UNPLUBLISHED
January 14, 1982
2:00 pm

THE WHITE HOUSE

WASHINGTON

THE PRESIDENT'S SCHEDULE
FRIDAY, JANUARY 15, 1982

9:00 am (30 min)	Staff Time (Baker, Meese, Deaver)	Oval Office
9:30 am (15 min)	National Secruity Briefing (Clark)	Oval Office
9:45 am (15 min)	Senior Staff Time	Oval Office
10:00 am (60 min)	Cabinet Council on Human Resources (Fuller) (Tab A)	Cabinet Room
11:00 am (55 min)	Personal Staff Time	Oval Office
11:55 am (5 min)	Photo with Max Binswanger (Fischer) (Tab B)	Oval Office
12:00 m (60 min)	Lunch and Personal Staff Time	Oval Office
1:00 pm (45 min)	Consultative Meeting with Senate GOP Leaders RE 1983 Budget (Duberstein) (Tab C)	Cabinet Room
1:45 pm	Personal Staff Time Remainder of Afternoon	Oval Office
5:30 pm (30 min)	Staff Time (Baker, Meese, Deaver)	Oval Office

THE WHITE HOUSE

WASHINGTON

January 14, 1982

MEETING WITH THE CABINET COUNCIL ON HUMAN RESOURCES

DATE: JANUARY 15, 1982
TIME: 10:00 AM (60 MINUTES)
LOCATION: CABINET ROOM

FROM: CRAIG L. FULLER

I. PURPOSE

The meeting with the Cabinet Council on Human Resources is to review the paper on a Pro-Competition Health Plan. It was developed by a working group within the Cabinet Council; however, it was not received in time to circulate for views from departments and agencies or White House Staff prior to the meeting.

II. BACKGROUND

The working group on pro-competition health care developed a detailed options paper which is attached.

You will receive a comprehensive presentation. No immediate decisions are required; however, guidance for HHS will be needed in the near future in order to draft the appropriate legislation.

III. PARTICIPANTS

A list will be attached to the agenda. It is a principals only meeting.

IV. PRESS PLAN

White House photographer only.

V. SEQUENCE

Secretary Schweiker, as the chairman pro-tempore of the Cabinet Council on Human Resources will lead the discussion.

THE WHITE HOUSE

WASHINGTON

CABINET COUNCIL ON HUMAN RESOURCES

January 15, 1982

10:30 AM

Cabinet Room

AGENDA

1. Pro-Competition Health Plan/CM141

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR THE PRESIDENT

FROM: ROBERT B. CARLESON, EXECUTIVE SECRETARY
CABINET COUNCIL ON HUMAN RESOURCES

SUBJECT: Pro-Competition Health Proposals

The Working Group on Reforming Health Care Incentives chaired by Robert J. Rubin, Assistant Secretary of Health and Human Services for Policy and Evaluation, has submitted the following:

Background

In 1981, health care costs continued to spiral upward, consuming an ever larger share of the GNP and the Federal budget. Hospital costs, for example, have been increasing at an annual rate of about 19 percent in contrast to the general inflation rate of about 10 percent. Neither the industry's program of self-restraint nor a tangled web of Federal and State regulations appears able to stem this trend.

Industry self-restraint and government regulation have failed because they have not addressed the most important cause of the health cost spiral: the Federal government's poorly designed tax and spending policies. Through the tax law and its health programs, the government has fostered the growth of comprehensive health insurance. The result is that a growing number of patients, physicians, and hospitals are insulated from the cost of the medical resources they consume. Because insurers and government stand by to pay whatever bills are submitted, patients and health care providers face economic incentives that tell them that more health care is better and that money is no object. The inevitable byproduct is inefficiency that can be eliminated without adversely affecting the health of the American people.

In keeping with this Administration's overall philosophy, HHS and this Cabinet Council Work Group have examined options that would make workers, employers, insurers, public beneficiaries, physicians, and hospitals more sensitive to the cost of medical care. Once appropriate incentives are in place, the government could then begin to reduce its role in this large and important sector of the economy, allowing private citizens to adjust their behavior in response to the incentives. Not only is this "market" or "competition" approach more likely than regulation to succeed in bringing the cost of medical care under control, it promises to reverse the recent tendency to bureaucratize and politicize an important and intensely personal service.

Options

Following are options for improving the efficiency of the health care system. The options are grouped under the headings "Public Sector" and "Private Sector." The "Public Sector" options are designed to improve Medicare, while the "Private Sector" options deal with employment-based health insurance. The budget estimates assume that the options are implemented in FY 1983.

Changes in Medicaid are not included in this package of options because HHS believes that the Budget Reconciliation Act of 1981 gives the States substantial authority to revamp their programs according to market principles. Before submitting new Medicaid legislation, then, HHS would like to see how States implement the existing law.

PUBLIC SECTOR

Under Medicare Part A (hospital insurance), most patient cost-sharing is imposed late in a spell-of-illness (after the 60th day) when the patient can least afford it and when it is least likely to influence physician and patient behavior. Nor is there a limit under Medicare on the out-of-pocket cost a seriously ill patient can incur. In addition, Medicare's rules for paying HMOs discourage Medicare beneficiaries from enrolling in such plans. Under current law, conventional insurers cannot enroll Medicare beneficiaries, except for "Medigap" coverage paid for by the beneficiaries themselves.

Option 1: Combine improved incentives for Medicare beneficiaries with added coverage for catastrophic illness.

- This option would combine 10 percent coinsurance ($26 per day) on all hospital days after the first day with a $2500 per year limit on beneficiary cost-sharing under Part A (hospital insurance) and B (supplementary medical insurance).

- The existing limits on the number of covered hospital days (90 days per spell of illness and 60 lifetime reserve days) would be eliminated.

- The $2500 limit on cost-sharing would be indexed to increase with the rise in the medical care component of the consumer price index (MCPI).

- This proposal would reduce Medicare outlays by $500 million in FY 1983 and by $950 million in FY 1984.

Discussion

This proposal would redress the most significant shortcoming in the existing Medicare benefit: the absence of adequate financial protection against the high cost of serious illness. In arriving

at this proposal, a number of alternatives were studied, including separate catastrophic limits on Medicare Parts A and B and an income-related catastrophic cap. Separate catastrophic limits on Parts A and B were rejected because separate limits are more costly to Medicare. To achieve $500 million in Medicare savings with separate Part A and B limits, beneficiaries would have to be exposed to a risk of more than $2500 in out-of-pocket costs. An income-related catastrophic cap was rejected because it would be very costly to administer, thus reducing the potential budget savings.

Decision: _____ Approve

_____ Disapprove

Option 2: Offer Medicare beneficiaries the option of enrolling in private health plans:

- The Federal government would offer to pay 95 percent of Medicare's adjusted average per capita (AAPCC) on behalf of an aged or disabled beneficiary enrolling in a private plan. The beneficiary would pay the difference, if any, between the government's contribution and the plan's premium.

- The amount of the government's contribution toward a private plan would be recalculated each year so as to reflect increases in the cost of the Medicare program.

- Enrollment in a private health plan would be optional, and all beneficiaries would retain the right to return to Medicare during an annual open enrollment period.

- Both HMOs and conventional insurers would be eligible to participate in this "voucher" system. To qualify, a plan would be required to offer benefits at least as comprehensive as Medicare's Part A and B benefits. Plans would also be free to offer added benefits as a way of attracting enrollees.

- This option would have only a small effect on Medicare outlays in FY 1983 and FY 1984.

Discussion

When offering Medicare beneficiaries a choice of health plans, the government would run the risk that the healthiest beneficiaries would choose to enroll in private plans, leaving the less healthy in Medicare. Since the amount of the "voucher" granted to beneficiaries enrolling in private plans is tied to the per capita cost in Medicare, such "adverse selection" against Medicare would drive up the voucher amount and the total costs of Medicare.

It should be noted, however, that our proposal would reduce the risk of cost-increasing adverse selection by:

- o adjusting the amount of the voucher for actuarial factors, such as the beneficiary's age, sex, and disability status;
- o paying only 95 percent of the AAPCC, thus allowing the government a 5 percent offset against adverse selection;
- o requiring the participating private plans to have benefits at least as comprehensive as Medicare's;
- o prohibiting the participating private plans from discriminating against high risk beneficiaries; and
- o requiring that participating plans charge all Medicare beneficiaries the same incremental premium.

Decision: _____ Approve

_____ Disapprove

PRIVATE SECTOR

Unlike cash wages, an employer's contribution to an employee health plan is not taxable income to the employee. The employer may, however, deduct the contribution from its taxable income, just as it can deduct other business expenses. The preferential tax treatment for health insurance premiums encourages comprehensive, employment-based insurance with few, if any, controls designed to hold down the cost of medical care. In addition, this tax preference drains the Treasury and the Social Security Trust Funds of tax revenue. CBO estimates that in FY 1982, the tax preference for employer-paid health benefits will reduce Federal income tax revenues by about $20 billion and Social Security tax revenues by about $8 billion.

The options that follow are designed to limit or offset the tax law's distorting effect on the demand for private insurance. An "employer deduction limit" is a limit on the amount of health plan contribution that an employer may deduct as a business expense. The employee's taxable income would be unaffected by an employer deduction limit. In contrast, an "employee exclusion limit" would limit the amount of employer health plan contribution that is excluded from the employee's taxable income. The employer's tax deduction for health plan contributions would be unaffected by an "employee exclusion limit."

Option 3: Limit the employer deduction or the employee exclusion for health insurance.

- The limit would be a set dollar amount -- for example, $150 per month per employee with family coverage and $60 per month for individual coverage.

- The dollar limit would be indexed so that it would increase as prices rise.

Suboption 3A: Employer deduction limit.

HHS prefers this option for the following reasons:

- A limit on the employer's business deduction would have a more immediate impact than an employee exclusion limit. Employers know more than employees about health insurance and how costs can be cut. Moreover, it is employers who bargain with health insurers.

- If the tax limit is imposed on the employee, the employer would have little direct incentive to incur the start-up costs necessary to offer employees a choice of plans. The employer deduction limit, on the other hand, would give employers a more direct incentive to offer lower cost options and encourage employees to enroll in them. Creating health plan choices is an important HHS objective.

- The long run effect of an employer deduction limit and an employee exclusion limit would be about the same. In either case, the most common employer response would be to stop making contributions higher than the limit, leaving the employee to pay any excess out-of-pocket with "after tax" dollars.

- The individual tax cuts in the Economic Recovery Tax Act will do little more than offset the inflation-induced "bracket creep" in individual tax rates that is expected over the next three years. In contrast, the corporate tax cuts were much deeper and more enduring.

- Although 25 to 40 percent of employees work for non-profit organizations or government and would not be affected by an employer deduction limit, these workers on average do not have costly health benefits and would not be affected by either form of limit.

Suboption 3B: Employee Exclusion Limit.

Treasury recommends this option for the following reasons:

- A fraction of the labor force is employed by tax-exempt organizations and corporations with no tax liability. A cap on employer deductions would have no effect for at least 25 percent and perhaps as much as 40 percent of the labor force.

- A limitation on the employer deduction would eventually impact employee's wages, but, because it is less visible, it would create less of a disincentive for employees to demand excess amounts of health insurance in wage bargaining.

- Application of income tax principles indicates that an employee's income, be it from insurance payments or other sources, is taxable to the employee. By the same token, all components of an employer's labor costs should be deducted, or else his income is mismeasured.

- The perception that a limitation on the employee exclusion will appear to raise taxes on the "common man" is incorrect. A cap of $150 a month or $1800 a year, for instance, would generally affect those with generous compensation packages. (Some relatively low income workers would be affected if they are members of unions that have bargained for expensive health benefits.) Even then, only the excess over $1800 would be treated as employee income and therefore taxable to the employee. Generous grandfathering or phase-in rules can also avoid any immediate impact on employees.

- All bills proposed in Congress have placed the cap on the employee's exclusion rather than the employer deduction.

Discussion

In addition to deciding whether to impose a limit on the employer's deduction or the employee's exclusion, decisions must be made on the dollar amount of the limit, the rate at which the limit increases over time, and whether to "grandfather" firms (individuals) with employer health plan contributions higher than the limit in the base year. In addition to recommending that an employer deduction limit be used, HHS recommends that the limit be set at $150 per family and $60 per individual; that the limit be indexed to increase with the MCPI; and that firms exceeding the limit in the base year be grandfathered. Such a proposal would have no effect on tax revenues in FY 1983 and would increase revenus by $1.3 billion in FY 1984 and by $3.0 billion in FY 1986.

Treasury concurs with HHS' recommendations on the level of the limit, indexing, and grandfathering. An employee exclusion limit with the same characteristics would have no tax revenue effect in FY 1983 but would increase revenues by $2.4 billion in FY 1984 and by $5.9 billion in FY 1986.

Decision: _____ Employer Deduction Limit

_____ Employee Exclusion Limit

Option 4: Reimburse employers for costs of offering a choice of health plans.

- Employers would be given subsidies to offset part of the start-up costs that a firm incurs in switching from a single health plan to a choice of health plans.

- The amount of the subsidy would vary with firm size. For example, the subsidy could be set at $5,000 per firm plus $25 per covered employee, up to a maximum of $100,000.

- To qualify for the subsidy, the employer would be required to offer a plan with at least 20 percent coinsurance on all services (except specified preventive services) and, where available, a health maintenance organization. To assure that workers have adequate protection against the costs of catastrophic illness, all plans would be required to limit a family's exposure to out-of-pocket costs to no more than $3500 per year (indexed to increase with the MCPI).

  Employers who offer a choice of plans would have to make the same premium contribution to them all. As an incentive to select cost-effective coverage, those employees who chose a plan that cost less than the employer contribution would get a cash rebate. To reduce adverse selection against the comprehensive plans, the rebate would be limited to some percentage of the difference between the premium of the High Option plan and the premium of the plan actually selected, up to a maximum of $50 per month per family or $20 a month per individual. The maximum rebate would be indexed to the MCPI.

Discussion

HHS recommends that employers be given subsidies for offering a choice of plans because:

- An employer's start-up costs for moving from a single health plan to multiple plans are significant. (For example, PepsiCo spent about $300,000.)

- Allowing employees to choose among health plans is important for generating competition. In particular, employee choice is necessary to create a market for innovative plans.

- Subsidies would hasten the development of employee choice in response to the deduction limit.

Treasury opposes subsidies for offering a choice of plans because:

- A cap by itself eventually will create a substantial incentive for employers to offer a choice of plans and to allow employees to save the difference in costs between more expensive and less expensive plans.

- The "tax credit" device requires regulation of which plans qualify and which do not. Although regulation may sound simple, it is not.

- Treasury favors encouraging employers to offer employees a choice of plans within the context of cafeteria plans, only recently allowed by Congress. Such plans allow employees to choose cash instead of high option fringe benefits. As more of these types of plans are offered, employees will again be presented with greater choices of health plans, as well as other packages of fringe benefits.

- The precedent is bad. For instance, we do not offer tax credits for employers to offer pension plans nor do we give tax credits for meeting regulatory requirements.

OMB opposes subsidies for offering a choice of plans because:

- The only justification for a subsidy is that the HHS proposal, as presently drawn, establishes substantial rules and requirements on employers who choose to exercise the choice option. The subsidy becomes, in effect, compensation for complying with new Federal mandates.

- The need for the subsidy could be eliminated if the new mandates were limited to the minimum necessary to ensure effective competition between insurers and health providers. In particular, the requirement that employers offer certain specific choices of plans is unnecessary, and may even have the perverse effect of limiting the sort of innovation in the market that this proposal is designed to foster.

- OMB believes that, under a system where employees have a financial incentive to choose cost-effective plans, the normal operations of the free market will provide an adequate range of product choices to the consumer.

It is not necessary to rig the rules of the game to ensure that particular types of products are offered, and then compensate employers for the cost of complying with the rules. By contrast, the catastrophic requirement is a sensible feature, and should be retained, as should the equal contribution rule.

Decision: _____Approve

_____Disapprove

If a subsidy is approved, a decision must be made on the form of the subsidy.

Suboption 4A: Tax credit.

HHS recommends that the subsidy be in the form of a tax credit for the following reasons:

- o A tax credit does not require new application forms or a new bureaucracy.
- o Employers will be more likely to take advantage of the subsidy if they can do so in the course of filing their regular tax returns.

Suboption 4B: Grants to Employers.

If a subsidy is to be offered, Treasury recommends that it be a direct grant to employers administered by HHS and included in HHS' budget.

- o If credits are indeed appropriate for health policy reasons, then they should be placed in the health budget where they can be adequately examined and administered, as well as through the budget process.
- o A tax credit would have little effect on plans offered by the non-profit sector or by non-profitable corporations.

Decision: _____ Tax Credit

_____ Grants to Employers

THE WHITE HOUSE

WASHINGTON

January 14, 1982

MEETING WITH MAX BINSWANGER
DATE: January 15, 1982
LOCATION: Oval Office
TIME: 11:55 a.m.

FROM: Michael K. Deaver

I. PURPOSE

Mr. Binswanger is leaving for Jamaica and has requested the opportunity to say good-bye and have a photo taken for display in his new office.

II. BACKGROUND

Mr. Binswanger will be the Country Director of the Peace Corps for Jamaica.

III. PARTICIPANTS

Mr. and Mrs. Max Binswanger (Evelyn)

IV. PRESS PLAN

White House photographer only.

V. SEQUENCE OF EVENTS

Greet Max and Evelyn Binswanger.

C

THE WHITE HOUSE

WASHINGTON

January 14, 1982

MEETING WITH SENATOR HOWARD BAKER (R-TENNESSEE)
SENATOR ROBERT DOLE (R-KANSAS), AND
SENATOR PETE DOMENICI (R-NEW MEXICO)

DATE: Friday, January 15, 1982
PLACE: The Oval Office
TIME: 1:00 p.m. (45 minutes)

FROM: Kenneth M. Duberstein

I. PURPOSE

To discuss the Fiscal Year 1983 budget and consult with the Senate Majority Leader, the Chairman of the Senate Finance Committee, and the Chairman of the Senate Budget Committee.

II. BACKGROUND

During the first session of Congress, Senate Majority Leader Howard Baker assembled a small group of Republican Senators to work with Administration officials in devising a consensus on the budget and other economic plans. This economic working group consists of Majority Leader Baker, Assistant Majority Leader Ted Stevens, Senator Paul Laxalt, Finance Committee Chairman Robert Dole, Appropriations Committee Chairman Mark Hatfield, and Budget Committee Chairman Pete Domenici.

Prior to adjournment of the first session, OMB Director Dave Stockman met twice with this group with respect to the Fiscal Year 1983 budget. These discussions were general in nature. The only meeting involving the President took place on December 18, two days after adjournment of the first session of Congress.

The purpose of today's meeting is to allow one more opportunity for consultation with these Senate leaders prior to finalizing decisions on the budget package.

III. PARTICIPANTS

See Attachment A.

IV. PRESS PLAN

White House photographer only.

V. SEQUENCE OF EVENTS

The Senators will enter through the Northwest Gate to the West Lobby where they will be escorted to the Oval Office for a 45-minute meeting with the President.

Attachments: Participants (Attachment A)
Talking Points (Attachment B)

ATTACHMENT A

PARTICIPANTS

The President
Vice President Bush
Secretary of the Treasury Regan
OMB Director Stockman

Senator Howard Baker, Majority Leader
Senator Robert Dole, Finance Committee Chairman
Senator Pete Domenici, Budget Committee Chairman

Invited, but unable to attend

Senator Ted Stevens, Assistant Majority Leader
Senator Paul Laxalt
Senator Mark Hatfield, Appropriations Committee Chairman

Staff

Edwin Meese III
James Baker III
Michael K. Deaver
Martin Anderson
Richard Darman
Kenneth M. Duberstein
Pamela J. Turner

ATTACHMENT B

TALKING POINTS FOR

PRESIDENT'S
FRIDAY, JANUARY 15 MEETING
WITH REPUBLICAN SENATORIAL
LEADERSHIP

-- Contrary to what you may have read in the press, the major budget decisions are still being resolved. I would welcome your candid advice and thoughtful guidance at this point in the process.

-- The budget we will propose must show steady downward progress in reducing projected deficits year after year.

-- I am aware that this coming budget season will be even more difficult than the last one. Yet I think we should all be encouraged by the results we've achieved so far. We've already cut the rate of spending growth in half. The budget we will send to the Hill next month will be a balanced package of additional savings to further restrain the growth of government.

-- I want to assure you that I will never retreat from the essential elements of the program which, working together, we've put into place -- personal and business tax rate cuts, continued spending restraint, and adequate resources for our national defense. The proposals that we put forward in this budget will be consistent with the progress we've already achieved.

THE WHITE HOUSE

WASHINGTON

January 14, 1982

MEETING WITH THE CABINET COUNCIL ON HUMAN RESOURCES

DATE: JANUARY 15, 1982
TIME: 10:00 AM (60 MINUTES)
LOCATION: CABINET ROOM

FROM: CRAIG L. FULLER

I. PURPOSE

The meeting with the Cabinet Council on Human Resources is to review the paper on a Pro-Competition Health Plan. It was developed by a working group within the Cabinet Council; however, it was not received in time to circulate for views from departments and agencies or White House Staff prior to the meeting.

II. BACKGROUND

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You will receive a comprehensive presentation. No immediate decisions are required; however, guidance for HHS will be needed in the near future in order to draft the appropriate legislation.

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V. SEQUENCE

Secretary Schweiker, as the chairman pro-tempore of the Cabinet Council on Human Resources will lead the discussion.

THE WHITE HOUSE

WASHINGTON

CABINET COUNCIL ON HUMAN RESOURCES

January 15, 1982

10:30 a.m.

Cabinet Room

AGENDA

1. Pro-Competition Health Plan/CM141

THE WHITE HOUSE

WASHINGTON

January 14, 1982

MEMORANDUM FOR THE PRESIDENT

FROM: ROBERT B. CARLESON, EXECUTIVE SECRETARY
CABINET COUNCIL ON HUMAN RESOURCES

SUBJECT: Pro-Competition Health Proposals

The Working Group on Reforming Health Care Incentives chaired by Robert J. Rubin, Assistant Secretary of Health and Human Services for Policy and Evaluation, has submitted the following:

Background

In 1981, health care costs continued to spiral upward, consuming an ever larger share of the GNP and the Federal budget. Hospital costs, for example, have been increasing at an annual rate of about 19 percent in contrast to the general inflation rate of about 10 percent. Neither the industry's program of self-restraint nor a tangled web of Federal and State regulations appears able to stem this trend.

Industry self-restraint and government regulation have failed because they have not addressed the most important cause of the health cost spiral: the Federal government's poorly designed tax and spending policies. Through the tax law and its health programs, the government has fostered the growth of comprehensive health insurance. The result is that a growing number of patients, physicians, and hospitals are insulated from the cost of the medical resources they consume. Because insurers and government stand by to pay whatever bills are submitted, patients and health care providers face economic incentives that tell them that more health care is better and that money is no object. The inevitable byproduct is inefficiency that can be eliminated without adversely affecting the health of the American people.

In keeping with this Administration's overall philosophy, HHS and this Cabinet Council Work Group have examined options that would make workers, employers, insurers, public beneficiaries, physicians, and hospitals more sensitive to the cost of medical care. Once appropriate incentives are in place, the government could then begin to reduce its role in this large and important sector of the economy, allowing private citizens to adjust their behavior in response to the incentives. Not only is this "market" or "competition" approach more likely than regulation to succeed in bringing the cost of medical care under control, it promises to reverse the recent tendency to bureaucratize and politicize an important and intensely personal service.

Options

Following are options for improving the efficiency of the health care system. The options are grouped under the headings "Public Sector" and "Private Sector." The "Public Sector" options are designed to improve Medicare, while the "Private Sector" options deal with employment-based health insurance. The budget estimates assume that the options are implemented in FY 1983.

Changes in Medicaid are not included in this package of options because HHS believes that the Budget Reconciliation Act of 1981 gives the States substantial authority to revamp their programs according to market principles. Before submitting new Medicaid legislation, then, HHS would like to see how States implement the existing law.

PUBLIC SECTOR

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Option 1: Combine improved incentives for Medicare beneficiaries with added coverage for catastrophic illness.

- This option would combine 10 percent coinsurance ($26 per day) on all hospital days after the first day with a $2500 per year limit on beneficiary cost-sharing under Part A (hospital insurance) and B (supplementary medical insurance).

- The existing limits on the number of covered hospital days (90 days per spell of illness and 60 lifetime reserve days) would be eliminated.

- The $2500 limit on cost-sharing would be indexed to increase with the rise in the medical care component of the consumer price index (MCPI).

- This proposal would reduce Medicare outlays by $500 million in FY 1983 and by $950 million in FY 1984.

Discussion

This proposal would redress the most significant shortcoming in the existing Medicare benefit: the absence of adequate financial protection against the high cost of serious illness. In arriving

at this proposal, a number of alternatives were studied, including separate catastrophic limits on Medicare Parts A and B and an income-related catastrophic cap. Separate catastrophic limits on Parts A and B were rejected because separate limits are more costly to Medicare. To achieve $500 million in Medicare savings with separate Part A and B limits, beneficiaries would have to be exposed to a risk of more than $2500 in out-of-pocket costs. An income-related catastrophic cap was rejected because it would be very costly to administer, thus reducing the potential budget savings.

Decision: _____ Approve

_____ Disapprove

Option 2: Offer Medicare beneficiaries the option of enrolling in private health plans:

- The Federal government would offer to pay 95 percent of Medicare's adjusted average per capita (AAPCC) on behalf of an aged or disabled beneficiary enrolling in a private plan. The beneficiary would pay the difference, if any, between the government's contribution and the plan's premium.

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- This option would have only a small effect on Medicare outlays in FY 1983 and FY 1984.

Discussion

When offering Medicare beneficiaries a choice of health plans, the government would run the risk that the healthiest beneficiaries would choose to enroll in private plans, leaving the less healthy in Medicare. Since the amount of the "voucher" granted to beneficiaries enrolling in private plans is tied to the per capita cost in Medicare, such "adverse selection" against Medicare would drive up the voucher amount and the total costs of Medicare.

It should be noted, however, that our proposal would reduce the risk of cost-increasing adverse selection by:

- adjusting the amount of the voucher for actuarial factors, such as the beneficiary's age, sex, and disability status;
- paying only 95 percent of the AAPCC, thus allowing the government a 5 percent offset against adverse selection;
- requiring the participating private plans to have benefits at least as comprehensive as Medicare's;
- prohibiting the participating private plans from discriminating against high risk beneficiaries; and
- requiring that participating plans charge all Medicare beneficiaries the same incremental premium.

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_____ Disapprove

PRIVATE SECTOR

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- The limit would be a set dollar amount -- for example, $150 per month per employee with family coverage and $60 per month for individual coverage.

- The dollar limit would be indexed so that it would increase as prices rise.

Suboption 3A: Employer deduction limit.

HHS prefers this option for the following reasons:

- A limit on the employer's business deduction would have a more immediate impact than an employee exclusion limit. Employers know more than employees about health insurance and how costs can be cut. Moreover, it is employers who bargain with health insurers.

- If the tax limit is imposed on the employee, the employer would have little direct incentive to incur the start-up costs necessary to offer employees a choice of plans. The employer deduction limit, on the other hand, would give employers a more direct incentive to offer lower cost options and encourage employees to enroll in them. Creating health plan choices is an important HHS objective.

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- Although 25 to 40 percent of employees work for non-profit organizations or government and would not be affected by an employer deduction limit, these workers on average do not have costly health benefits and would not be affected by either form of limit.

Suboption 3B: Employee Exclusion Limit.

Treasury recommends this option for the following reasons:

- A fraction of the labor force is employed by tax-exempt organizations and corporations with no tax liability. A cap on employer deductions would have no effect for at least 25 percent and perhaps as much as 40 percent of the labor force.

- A limitation on the employer deduction would eventually impact employee's wages, but, because it is less visible, it would create less of a disincentive for employees to demand excess amounts of health insurance in wage bargaining.

- Application of income tax principles indicates that an employee's income, be it from insurance payments or other sources, is taxable to the employee. By the same token, all components of an employer's labor costs should be deducted, or else his income is mismeasured.

- The perception that a limitation on the employee exclusion will appear to raise taxes on the "common man" is incorrect. A cap of $150 a month or $1800 a year, for instance, would generally affect those with generous compensation packages. (Some relatively low income workers would be affected if they are members of unions that have bargained for expensive health benefits.) Even then, only the excess over $1800 would be treated as employee income and therefore taxable to the employee. Generous grandfathering or phase-in rules can also avoid any immediate impact on employees.

- All bills proposed in Congress have placed the cap on the employee's exclusion rather than the employer deduction.

Discussion

In addition to deciding whether to impose a limit on the employer's deduction or the employee's exclusion, decisions must be made on the dollar amount of the limit, the rate at which the limit increases over time, and whether to "grandfather" firms (individuals) with employer health plan contributions higher than the limit in the base year. In addition to recommending that an employer deduction limit be used, HHS recommends that the limit be set at $150 per family and $60 per individual; that the limit be indexed to increase with the MCPI; and that firms exceeding the limit in the base year be grandfathered. Such a proposal would have no effect on tax revenues in FY 1983 and would increase revenus by $1.3 billion in FY 1984 and by $3.0 billion in FY 1986.

Treasury concurs with HHS' recommendations on the level of the limit, indexing, and grandfathering. An employee exclusion limit with the same characteristics would have no tax revenue effect in FY 1983 but would increase revenues by $2.4 billion in FY 1984 and by $5.9 billion in FY 1986.

Decision: _____ Employer Deduction Limit

_____ Employee Exclusion Limit

Option 4: Reimburse employers for costs of offering a choice of health plans.

- Employers would be given subsidies to offset part of the start-up costs that a firm incurs in switching from a single health plan to a choice of health plans.

- The amount of the subsidy would vary with firm size. For example, the subsidy could be set at $5,000 per firm plus $25 per covered employee, up to a maximum of $100,000.

- To qualify for the subsidy, the employer would be required to offer a plan with at least 20 percent coinsurance on all services (except specified preventive services) and, where available, a health maintenance organization. To assure that workers have adequate protection against the costs of catastrophic illness, all plans would be required to limit a family's exposure to out-of-pocket costs to no more than $3500 per year (indexed to increase with the MCPI).

  Employers who offer a choice of plans would have to make the same premium contribution to them all. As an incentive to select cost-effective coverage, those employees who chose a plan that cost less than the employer contribution would get a cash rebate. To reduce adverse selection against the comprehensive plans, the rebate would be limited to some percentage of the difference between the premium of the High Option plan and the premium of the plan actually selected, up to a maximum of $50 per month per family or $20 a month per individual. The maximum rebate would be indexed to the MCPI.

Discussion

HHS recommends that employers be given subsidies for offering a choice of plans because:

- An employer's start-up costs for moving from a single health plan to multiple plans are significant. (For example, PepsiCo spent about $300,000.)

- Allowing employees to choose among health plans is important for generating competition. In particular, employee choice is necessary to create a market for innovative plans.

- Subsidies would hasten the development of employee choice in response to the deduction limit.

Treasury opposes subsidies for offering a choice of plans because:

- A cap by itself eventually will create a substantial incentive for employers to offer a choice of plans and to allow employees to save the difference in costs between more expensive and less expensive plans.

- The "tax credit" device requires regulation of which plans qualify and which do not. Although regulation may sound simple, it is not.

- Treasury favors encouraging employers to offer employees a choice of plans within the context of cafeteria plans, only recently allowed by Congress. Such plans allow employees to choose cash instead of high option fringe benefits. As more of these types of plans are offered, employees will again be presented with greater choices of health plans, as well as other packages of fringe benefits.

- The precedent is bad. For instance, we do not offer tax credits for employers to offer pension plans nor do we give tax credits for meeting regulatory requirements.

OMB opposes subsidies for offering a choice of plans because:

- The only justification for a subsidy is that the HHS proposal, as presently drawn, establishes substantial rules and requirements on employers who choose to exercise the choice option. The subsidy becomes, in effect, compensation for complying with new Federal mandates.

- The need for the subsidy could be eliminated if the new mandates were limited to the minimum necessary to ensure effective competition between insurers and health providers. In particular, the requirement that employers offer certain specific choices of plans is unnecessary, and may even have the perverse effect of limiting the sort of innovation in the market that this proposal is designed to foster.

- OMB believes that, under a system where employees have a financial incentive to choose cost-effective plans, the normal operations of the free market will provide an adequate range of product choices to the consumer.

It is not necessary to rig the rules of the game to ensure that particular types of products are offered, and then compensate employers for the cost of complying with the rules. By contrast, the catastrophic requirement is a sensible feature, and should be retained, as should the equal contribution rule.

Decision: _____Approve

_____Disapprove

If a subsidy is approved, a decision must be made on the form of the subsidy.

Suboption 4A: Tax credit.

HHS recommends that the subsidy be in the form of a tax credit for the following reasons:

- o A tax credit does not require new application forms or a new bureaucracy.
- o Employers will be more likely to take advantage of the subsidy if they can do so in the course of filing their regular tax returns.

Suboption 4B: Grants to Employers.

If a subsidy is to be offered, Treasury recommends that it be a direct grant to employers administered by HHS and included in HHS' budget.

- o If credits are indeed appropriate for health policy reasons, then they should be placed in the health budget where they can be adequately examined and administered, as well as through the budget process.
- o A tax credit would have little effect on plans offered by the non-profit sector or by non-profitable corporations.

Decision: _____ Tax Credit

_____ Grants to Employers