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001. letter	Brian J. Turner, Industrial Union Department, AFL-CIO, to Ira Magaziner [partial] (1 page)	01/25/1993	P6/b(6)

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Clinton Presidential Records
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RESTRICTION CODES

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May 10, 1993

Mrs. Hillary Rodham Clinton, Chair
The White House Task Force on Health Care Reform
Washington, D. C. 20500

Dear Mrs. Clinton:

As the work of your Health Care Task Force draws to a close, the nation faces a rare opportunity to resolve a number of longstanding and complex problems. However, this is also a critical time when conflicting views, could undermine your efforts.

Two basic questions are of particular concern. Will the new health care system be financed fairly and will it be universal?

In recent days there has been much debate over the concept of a payroll-based financing system. In addition, many in the business community have argued for the option to stay out of the new system and to continue providing health coverage on their own for their own employees. These issues must be confronted, and, I would argue, they must be considered together.

In so doing, we must not lose sight of the fact that the current health care system is unorganized, inefficient, unfairly financed, administratively complex, almost incomprehensible and discriminatory. If it were a business, it would be bankrupt.

The present system is premium-financed, an approach that is fundamentally unfair because premiums cost the same whether you are a minimum-wage worker or a millionaire. While some may find it appealing to build on this familiar system, we would be building on a house of cards. The inherent unfairness of the system is what has led to millions of Americans being priced out of it and caused millions more to demand greater security.

A payroll-based financing system offers the opportunity to provide health security to all Americans in the fairest possible way -- that is, based on ability to pay. Those at the upper end of the income scale can afford to

Mrs. Clinton
May 10, 1993
Page Two

contribute more to maintaining a first-class system that provides quality health care and peace of mind to all, while enhancing the country's economic competitiveness. It is the essence of fairness to distribute the overall cost of the system this way.

The payroll-based premium approach has the added advantage of offering a rational way to keep contribution rates predictable and under control through caps that are set within a budgeted health care delivery system. A payroll-based system is inherently superior to other proposals that have been under consideration, such as taxing workers' health benefits.

I submit that this is one of those rare situations when management and labor should be seeing eye-to-eye. A payroll-based system offers mutually attractive economic advantages. First, it would be simple to administer. Second, it would distribute the burden across the entire economic spectrum--requiring the participation of all employers, regardless of size, and all employees. Third, unlike the present insurance system, it would not discriminate on the basis of age, medical history, occupation, size of household, geographic location or even race or sex.

The present, premium-financed system penalizes employers and employees who have good (and costly) benefits because they are forced to subsidize those employers who contribute little or nothing to the health care of their workers. Thus the system creates incentives to avoid hiring those who are or might become medical risks, or those for whom premiums would represent a disproportionately high percentage of total compensation. A payroll-based system, on the other hand, offers relief to businesses that have been paying more than their fair share while requiring reasonable contributions from those not currently participating.

As in the past, it will be easy for opponents of health care reform to distort key questions and instill fear in the public. For example, it will be said that a payroll-based system discriminates against two-earner families. This argument weakens when seen in its proper context.

Life is unpredictable. Circumstances change. Families grow -- and age. Some of us stay well. Some of us fall ill. A family may go for years without any major health problems at all, and then incur the enormous costs of a catastrophic illness. The reason people buy insurance is to buy peace of mind, and it works only if enough people buy it to distribute both the risks and the costs broadly. The fact that 37 million people now have no coverage whatsoever and that another 50 million have inadequate protection are two

Mrs. Clinton
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of the most vexing problems that we face. As people move in and out of the labor force, the fairest and most efficient way to protect everyone, regardless of circumstance, is to ask everyone who can do so to participate in a universal payroll-based system. If need be, tax credits can be used to ameliorate perceived inequities. But such perceptions should not be permitted to undercut the momentum for reform.

It will also be said that a payroll-based system increases the cost of hiring workers and makes it more difficult for businesses to create jobs. But the reality is that a payroll-based system is the best way to remove artificial barriers to job creation. Under our present premium-based insurance system, an employer of any size who contemplates creating an entry-level job slot must choose between providing no health coverage or increasing total compensation by as much as 50 percent. A payroll-based system, by distributing costs proportionately across the entire income spectrum, would make it more feasible for all businesses to make employment decisions rationally rather than on the basis of health care costs.

But this will not happen unless everyone is included in the same system. There is much talk these days of allowing employers to choose whether to participate in the new system or to maintain their own plans. I submit that without universal participation we cannot expect to control costs, reduce regulatory complexity, improve administrative efficiency, and eliminate gaps in coverage. In short, the entire success or failure of the health care reform effort may hinge on how the opt-out issue is resolved.

Some employers make the argument that only by staying out of the system can they control their costs and encourage innovations in health care delivery. This argument is seriously flawed.

It assumes, first, that companies will have the leverage to control their own costs regardless of what happens to everyone else. But we should call that by its rightful name -- cost-shifting, not true cost containment. Rather than one coordinated health care delivery system, the country would have a plethora of independent operators, each looking out for its own short-term gains rather than contributing to solving problems that properly concern us all.

Under the opt-out approach, companies could contain costs over the long run by maintaining rigid control over workforce demographics: hiring the youngest and healthiest, getting rid of the older and riskier, avoiding workers with large families, and using various other forms of subterfuge to drive down their own health care costs.

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Second, we must ask whether this scenario really represents a departure from what we have now. The potential for endless administrative complexities sounds distressingly familiar, and it appears to offer little consolation to those who are rightfully concerned about coverage gaps in the present system.

Thanks in large part to the work of your task force, the nation finally has within its grasp the makings of a truly fair, comprehensive, understandable and broadly acceptable health care reform program. Now is the time to take the case for a universal, income-based system directly to the American people and to explain, candidly and straightforwardly, why this represents the fairest and most efficient way to provide quality health care for all at affordable cost.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul R. Killalea". The signature is fluid and cursive, with a large, stylized initial "P".

President

c: Ira Magaziner ✓

AMERICAN FEDERATION
OF LABOR AND CONGRESS
OF INDUSTRIAL ORGANIZATIONS



Gary / Ira
[Handwritten signature]
NB

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May 3, 1993

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Frank Hurt

Mr. Ira Magaziner
Senior Advisor to the President
for Policy Development
Old Executive Office Building
Room 216
Washington, D.C. 20500

Dear Mr. Magaziner:

The American Insurance Association shared with us the April 26, 1993 letter that Robert Vagley sent to Hillary Rodham Clinton concerning the integration of the medical portion of workers' compensation into overall health care reform.

The AFL-CIO understands why the commercial insurance industry is opposed to this integration. We believe, however, that the arguments presented by Mr. Vagley in his letter to Mrs. Clinton are either inaccurate representations of the existing workers' compensation system or fail to correctly represent the proposed integration--particularly the integration advocated by the AFL-CIO.

Integration of the medical portion of workers' compensation into a national health care system can work and is likely to decrease both medical and wage replacement costs--exactly the opposite outcome predicted by Mr. Vagley. This is so because integration will discourage the "gaming of the system by those interested in abusing it." A vast amount of the litigation in the current workers' compensation system is directly attributable to a lack of trust and confidence in the medical determinations that provide the basis for monetary decisions.

To our knowledge, no one associated with the Task Force and no one advocating the integration of workers' compensation medical into a national health care system has suggested the "dismantling of the workers' compensation system." Most industrialized democracies have workers' compensation programs that operate in concert with universal

health care systems. The proposals for integration clearly involve close coordination between medical benefits and wage loss benefits.

The implication that insurers presently have broad authority to "manage the medical treatment" in workers' compensation simply ignores reality. So-called "managed care" is a very new concept in workers' compensation and has only recently been introduced in a small number of states.

Mr. Vagley also asserts that it is "medical treatment that determines" wage loss payments. This is a dangerous argument that is at the heart of insurer efforts to control the choice of treating physician. Indemnity, or cash, payments to injured workers are frequently based on medical determinations--not treatment. Decades of experience with employer or insurer chosen doctors have taught us that control over the choice of physician can result in critical influence over vitally important determinations that translate into indemnity benefits. These include decisions about the "work-relatedness" of the condition, the extent of impairment, and physical or work restrictions. "Medical treatment" of injured workers should be based on medical conditions and not the amount or duration of cash benefits for which insurers may be liable.

Injured workers resent directed care and are skeptical of the objectivity of doctors chosen by employers or insurers. Similarly, doctors are sometimes viewed by employers or insurers as being too "generous" to injured workers. Both of these situations commonly result in multiple medical examinations and extensive litigation. If employers and workers, the real "stakeholders" in this system, have trust and faith in the medical determinations that are being made, there is an opportunity for enormous savings. That trust and faith can only occur when the worker seeks treatment and medical determinations from a physician or health provider that was chosen before a workplace injury and within the delivery system established for all other Americans.

The AIA argues that integration will reverse two historic principles of workers' compensation--experience rating and full employer liability for medical treatment for job-related injuries.

On the first point, the Task Force should be aware that so-called experience rating is not universally available to all employers and whether it acts as an incentive to provide safe workplaces is viewed by some as questionable. (See Geoffrey C. Beckwith's "The Myth of Incentives in Workers' Compensation Insurance, New Solutions, Winter 1992,

Volume 2, No. 3, 52-73"). Nevertheless, all of the proposals for integration of workers' compensation medical into national health care reform have included some method of experience rating in order to retain the safety incentives that should flow from allocating liabilities to those employers who should bear them based on experience. Some have even argued that it would be possible to do a better job in this regard than is currently being done by the insurance industry.

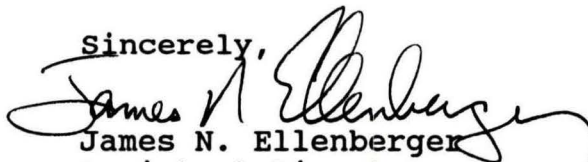
The other "historic" principle that the AIA charges would be reversed is that employees would be required to pay insurance premiums for medical treatment for job-related injuries. The AFL-CIO does not advocate nor would the public support any national health care proposal that suggests that employee premiums would be expanded to include the payment of medical care for occupational injuries and illnesses.

The bottom line of the AIA approach to national health care reform is to continue the present insurance arrangements for workers' compensation but to permit self-insured employers and insurers to enter into agreements with individual providers authorized under the national plan.

Please excuse our skepticism but this is strikingly similar to the current system, particularly in those states that presently give the employer (or the employer's insurer) control over the treating physician.

Workers' compensation is a system in trouble. Maintaining a separate medical delivery system for work-related injuries and illnesses, as we do now, will simply lead to an exacerbation of current problems including the improper shifting of costs between the workers' compensation and health care delivery systems. It is essential that national health care reform include the medical component of workers' compensation to achieve the goals of effectiveness, cost containment, quality and confidence in a unified system.

Sincerely,



James N. Ellenberger
Assistant Director
Department of Occupational
Safety and Health

Enclosures
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DATE: May 17, 1993

TO: Ira Magaziner

FROM: Karen Ignagni

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COMMENTS:



For your information.

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MT

THE CASE FOR A PAYROLL-BASED HEALTH CARE FINANCING SYSTEM

■ BRIEFLY...

The Clinton Administration is considering using a payroll-based system to help finance health care reform. Payroll-based financing would be:

- ✓ **Fair to workers**— because it is income-based, unlike premiums, which burden lower-wage workers more than the wealthy.
- ✓ **Fair to employers**— because it distributes health care costs much more equitably than a premium-based benefits system, thus removing artificial barriers to job creation.
- ✓ **Administratively simple**— so more money can go to providing health care services.
- ✓ **Good for health care providers**— because stable financing will encourage long-range planning and innovation.
- ✓ **Good for the economy**— because capped payroll contributions in a budgeted system can restrain increases in health care costs.

■ **PAYROLL-BASED FINANCING** of universal health care is an option being considered by the White House Task Force on Health Care Reform. For most workers and employers — and for the economy — the idea makes good sense.

Let's start with where we are now. The present premium-based system no longer works. Millions of Americans are being priced out of the system, and millions more live in fear of losing their insurance if anything goes wrong— if they or their

employers can no longer meet premium costs, or if they change jobs or get laid off. Employers who provide good benefits are paying inflated health care costs because they must help cover the cost of health care services used by uninsured workers. So the present system gives a competitive advantage to employers who offer no benefits and thereby shift costs to others. It also works against employers with aging work forces, creates incentives to avoid hiring people who may be medical risks, and results in controlling costs by using intermediaries who often frustrate health care providers and consumers alike. Health care financing reforms must address all of these problems.

■ **HOW IT WORKS:** Payroll-based financing sets aside a percentage of each employee's income for a specified purpose. Because the percent is usually the same regardless of income, higher-income people contribute more than lower-income earners. So the system is based on ability to pay, within limits: income caps and tax credits can be used to protect double-income couples and the self-employed against paying more than their fair share, and rate adjustments and exemptions can help protect low-wage workers.

■ **WHY IT'S FAIR TO WORKERS:** Payroll-based financing is progressive, because it's based on income — unlike premiums, which are flat whether you're rich or poor. The only way to make a premium-based system work fairly is with complex, costly administrative adjustments.

Across-the-board payroll-based financing means middle-class people can have access to exactly the same health care that the wealthy enjoy, because the cost is covered by pooled revenues. It means you don't have to worry about losing insurance →

when you change jobs, because your insurance is portable. You won't have to fear being turned down for a job because you have a chronically ill family member. And unlike premiums, which can suddenly skyrocket, payroll-based financing means you'll know from year to year how much of your income is going to go to health insurance.

Some people just don't like the idea of having some of their income set aside to help pay for a system that covers everyone, including those who aren't working. "It's not fair," they say, "for us to have to help pay everybody else's medical bills."

But that's not how it really works. Insurance is how we protect ourselves against the unknown. Personal circumstances change. Families grow — and age. Some of us stay well until the very day we die. Others don't. A family may go for years without trouble, then incur the staggering costs of a catastrophic illness. We buy insurance to buy peace of mind, and it works *if enough of us buy it to spread the risks and make costs manageable.*

As people move in and out of the labor force, the fairest and most cost-effective way to protect us all, regardless of circumstance, is to ask all who can to participate through a payroll-based plan. People will have real concerns about the impact on two-earner families — and these should be addressed by payroll rate adjustments or tax credits.

■ **FAIR TO EMPLOYERS:** Payroll-based financing offers the best way to distribute health care costs equitably within a given industry and across the entire economy. It levels the playing field. Because insurance costs are no longer risk-based, the competitor with a younger work force no longer has an unfair advantage. Nor do the competitors who have been offering no health benefits and thus saddling others with the bills when their employees require care. And payroll-based financing gives you better control of costs from year to year, because you know in advance what your payroll contribution rates will be.

Some argue that payroll-based financing would increase the cost of hiring workers, making it more difficult to create jobs. Generally the reverse will be true. Some companies that have been paying no benefits will see costs increase, but that's going to happen in any case — and the changes can be phased in. What about employers who *want* their employees protected? Today a small employer who wants to create a \$10-an-hour job with good health benefits can assume that the cost of those

benefits will add at least 25% to the cost of the job. That can be prohibitive. But if the employer's share of payroll-based financing is set at, say, 8%, it'll be easier to create that job. And if you're an employer with a large middle-income work force, health benefits now add as much as 19% to your total payroll costs. Just moving toward an across-the-board payroll-based system could mean big savings — and could help create many new jobs.

■ **ADMINISTRATIVELY SIMPLE:** Payroll-based financing is much simpler to administer than premium-based insurance plans, which require enormous paperwork. The savings can go to paying for needed health care services — and holding down the rise in health care costs.

Some people just don't trust the government to hold down costs. But that's not what's being proposed. An administratively simplified system with strong input from all who have a stake in reform is what's on the table.

■ **HEALTH CARE PROVIDERS** will benefit from payroll-based financing because it will free them from the uncertainty that clouds the future of health care. Right now, health care providers don't know what kind of system they'll be working under next year, let alone ten years from now. We owe it to America's health care professionals to give them a financing system that's stable and *predictable* so they can concentrate on planning, innovating, doing better at coordinating their services — and giving their patients quality care. Payroll-based financing gets us from here to there in the shortest time with the least pain.

■ **GOOD FOR AMERICA:** Payroll-based health care financing will help the economy. In combination with system-wide budgeting and caps on payroll contributions, the reformed health care financing system can play a major role in restraining cost increases.

America's health care delivery costs are still going to increase, however, and no system will be perfect. So which of these makes more sense:

① A coordinated system in which all employers and all employees participate and contribute, which delivers quality health care and operates within a budget? Or

② Many systems, each trying desperately to control its own costs regardless of what happens to quality of care and access to care?

If you chose ① above, payroll-based health care financing deserves your support.

AFL-CIO

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Telecopier Transmission

Date: March 15, 1993

To: Nolly Brostrom
Sra Tragajiner's Office

FAX Phone Number: 202-456-7739

From: Karen Ignagni

Department: Employee Benefits Department

Comments:

There is 8 page(s) following this cover sheet.

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March 15, 1993

Mr. Ira Magaziner
Senior Advisor to the President
for Policy Development
The White House
Washington, D. C. 20500

Dear Ira:

Thank you for agreeing to come and speak to our Health Policy Task Force. I have scheduled the meeting for March 16th from 2:00 - 4:00 p.m. in Conference Room A which is located on the first floor of the AFL-CIO building. I will have Debbie Reinecke from my staff meet you in the lobby and escort you to the room.

Enclosed you will find a list of people who serve on our task force along with their union.

Again thanks for your time and I look forward to seeing you.

Sincerely,

Karen Ignagni
Director
Employee Benefits Department

enclosure

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FEB 23 1993

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February 19, 1993

Mr. Ira Magaziner
Old Executive Office Building
Room 216
Washington, D. C. 20500

Dear Ira:

While I know we have a meeting on Monday, I thought you might like a copy of our health care statement that the AFL-CIO passed on Tuesday. I look forward to discussing this with you.

*actually
you meet
with her
on 2/19 3/3*

Sincerely,

Karen Ignagni
Director
Employee Benefits Department

attachment

Statement by the AFL-CIO Executive Council

on

National Health Care Reform

February 16, 1993
Bal Harbour, FL

There is now a broad consensus that runaway health care costs, uneven quality and decreasing accessibility are serious problems that cannot be solved by the "free market." Americans know they are paying more for health care and getting less in return than people in any other industrialized nation. They are deeply concerned about the effects of this crisis on the country's economic future, and they know that doing nothing will only make the problem worse.

In appointing a task force and directing it to formulate comprehensive health care reform legislation by the summer, President Clinton has indicated that he intends to act. We commend his leadership and pledge to work with his administration toward a bold legislative proposal that can be swiftly approved by Congress.

Nothing short of full-scale restructuring that achieves a unified health care purchasing and delivery system will solve this crisis. Since uncontrolled market forces and price competition have served only to subvert the goal of universal access while failing to hold down costs, we cannot accept a system that relies solely on market principles.

Soaring health care costs are inextricably linked with declining access and deteriorating quality. Legislation must proceed on all three fronts by establishing universal access to comprehensive health care, tough cost controls and measures to ensure quality.

We are determined to see that the costs of a new national health care system are distributed as broadly and equitably as possible. The AFL-CIO steadfastly opposes the taxing of employer-provided health insurance because it is highly regressive and would unfairly burden the middle class, older Americans and individuals with high health risks. It also would require unreasonable sacrifice from the millions of working people who have already given up wage increases in order to obtain or preserve their health care benefits. Any such tax would likely force millions of Americans into substandard health care delivery systems while the wealthy few maintain their access to an elite level of care.

Specifically, we urge that any national health care reform program do the following:

- o **Establish a universal right of access**, guaranteeing access to a comprehensive set of benefits and ensuring that age, sex, geographic location, employment status, health history or out-of-pocket payment requirements do not prevent anyone from receiving needed care.
- o **Put the health care system on a budget** that is enforceable and targets for elimination unnecessary medical services, price-gouging and excessive administrative costs, while ensuring that quality care is available to all who need it.
- o **Restructure the health care delivery system** to reduce the fragmentation, cost-shifting and administrative waste that is fueling the current crisis.
 - * Establish a unified purchasing and delivery system, organized on a regional basis with federal standards, to negotiate with providers, contract with plans, assure the appropriate allocation of capital and collect all necessary data -- including data on occupational disease and injury -- to monitor quality.
 - * Require all plans within the system to be community rated, with competition based solely on service and performance.
 - * Allow all consumers full choice among approved health plans.
 - * Require all purchasers, including Medicare, Medicaid and the Federal Employees Health Benefits Program to participate fully in the system and prohibit special arrangements that only shift costs to other payers.
 - * Designate centers of excellence for highly specialized services to be made available to all individuals.
- o **Create a national independent commission** of consumers, labor, business, government and health care providers that will administer the system.

- **Provide an effective quality assurance program** that encourages the development of practice guidelines, health outcomes research and coordinated technology assessment with mechanisms to ensure that this information is made available to the national and regional governing bodies.
- **Incorporate the health care services component of workers' compensation**, without jeopardizing the unique characteristics of this system.
- **Finance the system through the use of progressive, equitable funding mechanisms earmarked for health care.**
 - * Require all employers to contribute to the cost of health care coverage.
 - * Provide subsidies for low and moderate income families and adversely affected businesses.
 - * Allow for negotiation between workers and their employers for supplemental benefits and for the coverage of out-of-pocket payment requirements.
 - * Prohibit providers from charging fees that exceed what they are reimbursed by the program.
- **Address the problem of financing retiree health care** by lowering the age of eligibility for Medicare to the average retirement age of 60, thus maintaining the current system of social insurance for financing their benefits. Establish and maintain industry-wide financing mechanisms as appropriate for particular industries.
- **Devise a strategy for expanding access to long-term care**, making services available to all those that need them.
- **Encourage physicians to avoid unnecessary tests and medical procedures**, while developing a better system for handling malpractice disputes.
- **Increase the availability of primary and preventative care** by establishing health care centers in or near schools.

- o **Establish new policies for the health care workforce that improve the efficiency and quality of the health delivery system.**
 - * Provide initiatives to retrain workers, upgrade skills and promote job mobility within the new, expanded delivery system and to give workers a role in quality assurance.
 - * Ensure that the new reimbursement systems do not unfairly target health care workers for cost-cutting.

At this critical time in the AFL-CIO's grassroots campaign for national health care reform, we call on all national and international affiliates and state and local bodies to redouble their efforts to organize support for these principles among union members, employers, providers and community leaders. Only the expeditious enactment of these principles into law will solve the health care crisis, remove the threat to our economic future and put in place a health care system that serves everyone and not just those who can continue to afford its endlessly increasing cost.

###



JOHN GARAMENDI
Insurance Commissioner

California Department of Insurance
Office of the Commissioner
770 L Street, Suite 1120
Sacramento, CA 95814

For your information

Per your request

*AFL-CIO Executive Council
members list and enclosures
are attached.*

From the desk of...

VICKIE ORTIZ
Executive Assistant
916445-5483



FEB 22 1993

JOHN GARAMENDI
Insurance Commissioner

February 18, 1993

1~

Dear 2~:

I appreciate the recent opportunity to discuss the issue of health care reform with the AFL-CIO Executive Council. I'm also delighted to learn that you adopted a new policy on health care and that it is in line with the proposals I have been advocating.

The reform proposal that I made for California 18 months ago is now a leading model used in the Clinton program. I've enclosed an executive summary of this proposal, some editorials that help to explain its impact, and a federal version of the plan.

It is critical that the labor movement be involved in the design of the federal legislation. To that goal, I offer my service. I am available to you or your staff at anytime to discuss the details of the proposal and to seek improvements.

Sincerely,

JOHN GARAMENDI

JG:vog

Enclosure

cc: Hillary Rodham Clinton
Ira Magaziner, Senior Advisor
on Policy Development



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CALIFORNIA HEALTH CARE IN THE 21st CENTURY: *A VISION FOR REFORM*

by *John Garamendi*
Insurance Commissioner
State of California

EXECUTIVE SUMMARY

PRINCIPAL FEATURES

- The health care components of all insurance policies—workers' compensation, auto and health—would be consolidated into a single, unified health care system.

- All Californians would be guaranteed comprehensive health care benefits.

- All employers and employees would pay premiums into a single fund on an equitable basis. Small employers and low income workers would pay lower premiums.

- Private/public Health Insurance Purchasing Corporations—governed by employers and consumers and operating regionally throughout the state—would collect all premiums and purchase private health insurance for all Californians. The purchasing corporation would certify health plans capable of delivering the guaranteed benefits and high quality care.

- All consumers would have the right to enroll in any of the certified plans. There would be no pre-existing condition exclusions or waiting periods.

- The purchasing corporation would pay each certified health care plan the same amount for each individual enrolled (with

adjustments for such risk factors as age, sex and family status).

- At least two health plans in each region would charge consumers nothing for the state-guaranteed benefits. Other plans would also offer the guaranteed benefits, but could charge consumers a small additional amount for more amenities or flexibility (e.g. wider choice of providers). There would be a ceiling on the amount a health plan could charge consumers.

The health care components of all private insurance policies—workers' compensation, auto and health—would be consolidated into a single, unified health care system.

A SINGLE, UNIFIED SYSTEM FOR ALL CALIFORNIANS

- ◆ All Californians would obtain coverage from one health care system — managed by a public/private partnership—rather than through multiple employer systems that deliver coverage inefficiently and distribute it inequitably.

- ◆ A Health Insurance Purchasing Corporation (HIPC) would certify private health

plans to offer coverage. The plans would compete for enrollees on the basis of quality of service and price.

- ◆ The health care components of all private insurance policies — workers compensation, auto, and health — would be consolidated into a single, unified health care system. Individuals would receive the same protection and the same care regardless of when, where, or why an injury or illness occurred.

- ◆ The system would blend the best of regulatory and competitive features of health care reform approaches. It does not make a final determination of the appropriate blend, instead allowing the mix to vary over time and across re-

gions.

- ◆ The proposal would keep California's strongest economic players in one health care system, providing the impetus for them to make it work for everyone.

BUILT-IN MECHANISMS FOR CONTROLLING COSTS

- ◆ An overall health care budget would provide restraint. Public costs would increase faster than wages only if the state

increased employer/employee premium rates, always a difficult political act.

◆ Placing greater choice in the hands of consumers would encourage them to spend dollars more wisely.

◆ Inefficient insurers that now compete on the basis of their ability to avoid high risk individuals would be forced to compete on the basis of the value they offer to consumers.

◆ Much of the administrative waste in the current system would be eliminated:

- Employers would no longer need to buy insurance, a particularly important consideration for small businesses.

costs involved in fighting over who pays when someone gets sick or injured.

◆ Preliminary estimates indicate that consolidation would save an estimated \$2.8 billion in workers compensation costs (about 25% of total premiums), and add only an estimated \$1.8 billion to health care costs.

◆ Under the proposal, employees would be accepting some limits on health coverage for work-related injuries (e.g., using only providers affiliated with their health plan). It is therefore proposed that a portion of the savings from consolidation be used to increase disability benefits under workers compensation — California's temporary disability benefits are now ranked 35th in the nation — and that the remainder of the savings accrue to employers.

ered quality care, and would assist individuals in choosing among plans by providing consumer information (e.g., complaints against plans, waiting times, etc.).

◆ Consumers would be able to choose from among all of the health plans certified by the purchasing corporation to provide coverage in their region. Health plans would include many of those providing coverage today (e.g., HMOs and insurance companies).

◆ All health plans would be required to accept any individual regardless of health status. There would be no pre-existing condition exclusions, no waiting periods, and no extra charges due to health status or age and sex.

◆ Health Plans would not be allowed to compete by avoiding high risk individuals.

All health plans would be required to accept any individual regardless of health status. There would be no pre-existing condition exclusions, no waiting periods, and no extra charges due to health status or age and sex.

- Managed care plans — which generally have lower administrative costs than traditional insurers — would be promoted. Inefficient insurers would be unable to compete.

- With a Health Insurance Purchasing Corporation providing consumers with better information and direct access to health plans, the overhead cost of insurance broker commissions would be unnecessary.

- It is expected that competition would drive health plans to become more integrated (i.e., that they would form networks of physicians, hospitals, and other providers). Through such integrated arrangements, the administrative costs associated with hospital and physician billing would be reduced dramatically.

24-HOUR CARE: THE CONSOLIDATION OF HEALTH COVERAGE

◆ The consolidation of the health care components of workers compensation and auto insurance would reduce the cost of such coverage for employers and consumers, as well as reduce the administrative

ACCESS TO QUALITY HEALTH CARE FOR ALL CALIFORNIANS

◆ All Californians would be guaranteed access to comprehensive health care benefits.

◆ The benefits would be comparable to those now provided by HMOs, providing comprehensive medically necessary care (inpatient care, primary care, prescription drugs, inpatient and outpatient mental health care, home health care, etc.). Modest copayments would be required for some services, though they would be waived for low-income individuals. There would be no deductibles.

◆ Cost-effective preventive care would be encouraged, and would be provided with no copayments.

EXPANDED CONSUMER CHOICE

◆ The system would be managed by regional public/private sponsors — Health Insurance Purchasing Corporations (HIPC's). The purchasing corporations — which would be governed by employers and consumers — would ensure that all health plans deliv-

◆ The purchasing corporation would pay each certified health plan the same amount for each person enrolled (with adjustments for such risk factors as age, sex, and family status).

◆ At least two certified health plans in each region would offer the state-guaranteed benefits at no additional charge.

◆ Other plans would also offer the guaranteed benefits, but could charge consumers a small additional amount for more amenities or flexibility (e.g., wider choice of providers). There would be a ceiling on the maximum amount a health plan could charge consumers.

◆ Consumer choice and continuity of care would be enhanced by removing the link between health coverage and a job. Changing jobs — or becoming unemployed — would not mean a loss of coverage, or even having to switch to a different health plan or doctor.

EQUITABLE AND AFFORDABLE FINANCING

All employers and employees would pay health care premiums based on ability to pay:

EMPLOYERS: *Each employer would pay a premium based on payroll. The overall average premium would be 6.75% of payroll, which would include the current cost of health care under workers compensation. Small employers would pay less.*

- A sizable majority of employers who now provide coverage would pay less. These firms now pay about 8% of payroll on average for health coverage.

- Employers who do not now provide coverage would begin paying their fair share, but the payment would be more affordable for small businesses than having to purchase coverage directly:

- ~ Firms with fewer than 10 employees would on average pay 5.8% of payroll, and firms with fewer than 5 employees would pay 5.2% of payroll on average. This does not reflect savings of approximately

EMPLOYEES: *Each employee would pay a premium based on wages and salaries. The overall average premium would be 1.0% of wages and salaries, with low-income workers paying less.*

- There would be no additional charge for non-working dependents.

SELF-EMPLOYED: *The self-employed would pay a premium based on earnings and reflecting the combined employer/employee premium.*

- *Employers would pay a premium based on payroll.*
- *Employees would pay a premium based on wages and salaries.*
- *The self-employed would pay a premium based on earnings and reflecting the combined employer/employee premium.*

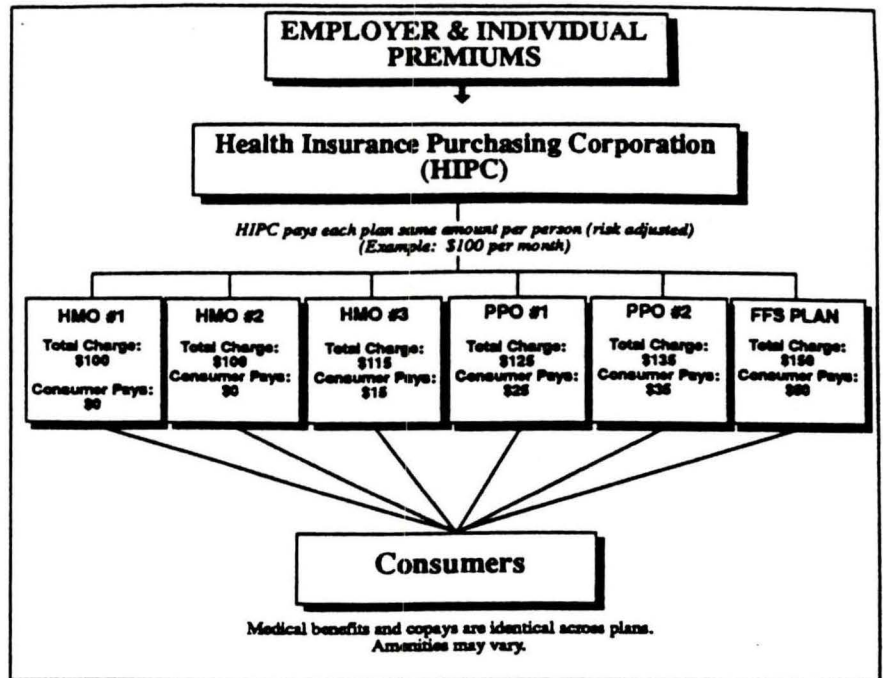
20% on average in workers compensation premiums from the consolidation of the health care component of such coverage.

- ~ The existing health insurance tax credit for small businesses would apply, further reducing their premiums by about 25%.

- ~ Employers would be freed of the responsibility for purchasing health coverage, a particularly important consideration for small businesses.

- Consumers would pay on average \$30 per family per month for the guaranteed benefits. This amount is less than what is now deducted from their paychecks for health insurance (about \$45 per family per month on average).

- Paying in while employed would guarantee the same coverage while unemployed, in much the same way that unemployment insurance works today.



The estimated \$34 billion cost (based on state employment figures and the actual cost of coverage in HMOs today, as shown in the attached financial analysis) is less than what employers and employees are now spending on health insurance premiums. This amount would guarantee access for all Californians to comprehensive

benefits. Total expenditures would ultimately depend on how much consumers chose to spend in addition to this (i.e., on their decisions about which plans to enroll in).

Editorial Comment About the Garamendi Plan

The reform framework unveiled by Insurance Commissioner John Garamendi stands out as the smartest and most practical vision of how to get affordable, universal care.

It frees health coverage from the workplace, allowing workers to change jobs without losing their insurance. It ends insurers' practice of trying to cover only healthy people, leaving the sick to their own devices. By consolidating all health costs into one system, it would eliminate the medical portions of workers' compensation and auto insurance, simplifying those systems and cutting down on the need for litigation.

SACRAMENTO BEE, February 14, 1991

As the medical insurance crisis deepens, Americans look for remedies from Washington. It may well be, to judge by sparkling news from California, the wrong place to look. The states, always meant to be laboratories, can show the way—and the reform plan just proposed by California's Insurance Commissioner, John Garamendi, offers a model for every state.

Health insurance costs are soaring—even as the present system leaves one of every seven citizens uncovered. The Garamendi plan would tackle both problems, in ways likely to work well in New York and other populous states.

The plan artfully combines regulation and competition. Regulations would help consumers make smart choices and protect the chronically ill. Competition would limit prices without resort to price controls and Government mandates. Mr. Garamendi's plan doesn't address every detail, but its overall design is exceptional.

NEW YORK TIMES, February 17, 1992

Business in particular should take a hard look at what Garamendi proposes to slow down sharply the costs of health care that are rising virtually out of control.

The goals of the California Health Reform Act of 1992 do not differ in any important ways from those of a plan being promoted in Washington by the National Leadership Coalition for Health Care Reform, which has widespread support among major American corporations.

LOS ANGELES TIMES, May 29, 1992

Health-care reform may be far off, but one need is clear: Insurance should no longer come from employers.

Breaking the link between health coverage and the workplace is a beginning for any health reform. Companies could go back to competing for workers with wages, and insurers would have to compete with quality and service instead of by avoiding sick people. Rather than despair about health-care reform, look west. There lies hope.

USA TODAY, June 19, 1992

Under the Garamendi plan, residents would pay a payroll tax to a regional authority, or sponsor. The sponsor would negotiate with private managed-care providers, like health maintenance organizations, to offer everyone basic coverage at no additional cost. Residents would be free to buy more extensive plans through the sponsor, at their own expense.

The plan provides universal coverage, guaranteeing protection for the poor and the chronically ill. That alone warrants applause. Even better, this plan can contain zooming health care costs without the straitjacket of price controls.

NEW YORK TIMES, September 1, 1992

For more information about this proposal, copy this form and send to:

Health Insurance Reform Project
Department of Insurance
3450 Wilshire Boulevard
Los Angeles, CA 90010

Name _____
Title _____
Organization _____
Address _____
City _____ State _____ Zip _____
Work phone _____
Fax _____
Home phone _____

Los Angeles Times

SUNDAY, DECEMBER 13, 1992

EDITORIALS of THE TIMES

A California Model for Health Insurance

Garamendi plan has something to offer Clinton

If anyone needs more evidence of the power of the President's bully pulpit, consider the tremendous effect of President-elect Bill Clinton's promise to reform the nation's health care system. He hasn't even taken office yet and already health industry lobbyists are scrambling to influence what reforms will garner support on Capitol Hill.

A major health care policy shift is in the air. Indeed, Clinton has promised such a shift, though he has been careful since the election to remind the voters not to expect miracles.

While a health care reform plan proposed in California doesn't fall into the miracle category — important details have yet to be worked out — the President-elect would do well to seriously consider what it has to offer the nation. The catchphrase for the plan — conceived by a Stanford health economist and a Wyoming physician and proposed by state Insurance Commissioner John Garamendi — is *managed competition*. The seeming contradiction in the term is the clue to its political appeal.

Managed competition implies that in some ways liberals were right: Every American should have access to affordable health care, and obviously the system isn't accessible or affordable when more than 35 million have no health insurance. And managed competition implies that in some ways conservatives were right: The way to fix the problem isn't to impose a government-run health care system but to rely on market incentives.

The Garamendi plan, although it has run into political

roadblocks in California, has been touted as having national potential because it covers both the necessary bases of true health care reform: cost containment and access for everyone to basic, quality medical care.

All Californians, employed or not, would be covered. The plan would create quasi-public regional insurance

purchasing corporations to bargain with the existing network of clinics, health maintenance corporations (HMOs), hospitals and doctors.

It would contain costs through the use of new insurance pools and simplified billing. Coverage for all would be financed through contributions from employers and employees based on payrolls and wages. In the current pell-mell system, employers and insured employees already are shouldering — and are buckling under — the burden of virtually unchecked spending for doctors, tests, prescriptions and hospitalization.

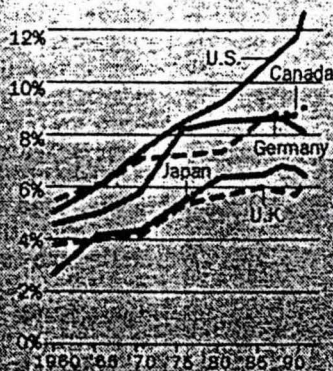
There's really nothing Clinton has said about reform that contradicts the basics of the Garamendi plan. Before the elec-

tion Clinton vowed to provide coverage for all, control costs, establish a minimum benefit package, encourage the development of community-based "managed care" networks of doctors, hospitals and insurers, and eliminate waste and fraud.

Government must have a place in ensuring fairness; the market must have a place in ensuring choices for the medical consumer. In the new thinking that must take place if the nation's health care system is to be reformed, the government and the market can meet.

Fever Chart

The U.S. spends more of its gross domestic product on health care than other industrialized countries. Health care expenditures as % of gross domestic product



Source: Organization for Economic Cooperation and Development, Consumer Survey

The New York Times

Founded in 1851

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SUNDAY, NOVEMBER 22, 1992

More Bureaucrats Won't Cut Health Costs

A Clinton Contradiction

President-elect Clinton promises to fix America's ruinously expensive health care system with managed competition. That's absolutely the right idea. Managed competition would encourage the use of large health maintenance organizations — and force them to compete. That's the way to preserve quality and control costs without having to hire an army of bureaucrats.

Mr. Clinton, meet Mr. Clinton.

Almost without pausing for breath, the President-elect also promises something else, ominously contradictory. Government, he says, should control costs by setting a limit on total health expenditures, what he calls a global budget, *enforced with price controls*.

Why the contradiction? Mr. Clinton evidently fears that competition alone can't do the job. Yet he must realize that trying to run the \$800 billion health care industry by government fiat is folly. Price controls would spawn bureaucracy and wholesale evasion. Worse yet, they would rob health care providers of the drive to innovate that now distinguishes the U.S. health care system.

There is a way out of this quandary, but only if Mr. Clinton owns up to the contradiction and reaches out for the remedy that's already at hand.

Clinton advisers have tried, so far without success, to explain away the contradiction. Sometimes they say price controls on physicians and hospitals wouldn't undermine competition because controls would apply only during a transition period. At other times they, and their principal, declare that global budgets and price controls are central. Which is it?

The advisers also minimize the impact of price controls on H.M.O.'s. These controls, they say, are not rigid limits on thousands of medical procedures but merely harmless ceilings on annual premiums. That defense is also hard to follow.

If such ceilings were set below what H.M.O.'s would otherwise charge, they'd jeopardize quality, innovation, even survival. If, alternatively, the ceil-

ing were set above the amount competitive H.M.O.'s would charge, they'd be an irrelevance.

The question remains: Can Mr. Clinton marry global budgets and managed competition?

John Garamendi, California's Insurance Commissioner, proposes a shrewd answer. His plan for California would set up regional purchasing agents, or sponsors. These sponsors, each representing perhaps several hundred thousand consumers, would drive hard bargains with private insurers, mostly H.M.O.'s. That's managed competition. Then he adds an ingenious twist: a market-driven payroll tax that fixes the cost of basic coverage.

Every company and worker would pay a payroll tax to the sponsor. The sponsor would then find at least two insurers willing to offer, for the amount already paid to the sponsor, basic benefits to every applicant. People would be free to buy more lavish coverage, but at their own expense.

This health care tax would add the fiscal discipline Mr. Clinton seeks from his global budget. Indeed, it's perfectly reasonable to describe such a cap on annual premiums as "global budgeting." The difference is that the Clinton plan would be driven by bureaucrats. The Garamendi plan would be driven by market forces.

If government tried to set the tax below the cost of health care, no qualified insurer would be willing to offer coverage.

The beauty of the Garamendi plan is that it doesn't require price controls and leaves providers plenty of room to compete. Under the plan, competition squeezes out wasteful practices and holds down prices. The obvious political difficulty of raising the payroll tax imposes another, powerful discipline against loading up basic benefits with unimportant coverage.

In short, the Garamendi plan does honest global budgeting. It is wholly compatible with the principles of managed competition. And it shows Mr. Clinton the way out of contradiction and into health care reform that matches his promises.

The New York Times

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TUESDAY, SEPTEMBER 1, 1992

California's Lead on Health

California's sullen two-month budget crisis has overshadowed a proud legislative victory on health care reform. The state legislature has just passed a bill that would provide every Californian affordable medical insurance through a reform known as managed competition. The bill creates a commission to work out details that would be presented to the legislature in 1994.

Gov. Pete Wilson must now decide whether to sign the bill. He has taken no position on its merits, but he is a Republican. The bill's author, John Garamendi, is the State Insurance Commissioner and an ambitious Democrat who might well desire Mr. Wilson's job. It would not be surprising if the Governor looked hard for reasons to veto the bill.

Citizens concerned about the health care crisis, and not just Californians, have good reason to hope for more from Governor Wilson. This measure offers an enviable standard for other states struggling with their own health care crises.

Under the Garamendi plan, residents would pay a payroll tax to a regional authority, or sponsor. The sponsor would negotiate with private managed-care providers, like health maintenance organiza-

tions, to offer everyone basic coverage at no additional cost. Residents would be free to buy more extensive plans through the sponsor, at their own expense.

The plan provides universal coverage, guaranteeing protection for the poor and the chronically ill. That alone warrants applause. Even better, this plan can contain zooming health care costs without the straitjacket of price controls.

The legislature would decide how much payroll tax is required — which also set the premium for basic coverage. That would be a giant step toward cost control. Yet insurers would still have the flexibility to negotiate physician fees, treatment practices and hospital reimbursement. Because most coverage would be provided by prepaid managed-care plans, insurers would have strong financial incentive to make sure that diagnosis and treatment are not botched.

Mr. Garamendi has designed, and the Legislature adopted, a remarkably shrewd solution to the health care crisis. Governor Wilson willing, California can now benefit directly, and the rest of the country can benefit by its example.

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Good Health — and Good Politics

Speaker Thomas Foley is committed to bringing health care reform to a House vote before next month's Democratic convention. Standing in the way of his election-year strategy is a fractured membership, split between contradictory approaches to reform.

But consensus may not be as far out of reach as it looks. Many Democrats have taken a hard second look at the approach called managed competition and like what they see. Managed competition, which has always seemed the best idea for insurance reform on the merits, may now become the best approach for political reasons as well.

The Democratic leadership has split over how to deal with the crisis in health care. Medical costs are rising three times faster than inflation, and almost 40 million Americans are uninsured.

Some members of Congress favor "play-or-pay," an approach that would preserve private insurers. Employers would enroll workers in private plans or else pay a tax to enroll them in a public backup plan. Other members favor single-payer plans, like Canada's. These would eliminate private insurers and enroll everyone in a single Government plan.

Play-or-pay appeals to members who fear turning health care over to government; single-payer appeals to those who want a universal system into which everyone pays for the same basic coverage. Democrats are coming to realize that, with managed competition, they can have it all.

John Garamendi, California's insurance commissioner, has proposed a plan, now working its way through the State Legislature, that provides the best of both worlds. Employers and employees would pay a payroll tax to a regional authority, or sponsor. The sponsor would contract with

private insurers to offer basic coverage, defined by the government, to any applicant at no additional cost. The sponsor would also contract with private insurers to offer members more generous plans. But buyers would have to pay for the entire additional cost, a useful brake on skyrocketing premiums.

Because the Garamendi plan builds in competition among private insurers, it appeals to some advocates of play-for-pay. And because the plan taxes everyone for identical basic coverage, it appeals to some single-payer advocates. The tax, in effect, imposes a global budget on basic health care without imposing the heavy hand of price controls.

Unable to win consensus for comprehensive reform, Democrats like Chairman Dan Rostenkowski of the tax-writing committee back piecemeal measures. They at least want to curtail repugnant practices like discriminating against applicants with certain medical conditions.

Such reform would surely be welcome but is not enforceable if imposed piecemeal. Telling insurers to enroll AIDS victims at fixed rates in effect tells the companies to lose money. That compels insurers to find loopholes. The Garamendi plan, however, would allow sponsors to reimburse insurers who enroll disproportionate numbers of people who have costly chronic illnesses.

The longer the House looks at managed competition, the better it looks. The leadership has already decided to put a managed competition bill, sponsored by the Democrats Jim Cooper of Tennessee and Michael Andrews of Texas, up for vote next month along with play-or-pay and single-payer. That's welcome news.

It's still unlikely that Congress can complete reform legislation this year, even though the crisis in health care costs obviously rolls the public. But now, at least, the House seems to be finding a path through the wilderness.

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California's Medical Model

As the medical insurance crisis deepens, Americans look for remedies from Washington. It may well be, to judge by sparkling news from California, the wrong place to look. The states, always meant to be laboratories, can show the way — and the reform plan just proposed by California's Insurance Commissioner, John Garamendi, offers a model for every state.

Health insurance costs are soaring — even as the present system leaves one of every seven citizens uncovered. The Garamendi plan would tackle both problems, in ways likely to work well in New York and other populous states.

The plan artfully combines regulation and competition. Regulations would help consumers make smart choices and protect the chronically ill. Competition would limit prices without resort to price controls and Government mandates. Mr. Garamendi's plan doesn't address every detail, but its overall design is exceptional.

The proposal calls for a variant of managed competition, whereby individuals buy health insurance as part of a large group, organized by a sponsor. The plan would create sponsors that would, by region, select insurance plans to offer their residents.

At least one plan — probably a Health Maintenance Organization — would offer basic coverage to anyone at no charge. Residents could choose other plans offering more expensive coverage, like picking any doctor they wish, but would pay for the

extra costs. The regional sponsor would help residents pick plans wisely, monitor treatment outcomes and forbid insurers to discriminate against people with chronic illnesses.

To pay for the basic benefits package, the sponsor would collect payroll taxes from every employer and employee. Insurers, in turn, would receive a fixed fee for each enrollee. To eliminate the urge to avoid the chronically ill, sponsors would pay insurers more for people at risk, like the elderly.

The payment scheme builds in all the right incentives. Insurers would wish to cut costs because they would keep the savings. They would offer quality care at competitive prices to attract business. And — because basic coverage would be paid with payroll taxes — premiums could not rise faster than wages.

The beauty of the plan can perhaps be best appreciated by understanding what it would *not* do. It would not rely on employers to insure employees, so workers would no longer be bound to particular jobs to maintain their coverage. The plan would not resort to rigid price controls, which would inevitably lead to rationing. And it would not put medical decisions in the hands of bureaucrats.

In the health reform plan he proposed last week, President Bush promised the states plenty of room to experiment. This California initiative shows how large that dimension can become. With Washington out of the way, Mr. Garamendi's plan for managed competition could take off.

**GUIDING
PRINCIPLES**

1. All employers and individuals should participate in financing the new system. Subsidies should be provided to small and/or low-wage employers and to low-income individuals.
2. Where appropriate, the new system should embody the principles of managed competition, emphasizing competition between accountable health care plans offering standardized benefits.
3. The establishment of hospital and physician payment rates is appropriate in some circumstances. But the new system should avoid government micro-management of health care.
4. As one means of controlling costs, a budget must be imposed on health care spending .
5. Government must guarantee all Americans the right to health care. But delivery of that care should be primarily in the hands of private health care plans. Individuals should have maximum choice among those plans.
6. Expanded access and cost controls should be pursued simultaneously.
7. The federal government should establish the parameters of the new system, but states should be given flexibility in meeting system goals.
8. Health coverage should be portable so that individuals maintain coverage as they change jobs or become unemployed.



**A PROPOSAL FOR
NATIONAL HEALTH CARE
REFORM**

John Garamendi
California Insurance Commissioner
January, 1993

INTRODUCTION

This proposal is based on the reform plan, *California Health Care in the 21st Century*, first proposed by California Insurance Commissioner John Garamendi, in February, 1992. The fundamental principles guiding the two proposals are the same. These include: universal access, a budget for health care, an emphasis on a competitive marketplace featuring the concepts embodied in managed competition, and a mandate on all employers and individuals to help finance a new health care system. The one significant difference in the two approaches is in the financing. The original "Garamendi Plan" called for tax-based financing. The model offered here recognizes that, at the national level at least, an employer mandate approach, with tax subsidies for low-wage employers and low-income individuals, may be more viable.

**1. UNIVERSAL ACCESS TO A
GUARANTEED BENEFITS PACKAGE**

- a. The federal government would define a guaranteed benefits package to which all Americans would be entitled.
- b. A Federal Health Board would assess new and existing technologies to determine whether they should be included as part of the guaranteed benefits package.

**2. ALL EMPLOYERS PROVIDE
COVERAGE FOR THEIR EMPLOYEES**

- a. The federal government would require that all employers contribute towards health coverage for their employees.
- b. For full-time workers and their families, employers would be required to contribute at least 75% of the lowest cost

health plan providing the guaranteed benefits in their region. Employees would pay no more than 25%, plus any additional amount to enroll in a more expensive plan.

c. For part-time workers, employers could provide coverage or pay contribution of 8% of wages.

d. Employer and employee premiums would be exempt from federal income taxes only up to the cost of the lowest priced plan in the region.

**3. MAKING THE SYSTEM
AFFORDABLE FOR ALL EMPLOYERS
AND EMPLOYEES**

a. Small employer contributions would be capped at a maximum of 6-8% of payroll, with federal subsidies making up

the shortfall between that amount and 75% of the lowest cost plan.

b. The premium contribution required of working families—25% of the lowest cost plan—would be capped at a maximum of 2-4% of income, with federal subsidies making up any shortfall

c. A variety of revenue sources could be used to finance these subsidies, including: capping the tax exemption for employer-sponsored health coverage at the lowest cost plan available in a region; an assessment on health care providers to capture windfall savings resulting from reduced uncompensated care and lower administrative costs; a small payroll assessment on all employers and/or employees; increases in cigarette or alcohol taxes.

4. ESTABLISHING STATE-SPONSORED HEALTH INSURANCE PURCHASING COOPERATIVES (HIPC) TO MANAGE COMPETITION

a. Each state would be required to establish one or more regional purchasing cooperatives, or to cede responsibility for operating a cooperative to the federal government.

b. All employers with fewer than 1,000 employees—about 62% of the labor force—would pay health insurance premiums to the purchasing cooperative rather than to individual insurance companies. The employer premium would be defined as 75% of the lowest cost health plan offering coverage in the region. The Federal Health Board would set the maximum year-to-year increase for employer and individual premiums paid the purchasing cooperatives (see Section 6).

c. Managed competition. In most circumstances, purchasing cooperatives would provide coverage by managing competition among private health care plans. Plans would all offer the same guaranteed benefits and be required to accept any individual regardless of health status.

For each person enrolled, the purchasing cooperative would pay a health plan an amount equal to the price of the lowest cost plan (with adjustments for risk). If a family chose to enroll in any health plan

other than the lowest cost plan, it would have to pay the full difference in cost.

d. State flexibility. Under specified conditions (e.g. rural areas, insufficient competing plans, etc.), an individual state could operate the purchasing cooperative differently across the state or in a particular region. In these areas, for example, the purchasing cooperative could create a single insurance plan and regulate provider prices, instead of contracting with multiple competing plans.

e. Large employers. Larger employers (with 1,000 or more employees) could choose to provide coverage directly to their employees or to join the purchasing cooperative. To keep the purchasing cooperative from attracting primarily older and/or sicker employees, the premiums paid by large employers joining it would be risk adjusted.

5. COVERING PART-TIME WORKERS, THE UNEMPLOYED, AND THE SELF-EMPLOYED

a. All individuals without an attachment to the labor force (i.e. those who are not working and do not have a working spouse) would be entitled to coverage through the purchasing cooperative.

b. Those with little or no income would pay nothing to enroll in the lowest cost plan. Those with resources would pay a percentage of income up to the full premium for the plan they choose. The federal government would provide revenue to purchasing cooperatives to pay for those whose contributions fall short of the full premium, perhaps through a small "unemployment health insurance contribution" paid by employers and/or employees.

6. A GLOBAL BUDGET TO CONTROL COSTS

a. Cap on premium increases. Each year, the Federal Health Board would set the maximum rate of increase for employer and employee premiums paid to purchasing cooperatives. This cap—along with the fixed subsidies paid by the federal government to purchasing cooperatives (see Sections 3 and 5)—would effectively establish an annual global budget

for each purchasing cooperative, and in the aggregate for the nation as a whole.

b. Global budgets for purchasing cooperatives. If the rate requested by the lowest price plan is greater than the per capita resources available to a purchasing cooperative, the cooperative could take various steps to bring costs in line with revenues. These steps could include: jawboning with plans; working with plans to discover ways of reducing costs regionwide; charging all individuals a small additional amount in excess of their 25% premium contributions (e.g. \$5 per month); or refusing to contract with any plan not willing to accept a defined rate of increase in its premium.

A purchasing cooperative's persistent inability to meet its budget—evidenced, for example, by having to charge individuals an additional amount to enroll—would trigger a review of its activities and circumstances.

c. Regulated prices as backup. The federal government would annually establish hospital and physician rates (perhaps based on current Medicare standards), with adjustments in the rates to reflect any increases in the overall volume of services delivered. States could choose whether or not to invoke these rates in order to aid them in meeting their budgets.

It is hoped, however, that most states would choose to meet global budgets through managed competition and control over *premium increases* rather than through *price regulation*. Capitation payments to health plans provide much greater flexibility in allocating resources (e.g. between doctors and hospitals) than price regulation. Even where a state has invoked price regulation, an insurance company or HMO should be able to choose whether or not to use the regulated rates or negotiate its own rates with providers.

7. MEDICAID AND MEDICARE

a. By a defined date, Medicaid would be eliminated (except for long-term care services), and clients would be entitled to coverage in the purchasing cooperative. Meanwhile, Medicaid spending would

fall as employer-provided coverage expanded.

b. Medicare, too, should be consolidated into the new system, though a long-term phase-in might be appropriate. For example, those now over age 65 might continue to be covered under Medicare, while those turning 65 might be covered through the purchasing cooperative (as most of them would be during their working lives).

8. 24 HOUR COVERAGE

a. Consolidating health coverage into a single, 24-hour policy would dramatically simplify the system and generate savings for employers and consumers under workers' compensation and auto insurance.

b. The federal government could promote consolidation by stipulating that the guaranteed benefits package cover illnesses or injuries regardless of where or when they occur. States would then have a strong incentive to remove coverage of medical care from workers' compensation and auto insurance policies.

9. PHASE-IN OPTIONS

In phasing in a health care reform plan, a fundamental decision is whether to con-

trol costs first and then expand access, expand access first and then control costs, or to do elements of both simultaneously. It is our view that expanded access and cost controls should be phased-in together, demonstrating progress on both fronts.

1. PHASE-IN THE REQUIREMENT THAT EMPLOYERS PROVIDE COVERAGE. There are several options for phasing in the mandate on employers:

a. Delay the requirement until a defined date (e.g. July 1, 1995)

b. Phase-in the requirement by size of employer (e.g. employers with more than 100 employees by January 1, 1994; employers with more than 50 employees by January 1, 1995; and all employers by January 1, 1996).

c. Subsidized coverage for the unemployed might begin when all employees have been covered.

2. PHASE-IN ESTABLISHMENT OF HEALTH INSURANCE PURCHASING COOPERATIVES (HIPCs). Purchasing cooperatives should be fully operational by the time small employers are required to provide coverage for their employees. To accomplish this, purchasing cooperatives could be established prior to mandated coverage, and small and

medium-sized employers already insuring voluntarily could be required to join the HIPC.

3. ESTABLISH TEMPORARY PRICE CONTROLS, IF NECESSARY. We believe that global budgets are best met through managed competition and, if necessary, control over premium increases rather than physician and hospital prices. However, even in areas of the country where managed care plans are well-established, such a budgeting system may take several years to develop and achieve cost savings. If short-term controls are perceived to be necessary (to achieve public and/or private sector savings), the following approach might be considered:

a. In the first year, all hospitals and physicians would be required to bill based on Medicare rates (i.e. DRGs for hospitals and RBRVS for physicians). Providers could apply an adjustment factor to the Medicare rates, up to a ceiling established by the federal government.

b. After the first year, the federal government would establish a maximum rate of increase for provider prices.

c. Insurance companies and HMOs could use the regulated prices or negotiate their own rates.

**For more information about this proposal,
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Los Angeles Times

Editorial—December 13, 1992

If anyone needs more evidence of the power of the President's bully pulpit, consider the tremendous effect of President-elect Bill Clinton's promise to reform the nation's health care system. He hasn't even taken office yet and already health industry lobbyists are scrambling to influence what reforms will garner support on Capitol Hill.

A major health care policy shift is in the air. Indeed, Clinton has promised such a shift, though he has been careful since the election to remind the voters not to expect miracles.

While a health care reform plan proposed in California doesn't fall into the miracle category—important details have yet to be worked out—the President-elect would do well to seriously consider what it has to offer the nation. The catch phrase for the plan—conceived by a Stanford health economist and a Wyoming physician and proposed by state Insurance Commissioner John Garamendi—is *managed competition*. The seeming contradiction in the term is the clue to its political appeal.

Managed competition implies that in some ways liberals were right: Every American should have access to affordable health care, and obviously the system isn't accessible or affordable when more than 35 million have no health insurance. And managed competition implies that in some ways conservatives were right: The way to fix the problem isn't to impose a government-run health care system but to rely on market incentives.

The Garamendi plan, although it has run into political roadblocks in California, has been touted as having national potential because it covers both the necessary bases of true health care reform: cost containment and access for everyone to basic, quality medical care.

All Californians, employed or not, would be covered. The plan would create quasi-public regional insurance purchasing corporations to bargain with the existing network of clinics, health maintenance corporations (HMOs), hospitals and doctors.

It would contain costs through the use of new insurance pools and simplified billing. Coverage for all would be financed through contributions from employers and employees based on payrolls and wages. In the current pell-mell system, employers and insured employees already are shouldering—and are buckling under—the burden of virtually unchecked spending for doctors, tests, prescriptions and hospitalization.

There's really nothing Clinton has said about reform that contradicts the basics of the Garamendi plan. Before the election Clinton vowed to provide coverage for all, control costs, establish a minimum benefit package, encourage the development of community-based "managed care" networks of doctors, hospitals and insurers, and eliminate waste and fraud.

Government must have a place in ensuring fairness; the market must have a place in ensuring choices for the medical consumer. In the new thinking that must take place if the nation's health care system is to be reformed, the government and the market can meet.

The New York Times

Editorial—November 22, 1992

President-elect Clinton promises to fix America's ruinously expensive health care system with managed competition. That's absolutely the right idea. Managed competition would encourage the use of large health maintenance organizations—and force them to compete. That's the way to preserve quality and control costs without having to hire an army of bureaucrats.

Mr. Clinton, meet Mr. Clinton.

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Why the contradiction? Mr. Clinton evidently fears that competition alone can't do the job. Yet he must realize that trying to run the \$800 billion health care industry by government fiat is folly. Price controls would spawn bureaucracy and wholesale evasion. Worse yet, they would rob health care providers of the drive to innovate that now distinguishes the U.S. health care system.

There is a way out of this quandary, but only if Mr. Clinton owns up to the contradiction and reaches out for the remedy that's already at hand.

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Every company and worker would pay a payroll tax to the sponsor. The sponsor would then find at least two insurers willing to offer, for the amount already paid to the sponsor, basic benefits to every applicant. People would be free to buy more lavish coverage, but at their own expense.

This health care tax would add the fiscal discipline Mr. Clinton seeks from his global budget. Indeed, it's perfectly reasonable to describe such a cap on annual premiums as "global budgeting." The difference is that the Clinton plan would be driven by bureaucrats. The Garamendi plan would be driven by market forces.

If government tried to set the tax below the cost of health care, no qualified insurer would be willing to offer coverage.

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- 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]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- 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]

Industrial Union Department AFL-CIO



Howard D. Samuel, President
Elmer Chatak, Secretary-Treasurer

815 16th Street N.W.
Washington, D.C. 20006
FAX 202/842-7838

January 25, 1993

Brian Turner
Executive Assistant
to the President
202/842-7845

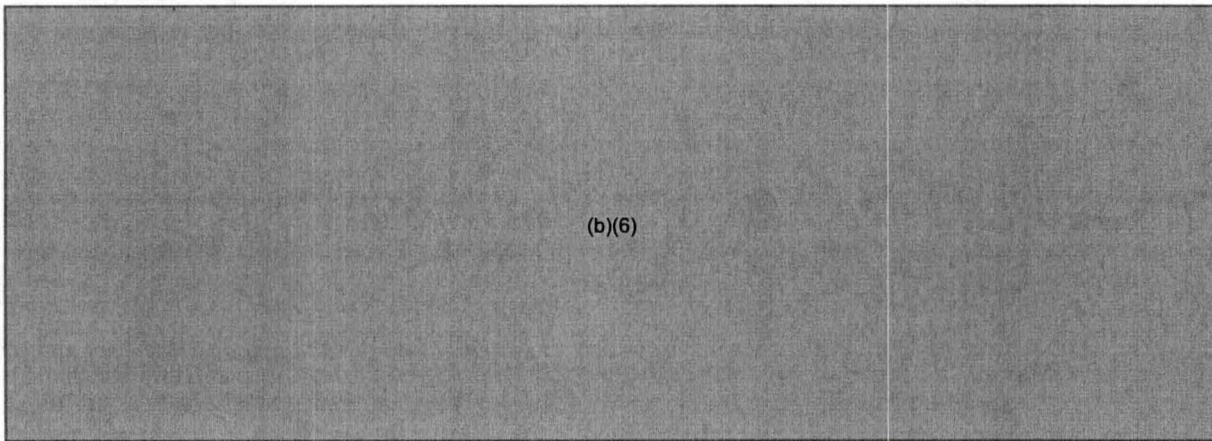
By Messenger

Mr. Ira Magaziner
Senior Adviser for Policy
Development
Old Executive Office Building
Room 216
Washington, DC 20500

file resume

Dear Ira:

We were very pleased to see the official announcement of your appointment as Senior Adviser for Policy Development with an early emphasis on health care reform. Like you, many of us in labor see control of health care costs with equitable universal access as critical to solving our long-term economic as well as budgetary crises. I'm glad that as President, Bill Clinton will be able to draw on your analytical and synthesizing skills for that major challenge and others to follow.



[001]

(b)(6)

Vice Presidents

Morton Bahr, President
Communications Workers of America

John Barry, President
International Brotherhood of Electrical Workers

Owen Bieber, President
United Automobile, Aerospace &
Agricultural Implement Workers of
America International Union

William Bywater, President
International Union of Electronic, Electrical,
Salaried, Machine & Furniture Workers

Kenneth L. Coss, President
United Rubber, Cork, Linoleum and Plastic
Workers of America

Dominick D'Ambrosio, President
Allied Industrial Workers of America,
International Union

Sandra Feldman, Vice President
American Federation of Teachers

Wayne E. Glenn, President
United Paperworkers International Union

Frank Hanley, President
International Union of Operating Engineers

James Hatfield, President
Glass, Molders, Pottery, Plastics and Allied
Workers International Union

Charles W. Jones, President
International Brotherhood of Boilermakers,
Iron Ship Builders, Blacksmiths,
Forgers and Helpers

John Kelly, President
Office and Professional Employees
International Union

George J. Kaurpias, President
International Association of Machinists and
Aerospace Workers

Sigurd Lucassen, President
United Brotherhood of Carpenters and
Joiners of America

William Lucy, Sec.-Treas.
American Federation of State, County &
Municipal Employees

Frank Martino, President
International Chemical Workers Union

Jay Mazur, President
International Ladies' Garment Workers
Union

William J. McCarthy, President
International Brotherhood of Teamsters,
Chauffeurs, Warehousemen and Helpers of
America

Joseph Misbroner, President
Oil, Chemical and Atomic Workers
International Union

James J. Norton, President
Graphic Communications International
Union

Jack Sheinkman, President
Amalgamated Clothing and Textile Workers
Union

John Sturdivant, President
American Federation of Government
Employees

John J. Sweeney, President
Service Employees International Union

Richard L. Trumka, President
United Mine Workers of America

Lynn Williams, President
United Steelworkers of America

Mr. Ira Magaziner
January 25, 1993
Page Two

We look forward to working with you in the revitalization and reorientation of the American economy and society in the years to come.

Sincerely,

A handwritten signature in black ink, appearing to read "Brian".

Brian J. Turner

BJT:lg