will not be universal. Single-payer advocates would put the mandate on government (and

the taxpayers). Others would put the mandate on individuals -- at least those who have the ability to pay. The Clinton plan, much like HIAA's, would impose a series of mandates (on governments to pay for lower-income families and on employers and employees to pay for workers and their dependents).

While the Administration understandably is trying to sell its plan by criticizing the health insurance industry, and many in the industry understandably are concerned about their survival, there is another way to think about health reform. Viewed broadly, the President's plan calls for universal coverage not by the government but by private health insurers, from group-model HMO's to traditional fee-for-service indemnity carriers. In that perspective, looking past the present high-decibel verbal volleys, health reform may offer unprecedented opportunities for the industry. These include not only continuing to insure those currently covered, but also the uninsured and Medicaid beneficiaries as well with a benefit package more comprehensive than many have today.

What then are the elements of the President's plan critical to its success, or what are the elements of the President's plan which could lead it to fail? In my judgment, there are three flaws so serious that unless they are corrected, reform cannot succeed:

(1) First, while the purchasing alliances initially would offer a broad fee-for-service option, adverse selection is likely

to force the withdrawal of such plans, leaving most families with far more limited choices than they are told they will have and far fewer choices than they have today.

(2) Second, the goal of reducing health care inflation to the CPI, adjusted only for population, is not achievable or indeed desirable; and

(3) Third, premium controls will make it impossible to retain needed risk capital and to attract new capital, preventing health insurers from providing protection for the entire population. In addition, the solvency of the regional alliances is a concern if they don't take in enough funds to pay premiums.

Important insurance principles and actuarial realities underlie each of these three points. Let me elaborate on these one by one.

While clearly the trend is towards managed care, physician choice remains highly valued by the public. The most rapid growth has been in preferred provider organization (PPO) and point of service (POS) plans which offer broader choices than traditional HMOs. While the Administration promises that the purchasing alliances will generally offer fee-for-service plans and PPOs, there is reason to anticipate such severe adverse selection that plans offering broad choices may not be available for long especially since we lack a risk adjuster that can work when employees choose. Risk adjusters can be developed that will

likely work in an employer choice environment, e.g., New York State.

Another hope would be a reinsurance mechanism far more comprehensive than currently envisioned in the Clinton plan. HIAA is planning to commission a study by an outside independent consultant to examine this issue further. Our preliminary conclusion is that the surest way to avoid this problem is to permit plans to be offered outside as well as inside the purchasing alliances -- all subject to the same rules -- to maximize the choices available to the insured and to maximize the number of competing health plans. Thus, we think that making the purchasing alliances mandatory rather than voluntary will undermine the success of (as well as public support for) the President's plan.

As for the goal of reducing healthcare inflation to the CPI, adjusted only for population, there is no evidence that this is attainable. Price Waterhouse recently completed an analysis of the experience of all Organization of Economic Cooperation and Development (OECD) countries over the period 1961 to 1991 and concluded that, over the long term, per capita health spending has grown more rapidly than general inflation in all OECD countries. A handful of countries -- Sweden, Ireland, Turkey and New Zealand -- kept the growth of per capita health spending below general inflation for a single five-year period, but no country has sustained such a growth rate for a longer period. And no OECD country achieved such a low rate for the most recent five-year period: 1986 through 1991 (although Sweden and Greece

managed to attain a rate less than one percent over general inflation during that period).

While the hope is that slamming on the brakes will reduce waste, fraud, abuse, and medically unnecessary and medically inappropriate procedures, there is no assurance that would happen. Queuing, rationing, slower diffusion and development of new technology, closing of needed inner-city and rural hospitals could also result. The basic question is whether the government is so wise about what the proper level of future health spending should be that it can safely put health spending on automatic pilot.

Since zero real health care inflation by the end of the decade is assumed to be achieved, all of the Administration's cost projections depend on the accuracy of this assumption. As the debate unfolds, it is urgent that a sensitivity analysis be applied to measure the impact on the costs of the program if U.S. experience is closer to the actual OECD results of recent years. Congress may want to include some mechanism to assure that the deficit is not increased should the Administration's zero real growth goal prove unattainable.

Finally, there is the issue of capital. I do not know how much capital will be needed by insurers to minimize insolvencies and reasonably assure universal coverage. To the best of my knowledge, no estimate of capital requirements was made by the President's healthcare task force and, if an estimate was made, it has not been made public. Private estimates of new capital

requirements vary all over the lot. The lowest I've seen is $30 billion over the phase-in period. The highest is $90 billion. Needless to say, neither is a trivial sum.

Capital adequacy is a concern in the present health insurance system; and it will be a greater concern under the President's plan. The insolvency of the West Virginia Blue Cross plan, and the concerns about capital adequacy of plans serving New York and the District of Columbia among others remind us that there is risk in the health insurance business. Reserves can quickly be depleted by unforeseen events. For example, reserves for all Blue Cross-Blue Shield plans dropped 43% in 1975, from 2.1 months to 1.2 months. And from the peak of 2.4 months in 1985 reserves dropped 54% to 1.1 months in 1988.

Implementation of the President's plan will increase the risks and therefore the need for capital, but will make accumulation of capital far more difficult than it is today. Premium controls -- even on a standby basis -- are the major impediment to raising new capital. Dr. John M. Ludden, medical director of the Harvard Community Health Plan, which serves 547,000 people in New England, was recently quoted as saying, "Premium caps will drive capital out of this business and will drive us straight to the rationing of health care." Standard & Poor's recently stated: "Uncertainty for health insurers used to result from the volatility of the market cycle and the threat of state reform and small group regulation. Added to the traditional risks of underwriting, pricing, and administration

uncertainties, S & P now expects federal intervention to further complicate the financial health of health insurers ... At best, a national solution will offer the industry more stable profits in return for lower margins. At worst, the solution will severely limit any hope of a reasonable return on capital."

A recent Ernst & Young survey of 38 CEOs of large insurance companies found that 95% said that imposition of caps on premiums will cause stock companies to reevaluate the amount of capital backing their business. And 79% believe it will be harder for them to attract capital for ongoing operations and expansion if there are caps on premiums.

The challenge of retaining and accumulating sufficient capital is heightened by two facts about the industry: (1) the major role of mutual insurers which write about two-thirds of all health insurance and whose only significant source of capital is retained earnings and (2) the diversification of major commercial insurers, which may choose to divert capital to their life insurance, property and casualty, disability income or other lines if earnings prospects in health insurance are not competitive.

Beyond the hazards of premium controls, there are other elements of the President's plan which increase the need for larger reserves than may seem prudent today. High on this list is shifting perhaps 130 million Americans from group choice of health plan (under which an entire group enrolls in one plan or a

small number of plans) to the individual choice model through the mandatory health alliances. Individual choice is likely to generate far greater adverse risk selection than group choice.

And, of course, moving into insured plans tens of millions of the health uninsured, Medicaid beneficiaries, and large numbers now covered by self-funded plans will require large amounts of capital. With perhaps $200 billion of added premium income, $33 billion of capital would be required based on reserve levels of about two months of annual premium income. If these numbers seem high, keep in mind that there currently is no dedicated capital or contingency reserves or claim reserves backing the just over half of Americans who are either uninsured or enrolled in government programs or covered by so-called "self insured" plans. These numbers are necessarily inexact. They would be reduced to the extent that universal coverage cuts cost shifting and increased by trending forward health care inflation and providing benefits more comprehensive than most families have today.

Lest these numbers be dismissed as way off the mark, Blue Cross-Blue Shield's internal estimates are that their members will need to add between $10-$17 billion to surplus by 2000 for both growth and to assure financial stability for certain of the plans. We must also take into account the capital that will be needed to set up networks. Estimates for this go up to $30 million per metropolitan area per plan.

Now that health reform has moved to the Congress, it is urgent that we move beyond rhetoric and focus attention on the nuts and bolts of reform proposals. We are often told that the devil is in the details; God is also in the details. I will feel this lecture was useful if it helps stimulate debate on these three issues: mandatory vs. voluntary health alliances, premium limits, and access to capital. Before us lies the possibility of success in achieving universal coverage which only yesterday seemed at best a dream. Let's do it right so that it works and is not just another example of the government promising more than it provides.

Premium Growth Targets Under the Clinton Proposal: Comparison with the OECD Experience

Prepared for
Health Insurance Association of America

by
Washington National Tax Services
Price Waterhouse

October 14, 1993

Abstract

The global budget caps under President Clinton's health care reform proposal would limit premium increases to the rate of growth in the consumer price index (CPI) by the year 1998. To provide a context for this proposal, Price Waterhouse examined the growth rates in real per capita health spending in twenty-four OECD countries during the period of 1961 to 1991. Only four countries -- Turkey, Ireland, Sweden, and Greece -- held per capita health spending to a level that was comparable to CPI growth for one of the five-year intervals since 1961. To reach the year 2000 growth targets in President Clinton's proposal, the United States would have to shift from being the fourth fastest growing country (as measured by growth in real health spending per capita during the 1986 to 1991 period) to being among the slowest growing OECD countries.

Health Spending in the United States, 1961 to 1991

The United States experienced a rapid rate of growth in health spending during the period of 1961 to 1991. According to data provided to the Organization of Economic Cooperation and Development (OECD) by the United States Department of Health and Human Services, national health expenditures (NHE) grew at an average annual rate of 11.5 percent during that period. Gross Domestic Product (GDP) grew at 8.2 percent during the same period. As a result of this differential growth rate, health spending rose from 5.5 percent of GDP in 1961 to 13.4 percent of GDP in 1991 (see Figure 1).

Spending on health care as a percent of GDP is much higher in the United States than in comparable industrial nations. Across the other OECD countries, health spending grew from 3.9 percent of GDP in 1961 to 7.7 percent in 1991. The ratio varies considerably from country to country. The lowest in 1991 was Turkey at 4.0 percent, and the United States was the highest at 13.4 percent. All OECD countries, however, experienced increases in health spending relative to GDP during the three-decade period, 1961 to 1991. Australia, the country with the lowest increase, grew from 5.3 percent of GDP in 1961 to 8.6 percent in 1991, an increase of more than 60 percent.

The President's Proposal

President Clinton's health care reform proposal contains strict limits on the growth in health spending.[1] Each year the proposed National Health Board would set maximum levels for the average premium for each regional alliance and each corporate alliance which would control virtually all private health spending. The premium limits would be set to reach a specific targeted rate of growth in national health spending.

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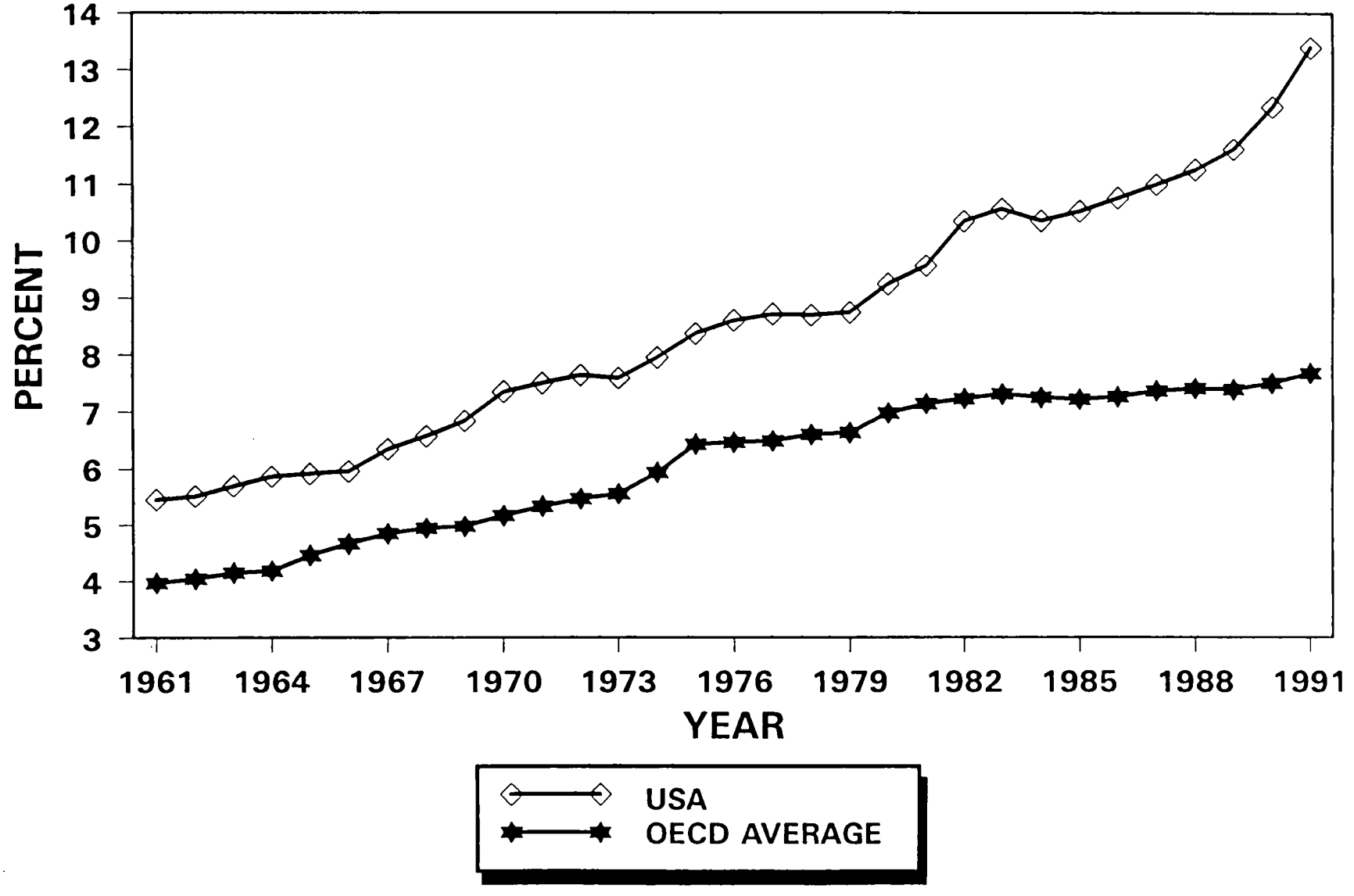
[1]The White House Task Force on Health Reform Working Group Draft Proposal, September 7, 1993.

Figure 1
NATIONAL HEALTH EXPENDITURES SHARE OF GDP, 1961-1991



Source: OECD Health Data 1993, Version 1.5.

The limit on national health spending would have two components: a limit on private sector spending and a separate limit on Medicaid and Medicare spending. Under the President's proposal, the growth in private spending in 1996 would be limited to the rate of growth in the consumer price index (CPI) plus 1.5 percent plus the rate of population growth. In 1997, the growth would be limited to the growth in the CPI plus 1.0 percent plus population growth. The 1998 growth would be limited to the growth in CPI plus 0.5 percent plus population growth. Thereafter, the growth in private spending would be limited to the growth rate in CPI plus population growth. Thus, by the year 1999 growth in per capita private health spending would be limited to the growth in the CPI.

The growth in public programs would be subject to a slightly higher limit each year. Medicaid and Medicare would be allowed to grow at a rate that is 0.9 percent higher than the private sector rate between 1995 and 1999. In 2000, that percent would fall to 0.4 percent. For example, in 1996, the growth in public spending would be limited to CPI plus 1.5 percent plus population growth plus 0.9 percent. By the year 2000, the growth in Medicaid and Medicare spending per capita would be limited to the CPI plus 0.4 percent.

Taken together, the two separate limits would bring per capita health spending down to nearly the CPI rate of growth by the year 2000. Specifically, the effects on each year's allowable growth rates would be as follows:

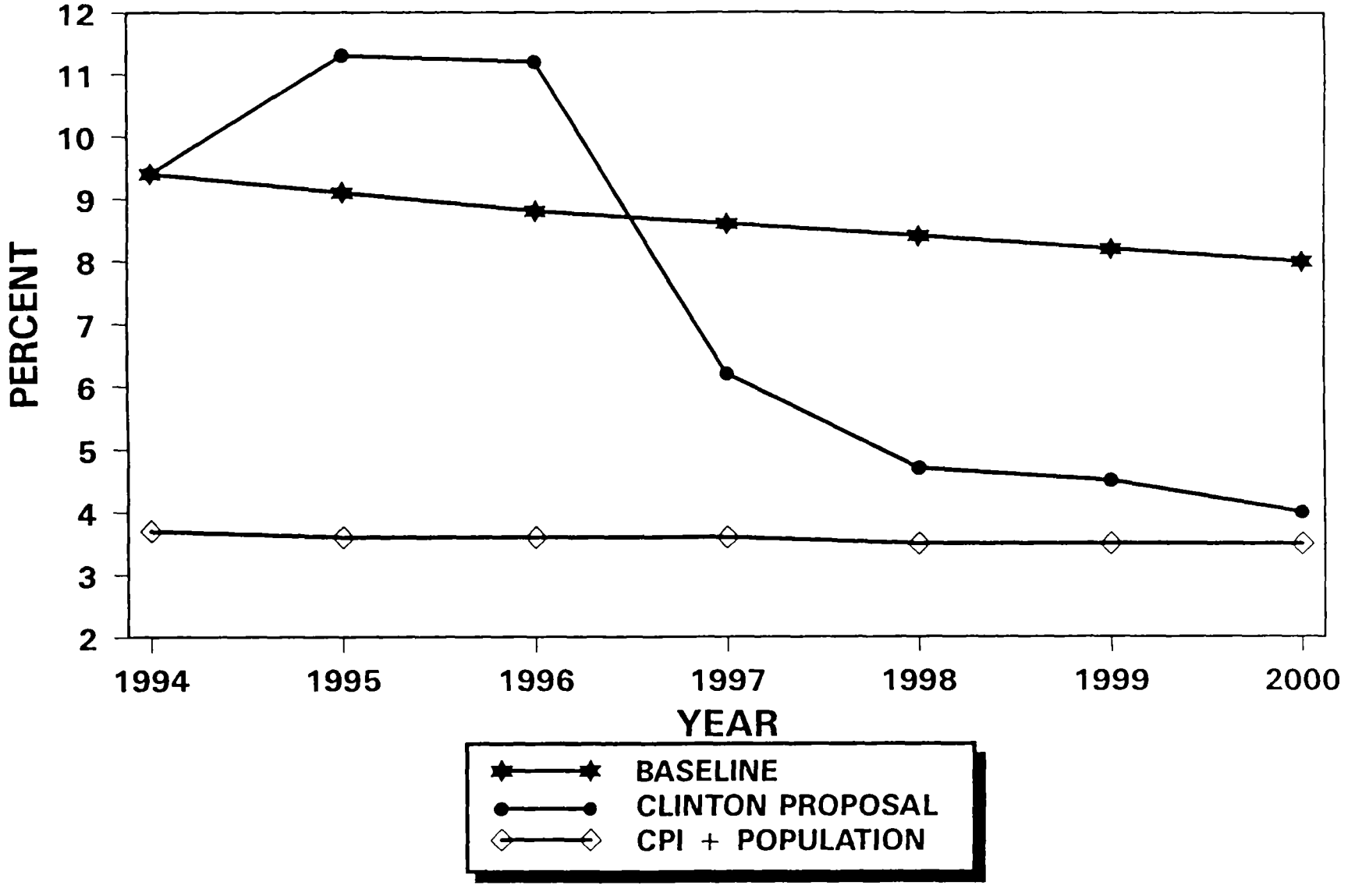
	1994	1995	1996	1997	1999	1999	2000
NHE:							
Baseline ($bill)	998	1,089	1,185	1,288	1,395	1,510	1,631
Clinton ($bill)	999	1,112	1,237	1,314	1,376	1,438	1,495
Growth Rate:							
Baseline (%)	9.4	9.1	8.8	8.6	8.4	8.2	8.0
Clinton (%)	9.4	11.3	11.2	6.2	4.7	4.5	4.0
CPI + Population (%)	3.7	3.6	3.6	3.6	3.5	3.5	3.5

SOURCE: The White House Task Force on Health Reform Working Group Draft Proposal, September 7, 1993 as provided by BNA Daily Tax Report, Special Supplement, September 13, 1993.

Despite the global budget caps, the growth rate of health spending would increase by about two percentage points in the early years as almost 40 million uninsured are brought into the system. The effect of the global caps, however, eventually overtakes the effect of universal coverage. Ultimately, if inflation is as forecasted, the growth rate in national health spending would be reduced to 4.0 percent in the year 2000 (from an expected rate of 9.4 percent in 1994, see Figure 2). In other words, the "real" rate of growth in per capita national health spending would be reduced from 5.5 percent to 0.5 percent. (The real rate of growth per capita is defined as the growth rate less general inflation and population growth.)

Figure 2

REAL HEALTH EXPENDITURES PER CAPITA, ANNUAL GROWTH RATE, 1994-2000



Source: Working Group Draft, September 7, 1993; from White House Task Force on Health Reform as provided by BNA Daily Tax Report, Special Supplement; September 13, 1993.

The OECD Experience

Are the limits in the President's proposal unrealistically low? An analysis of the experience of other major industrialized countries might shed some light on the ambitiousness, or realism, of the cost containment proposal. These countries have implemented a wide variety of health care financing and budgeting systems. The United Kingdom, for example, has a national health service with a strict national health budget. Other industrialized countries have global budgets for all, or part, of the health care system. Have other industrialized countries been better able to control health spending? Do any of them have records that approach the limits under President Clinton's proposal?

The most readily available data on health spending of other major industrialized countries is collected and published by the OECD. (The OECD includes 19 European nations, plus Canada, Japan, Australia, New Zealand, and the United States.) In order to compare the OECD record with the Clinton limits, measures for national health spending, population growth, and general inflation are needed. The OECD data base contains all three indicators, but the measure of general inflation is the GDP deflator instead of the consumer price index. Since both measures are available for the United States, a direct comparison of the two indicators is possible for one country. As can be seen in Table 1, the two series track each other quite closely. The two indicators produce even more similar average annual inflation rates over longer periods of time. Average annual inflation in the United States, as measured by the CPI, has been 5.2 percent during the past three decades. During the same period, the growth of the GDP deflator has averaged 5.1 percent (see Table 1). The average growth rate for each half-decade period has also been similar in the United States.[2]

[2]The correlation between the CPI and the GDP deflator is 0.999 between 1961 and 1991. The correlation between the rate of change in the CPI and the rate of change in the GDP deflator is 0.874.

Table 1

ANNUAL GROWTH RATES IN CPI AND GDP (UNITED STATES)

GROWTH PERIOD	CPI	GDP DEFLATOR
1961-91	5.2	5.1
1961-66	1.6	2.3
1966-71	4.6	4.7
1971-76	7.0	7.1
1976-81	9.8	8.6
1981-86	3.8	4.2
1986-91	4.4	4.0

Source: OECD Health Data 1993, Version 1.5; Economic Report of the President, January 1993.

Using the OECD data on national health spending, population, and the price deflator, "real" per capita health spending can be computed for each country. Table 2 shows real per capita health spending for the OECD countries. Health spending per capita in the OECD countries (excluding the United States) grew at an unweighted average annual rate of 5.4 percent during the three-decade period, 1961 to 1991 (see Table 2). In other words, during the three-decade period, the rate of increase in health spending per capita in the OECD countries was, on average, 5.4 percent higher than the rate of general inflation (as measured by the GDP deflator). During the same period, health spending per capita in the United States grew at an annual rate of 4.9 percent higher than general inflation.

In other OECD countries, however, the rate of increase in real health spending per capita has generally declined during the three-decade period. During the period 1961 to 1966, the rate of increase was 8.5 percent higher, on average, than general inflation. It fell each period until reaching a low point of 2.3 percent during the half-decade, 1981 to 1986. During the most recent period, the increase in real health spending per capita was 3.4 percent higher than general inflation, on average. By contrast, in the United States, the rate of increase in health spending per capita has fluctuated during the three-decade period, increasing with the introduction of Medicare and Medicaid, then declining each half-decade until 1981, and then rising during the two most recent half-decades.

Some OECD countries did better than the average and others did worse. Over the entire 1961 to 1991 period, 25 percent of all OECD countries had an average annual rate of growth in real health spending per capita that was less than 4.5 percent, roughly one percentage point below the average (see Table 3). The country with the lowest rate of growth, which was the United Kingdom, had a growth rate in health spending that was 3.7 percent above the rate of growth in prices as measured by the GDP deflator (see Table 4).

Table 2

ANNUAL GROWTH RATES IN REAL HEALTH EXPENDITURES PER CAPITA

GROWTH PERIOD	OECD AVERAGE[1/]		AUS.	CAN.	GER.	U.K.	U.S.A.
	UNWEIGHTED	WEIGHTED[2/]					
1961-91	5.4	5.1	3.9	4.5	4.6	3.7	4.9
1961-66	8.5	8.4	1.7	5.1	6.1	3.5	5.7
1966-71	8.1	7.2	8.6	7.2	6.1	3.7	6.3
1971-76	6.6	5.9	7.3	3.4	7.9	5.8	4.7
1976-81	3.8	4.5	1.3	3.2	3.7	3.0	3.8
1981-86	2.3	2.1	2.8	5.3	1.4	2.9	4.0
1986-91	3.4	4.2	1.6	3.1	2.4	3.6	5.3

Source: OECD Health Data 1993, Version 1.5.

1/ Excludes U.S.A.
2/ Weighted by population.

Table 3

DISTRIBUTION OF ANNUAL GROWTH RATES IN REAL HEALTH EXPENDITURES PER CAPITA

GROWTH PERIOD	MINIMUM	DISTRIBUTION			MAXIMUM
		25%	50%	75%	
1961-91	3.7	4.5	5.1	5.9	8.5
1961-66	1.7	5.7	7.5	9.0	18.8
1966-71	3.7	6.3	7.6	8.9	13.7
1971-76	3.4	5.0	5.9	7.3	11.8
1976-81	0.9	2.4	3.7	4.9	7.5
1981-86	(1.7)	1.1	2.2	2.9	5.3
1986-91	0.5	2.1	3.1	4.8	7.7

Source: OECD Health Data 1993, Version 1.5.

Table 4

ANNUAL GROWTH RATES IN REAL HEALTH EXPENDITURES PER CAPITA

COUNTRY	GROWTH PERIOD						
	1961-66	1966-71	1971-76	1976-81	1981-86	1986-91	1961-91
Australia	1.7	8.6	7.3	1.3	2.8	1.6	3.9
Austria	5.2	6.3	10.6	4.2	1.8	3.0	5.1
Belgium	7.0	6.0	11.8	4.9	2.4	4.1	6.0
Canada	5.1	7.2	3.4	3.2	5.3	3.1	4.5
Denmark	9.0	6.6	3.5	0.9	0.9	2.7	3.9
Finland	9.0	7.4	5.9	2.7	4.7	5.2	5.8
France	8.5	6.6	5.6	4.5	2.8	3.5	5.2
Germany	6.1	6.1	7.9	3.7	1.4	2.4	4.6
Greece	10.0	9.6	4.2	4.0	4.8	0.5	5.5
Iceland	15.0	7.6	7.0	7.5	4.7	2.1	7.2
Ireland	7.5	11.1	6.7	5.7	(0.5)	3.5	5.6
Italy	9.0	8.9	5.0	5.6	2.3	6.4	6.2
Japan	14.3	9.5	6.9	7.0	2.9	4.5	7.4
Luxembourg	n/a	n/a	6.1	5.9	2.2	4.8	n/a
Netherlands	6.7	11.2	5.8	2.7	0.9	2.8	5.0
Norway	7.2	8.4	9.7	2.4	5.2	2.5	5.9
New Zealand	n/a	n/a	n/a	2.3	1.3	1.5	n/a
Portugal	n/a	n/a	n/a	2.5	2.1	5.0	n/a
Spain	18.8	13.7	9.1	1.8	1.1	7.7	8.5
Sweden	8.9	7.7	4.2	3.8	(0.1)	0.9	4.2
Switzerland	9.9	7.6	4.8	2.3	1.8	2.1	4.7
Turkey	n/a	n/a	n/a	5.3	(1.7)	5.5	n/a
U.K.	3.5	3.7	5.8	3.0	2.9	3.6	3.7
U.S.	5.7	6.3	4.7	3.8	4.0	5.3	4.9

Source: OECD Health Data 1993, Version 1.5.

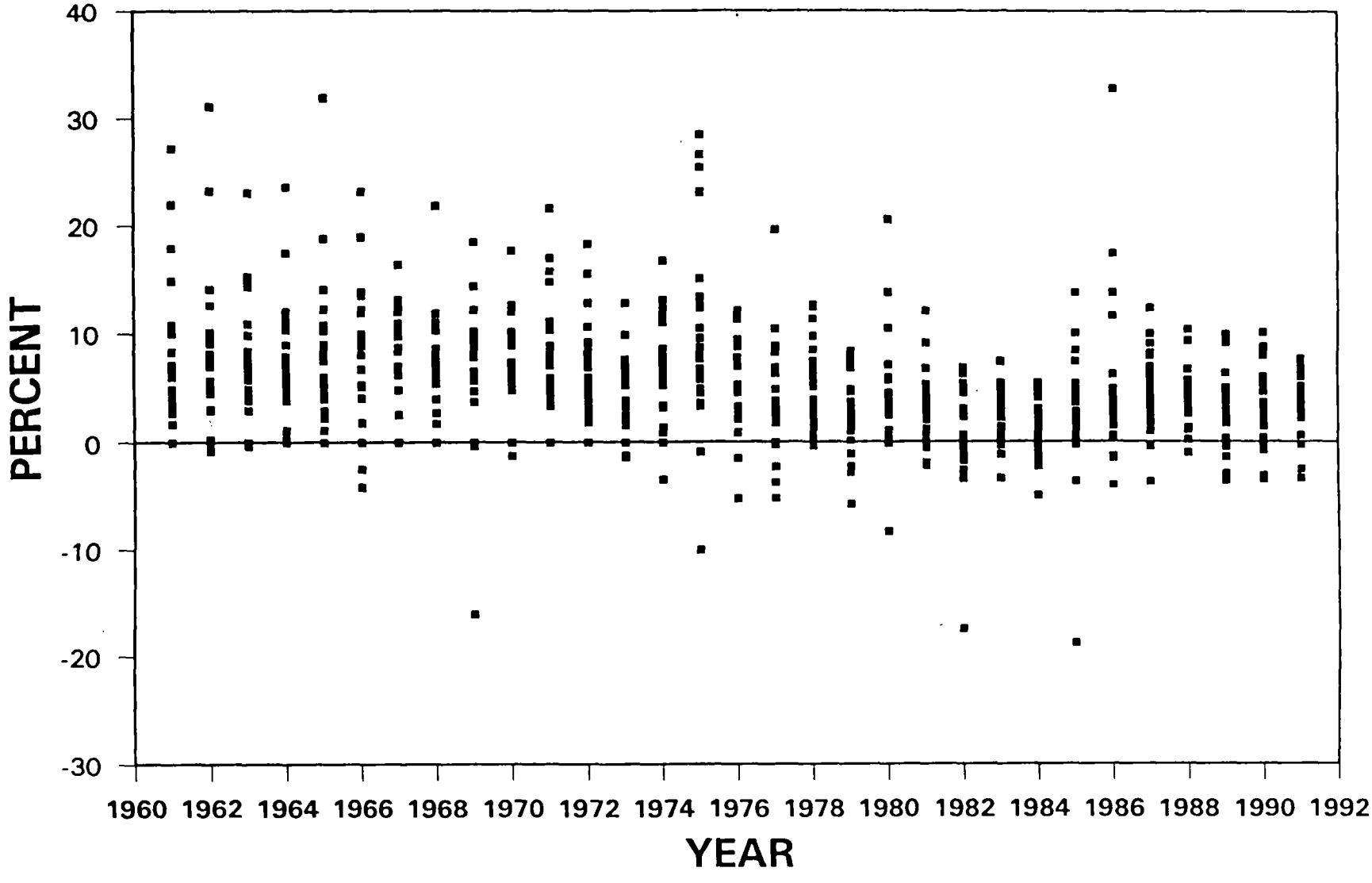
As noted above, the OECD countries had lower rates of growth in real health spending in recent years, especially since 1976. In fact, during the 1981 to 1986 period, three countries -- Ireland, Sweden, and Turkey kept the growth in health spending below the level of general inflation (see Table 4). Ireland and Turkey, did not maintain low growth rates during the next five years, but Sweden maintained a low growth rate in real health spending per capita for the entire decade, 1981 to 1991.[3]

Health spending in every OECD country grew faster than the GDP deflator in the most recent half-decade, 1986 to 1991. Greece, with growth in real per capita spending of less than 0.5 percent, is the only OECD country in the most recent period whose growth is nearly comparable to general inflation. In addition, Sweden had an average growth rate in real per capita health spending that was 0.9 percent above general inflation. Australia and New Zealand had growth rates that were less than two percentage points above general inflation. Canada, with its single-payer system, had increases in real spending per capita that were 3.1 percent higher than general inflation.

Five years is an arbitrary time period. Many countries, in fact, have reached levels of growth in health spending that were below (or close to) the level of general inflation, but for time periods that were shorter than five years. Figure 3 depicts the single-year growth rates of all the OECD countries by year, 1961 to 1991. The vast majority of all the

[3]A computer search of every possible five-year period revealed that one additional country had a growth rate that was less than zero for a five-year period other than 1981 to 1986. New Zealand, during 1979 to 1984, had a real growth in health spending per capita that was 0.4 percent less than the increase in the GDP deflator.

Figure 3
ANNUAL GROWTH RATES IN REAL HEALTH EXPENDITURES PER CAPITA, 1961-1991



Source: OECD Health Data 1993, Version 1.5.

observations were well above zero percent (the level at which the rate of growth in health spending equals the general level of inflation). About 10 percent of the observations (73 observations out of 694 in total) were below zero. Another 5 percent are between zero and one percent. In total, 15 percent were below one percent.[4, 5]

Most countries, however, have had rates of growth that are well above the rate of general inflation. In fact, during the most recent five-year period, three out of four OECD countries had growth rates that averaged 2.1 percent higher than the rate of growth in the general price level. One out of two countries had rates that were 3.1 percent higher. Italy, Spain, and Turkey had higher real rates of spending growth for the most recent five-year period than the United States (see Table 4).

In conclusion, to reach the year 2000 growth targets in President Clinton's proposal, the United States would have to shift from being the fourth fastest growing country (as measured by growth in real health spending per capita during the 1986 to 1991 period) to being among the slowest growing OECD countries. In fact, it would have to reach a growth rate in health spending equal to, or better than, the growth rate for Greece, the slowest growing country in the OECD during 1986 to 1991 period.

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[4]The most recent record has been somewhat better. During 1981 to 1991, 18 percent of the observations were below zero and 28 percent of the observations were below one percent.

[5]The annual fluctuation in real growth rates per capita appear to contain a lot of what statisticians call "noise." Noise is the term for fluctuations that are due to errors in the data, changes in accounting methods, or other changes that are not related to real changes in the provision of health services. The effects of random fluctuations in the data tend to cancel each other over longer time periods. For that reason, five-year growth rates tend to be more reliable indicators of changes in reach growth rates per capita.

Limitations to the Analysis

Interpretation of international statistics, particularly as it applies to President Clinton's proposal, is subject to a number of limitations. First, and foremost, are differences in the data on spending that limit comparisons between countries. For example, the part of economic activity that is included in the GDP and in national health spending varies from country to country within the same year and from year to year within the same country. Moreover, comparing health spending statistics when the health care systems are completely different may be misleading.

Second, none of the OECD countries has ever reached the level of health spending that the United States has today. It may prove easier to limit growth in spending when the level has reached 14 percent of GDP than it is to limit spending when it is only 6 percent, or even 11 percent.

Third, analysis of the data on spending does not shed any light on the question of how many OECD countries tried to limit spending to a level that would be comparable to the CPI growth. Most of the OECD countries did not abruptly change their health care systems during the period under study. Certainly, none of them adopted managed competition, or anything similar. On the other hand, many OECD countries have systems that are similar to what Americans would call a single-payer system. Many OECD countries also have global budgets, especially for hospital expenditures.

THE WHITE HOUSE

WASHINGTON

October 19, 1993

Mr. Bill Gradison
President
Health Insurance Association
of America
1025 Connecticut Avenue, N.W.
Washington, D.C. 20036-3998

Dear Bill:

Thank you for writing. I appreciate your sharing your concerns about the health security plan with me.

I am pleased to hear of the interest of the health insurance industry in reforming our nation's health care system. I know that we agree on many aspects of the reform our country needs, and I look forward to working with you toward these beneficial changes.

I can assure you that we are working to make the system less bureaucratic. That is why my plan uses the federal government only to set up the principal guidelines of the health system and lets the states and local health alliances actually run the system.

We are also in agreement that a system based on price controls will not be an effective one. Therefore, rather than concentrating on price controls, my plan encourages savings by promoting competition among health plans, emphasizing prevention, reducing excessive paperwork, and cracking down on waste and fraud. The premium caps provide a balance between the over-regulation that currently exists and the danger that in the absence of budget targets, our health care costs will continue to rise out of control.

This plan is, of course, a massive undertaking and will require that all Americans take some responsibility for their health care. There will certainly be challenges for companies like those you represent as we attempt these reforms and promote competition. If we do not make these important changes, however, medical inflation

will continue to eat away at our wages, our capital, and our ability to create new jobs. My plan will control costs, provide universal coverage, and help keep our nation competitive. We all have a great deal to gain by embracing these changes, and I hope I can count on your support.

I will keep your concerns in mind as we move ahead.

Sincerely,

Bill Clinton