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REPUBLICAN HEALTH CARE TASK FORCE PROPOSAL (CHAFEE/DOLE) SUMMARY

The Republican Health Care Task Force has proposed a health care reform plan which would gradually phase-in coverage. The program is based on mandating that all individuals buy health insurance. A national board would establish two benefits packages, standard and "bare bones" with a high deductible. Government vouchers, paid for with Medicare and Medicaid savings, would be provided to help poor people buy insurance. The level of benefits included in the package and the availability of the vouchers would depend on the savings generated from Medicare and Medicaid.

The plan would establish cooperatives within each state to help small businesses and individuals purchase coverage. It would continue to permit -- but would not require -- that employers contribute toward coverage for their employees. By allowing employers to decide whether or not to provide insurance and giving them the option of purchasing coverage through the alliance or on their own, employers would still determine the kind of health care plan their workers would receive. The health cooperatives will be small and voluntary, weakening their bargaining power with health care plans and limiting their ability to bargain for affordable rates.

The Republican Health Task Force plan would control costs by encouraging competition between plans within the alliances and by taxing individuals and employers who buy benefits that cost more than an established cap. The plan also includes measures to reduce administration and bureaucracy, and reforms malpractice laws.

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REPUBLICAN HEALTH CARE TASK FORCE PROPOSAL (CHAFEE/DOLE) SOME CONCERNS

The proposal put forth by the Republican Health Care Task Force indicates that we are closer than ever before to a bi-partisan approach to comprehensive health care reform. For the first time, 23 Republican Senators have committed themselves to guaranteeing comprehensive coverage for all Americans, and have put forth a serious proposal. We agree with much of their approach. We agree that coverage for all Americans is the first and most important goal of health reform. We agree that market forces and changed incentives can bring down health care costs, and that competing health plans and health alliances will make it happen . We agree that individuals should take responsibility and contribute toward their care.

But we cannot support the Republican plan because it does not go far enough. It says that individuals have an obligation to buy health insurance, but that the companies they work for don't need to contribute. It says that small businesses and individuals deserve the better bargaining power of a health alliance, but doesn't guarantee they'll get that clout. It says that comprehensive benefits are a must, but fails to say what's covered. It limits spending for public programs, but has no similar protections on the private side. It says that we can slow spending in Medicare and Medicaid, but doesn't use that money to buy new benefits for seniors. This plan is like a car that heads down the right road, but runs out of gas half way there.

Does Not Achieve Universal Coverage in this Century

The Chafee proposal promises universal coverage for comprehensive benefits by the year 2000.......<u>if</u>. <u>If</u> the savings they project materialize. If savings don't come as quickly, they' will extend coverage more slowly, leaving more people without coverage for longer.

Does Not Guarantee Comprehensive Benefits

The proposal promises that the benefits package will cover a broad range of services........<u>if</u>. <u>If</u> the Commission the Republican plan sets up decides those benefits are affordable. And if costs go up faster than they expect, the benefits could be cut back. These are big ifs. People need the security of knowing what's covered, and knowing that those services won't be watered down over time.

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Shifts Costs to Businesses and Individuals

The Chafee proposal controls costs by pooling small businesses into regional purchasing cooperatives and forcing plans to compete on quality and price. The evidence suggests that competition and better incentives will control costs-- but it doesn't guarantee it. By contrast, public sector savings are guaranteed in this proposal--it caps Medicare and Medicaid growth at 7%, from a projected 12%.

Capping the growth of public programs with no control on the private side will continue the same "cost shift" we have today, where prices go up slower in the Medicare and Medicaid programs, and doctors and hospitals raise prices higher and faster in the private sector to make up for it. Individuals and businesses will keep paying more, weakening the cost-slowing effects of competition.

Shifts Responsibility from Businesses to Individuals

Under the Republican Health Task Force plan, individuals would be required by law to buy insurance. While employers would still be free to contribute for insurance coverage, they would have no responsibility to do so. That means that middle-class families will bear the full cost of their insurance, if employers choose not to help pay for health coverage. For the same price you pay to cover part of the cost of good benefits today, you may pay the full cost for bare-bones coverage under reform. And if you want the protection of comprehensive benefits even if it's beyond your means, you'll just have to tighten up elsewhere in your family budget and forgo other necessities.

No Guaranteed Bargaining Leverage for Small Businesses

By making purchasing alliances both small and voluntary, this proposal significantly weakens the bargaining muscle of the alliance, and their effectiveness in bargaining with plans.

And what's worse, it keeps in place an insurance system which avoids risk by "cherry picking" firms with young healthy employees and rewarding them with lower rates. Any group that can get a better deal outside the alliance will stay outside. This approach pools vulnerable small businesses with the poor and uninsured, and will almost certainly mean that premiums in the alliances are higher than outside. That's no help at all to small businesses.

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Continuous Disruption for Many Americans

The average person changes jobs 10 times in a lifetime, more for people in small firms. If the pools are voluntary, workers will be in and out of different plans based on their employer, and may lose their work-based plan if they lose their job.

Allows Huge Variations Among States

It's one thing to give states flexibility, it's another thing to tell them they can set up a whole different system than their neighbors. The Chafee plan tells lets set up basically whatever kind of system they want as long as they meet certain federal rules. That could mean a single-payer program in Vermont, an individual mandate in New Hampshire, pay-or-play in Massachusetts, an employer mandate in Rhode Island, and Med-Save accounts in Connecticut.

Such vastly different approaches in such close proximity could guide business decisions and other factors that skew economic development and have differing effects on state economies. And states that want to build on the current system through an employer requirement can't do so without worrying that businesses could move to the state across the border -- tying the hands of governors who support employer-based reforms.

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"THE MANAGED COMPETITION ACT OF 1993" (COOPER) SUMMARY

Congressman Cooper's plan, The Managed Competition Act of 1993, attempts to control costs and improve access to health insurance by coupling the market forces of the private sector with government regulations. The health insurance market would be reformed, combining insurance companies and health care providers into Accountable Health Plans (AHP's). These AHP's would be prohibited from medical underwriting, excluding individuals for pre-existing conditions, and setting premiums based on health status. Health plan purchasing cooperatives (HPPC's) would be established by the states and would organize individuals and small group purchasers into pools. These pools, now with the larger economic clout of several purchasers, would negotiate with the AHP's for health insurance in a competitive marketplace.

A national health board would be established to oversee the creation of the AHP's and HCCP's. The board would be in charge of specifying the uniform set of health benefits along with providing standard deductibles and cost sharing. Standards for reporting prices, health outcomes, and measures of consumer satisfaction would also be established by the board, and plans which met these standards would be certified as AHP's.

The Managed Competition Act would modify the tax code to encourage the use of the board certified AHP's. Tax deductibility would be limited to the cost of the least expensive AHP in the region for both employers and individuals. There would be no tax deductibility for plans not certified by the board. Medicaid would be replaced with a new federal program which would assist low income individuals to purchase health care insurance though their HCCP's.

In addition, this bill contains provisions to improve access to rural and underserved populations, increase programs to promote preventive health care, simplify the paperwork involved in the administration of health insurance, and implement malpractice reforms.

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Documents obtained by Judicial Watch.

"THE MANAGED COMPETITION ACT OF 1993" (COOPER) SOME CONCERNS

There are many components of this approach we agree with. Like Congressman Cooper, we believe community rating returns insurance to a community responsibility, not an exercise in profit making and risk avoidance. Like Congressman Cooper, we believe that an increased emphasis on competition will promote efficiency, reduce waste, and lower costs. And finally, like Congressman Cooper, we believe increased cost-consciousness is an important aspect of health care reform, and a necessary ingredient for cost control.

But we cannot support the Cooper bill because it does not provide health security for all Americans. We believe all Americans need and deserve health care security; this plan just doesn't provide that. We believe that comprehensive benefits should be spelled out and guaranteed; this plan doesn't provide that. We believe choice of doctor is a right; this plan considers choice a taxable luxury. We believe HMOs are one alternative; this plan believes HMOs are for everyone.

Does Not Achieve Universal Coverage

The Cooper plan assumes that between better incentives and government help for the poor, more Americans will be covered. But individuals can still decide that health care isn't their responsibility-- it's yours and mine. Employers can continue to drop workers who are costly, or decide not offer coverage. In fact, this plan encourages employers with low wage workers to drop the coverage they now provide and let the government pay for their care. The result? After Cooper-style health reform, 22 million Americans will still be uncovered. [Congressional Budget Office, July 1993] And with incentives for employers to drop coverage, CBO warns of 6 million newly uninsured Americans.

Encourages "Bare-Bones" Coverage

This plan does not even specify -- much less guarantee -- a comprehensive set of benefits, nor does it protect American families from exorbitant out-of-pocket costs. And because it does not eliminate lifetime limits, it cannot assure that your insurance coverage never run out . The Cooper proposal shifts the responsibility for defining the benefits package to a National Board -- to be determined after the legislation has passed and become law. The plan encourages employers to reduce benefits by levying tax penalties on employers that give their workers comprehensive coverage. The Cooper proposal would set a "tax cap" at the lowest cost plan in the area -- a plan with benefits that are less generous than what most people have today.

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Documents obtained by Judicial Watch.

Americans Will Pay a Choice Tax

You could be penalized if you pick your own doctor and pay a "choice tax" to belong to certain plans or see certain doctors. Millions of Americans will pay new taxes for the same benefits. By trying to reward consumers for choosing tightly managed, cost-efficient plans like HMOs, the proposal punishes individuals and their employers for any other choices. If you want to continue to get health care the way you do now -- or to see the same doctor you've always seen outside of an HMO -- you get taxed. If you choose not to go into an HMO or HMO-type organization, you and your employer both pay new taxes on your health care premiums.

Older Americans Pay the Price

The Cooper plan worsens today's cost shifting, rising private sector costs and endangers access for Medicare beneficiaries. It slows Medicare spending, both by reducing rates to providers and by dramatically increasing Part B premiums for upper-income recipients. And yet it doesn't reinvest any of that money to new benefits or increased protections for seniors. By slowing Medicare spending without controlling private health spending, the unrestricted private sector will continue to be threatened by ever-rising costs shifted to it from budgeted public programs. The widening gap between Medicare rates and private rates will result in more and more doctors deciding not to see Medicare patients, limiting choices for older Americans.

"The IRS Full Employment Bill"

This plan is an administrative nightmare; it might as well be called "the IRS full employment bill." This plan significantly expands the reach of government bureaucracies and government involvement in the workplace. It requires the IRS to determine and monitor the low-cost plan in every HPPC region, and match that against spending on health care by every employer for every employee. And this adds a tremendous new administrative burden for businesses -- particularly small businesses who now suffer tremendous administrative burdens -- by forcing them to keep on top of the "lowest cost plan" the way an investor would follow changes in the stock market.

Increases the Deficit

The Cooper Plan increases the deficit by $70 billion. This proposal doesn't even pay for itself. In fact, the CBO/Joint Tax Committee analysis of the plan found that it increases the deficit by $70 billion in the first 5 years alone.

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Shifts Financial Burden to the States

The Cooper plan does not address long term care other than shifting enormous federal costs onto the states. The Cooper plan says that states should bear those costs completely on their own. This unfunded mandate would bankrupt many states.

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"THE COMPREHENSIVE FAMILY HEALTH ACCESS AND SAVINGS ACT" (GRAMM-MCCAIN): SUMMARY

The Gramm/McCain bill attempts to make health care insurance more portable and affordable by eliminating state requirements for minimum insurance benefits to create a market for "bare bones" health plans which would cover only major medical expenses. Tax incentives and government assistance would encourage the purchase of such plans. The bill would also create tax free "Medisave" accounts, much like Individual Retirement Accounts, which individuals would use to pay small medical bills. Individuals would pay for routine care and deductibles out of "Medisave" accounts, only using insurance for serious or catastrophic care. All "Medisave" funds not used for routine treatment would be retained by the individual for future medical expenses, creating an incentive to keep unnecessary health care use down.

In addition, employers who currently provide health insurance would be required to offer the employee an option of a "Medisave" account, an HMO, or continue their current coverage. The self-employed and uninsured would be allowed to exclude from their income the percentage of medical insurance coverage costs equal to the national average contributed by employers. This would also create an incentive to choose lower cost "bare bones" or HMO plans.

Under the Gramm/McCain bill, health care insurance companies would be prohibited from excluding individuals with pre-existing conditions from coverage but could charge a higher rate. There would be no limit on how much higher the premiums could be, but federal subsidies would be available if the cost exceeded a percentage of family income. Insurance discounts would be offered to individuals who engage in activities determined to constitute a "healthy" lifestyle. Federal assistance would be reduced for individuals who engage in "unhealthy" activities.

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SINGLE PAYER (MCDERMOTT/WELLSTONE): SUMMARY

Under the McDermott/Wellstone single payer proposal the government would take full responsibility as the sole purchaser of health care services for all legal residents. The government would replace all other public and private health care coverage. The plan would be administered by the states under a fee-for-service program. States would also have the option of enrolling their residents, through capitated managed care, in health service organizations meeting federal requirements.

The program would be funded through $500 billion in increased taxes on individuals and businesses, including payroll taxes and income taxes. A trust fund would be established by combining new taxes with funds from existing federal programs (with the exceptions of IHS and VA.)

The government would establish payment rates for all physicians and other providers. The Secretary of Health and Human Services would establish annual state and national budgets. In order to contain costs, total spending would be strictly limited by this national health budget and would grow no more rapidly than the annual percentage increase in the gross domestic economy. Providers would not be able to bill their patients for covered services.

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SINGLE PAYER (MCDERMOTT/WELLSTONE): SOME CONCERNS

Many elements of the single payer bills are central features of our plan. For example, both plans guarantee a comprehensive package of benefits for all Americans. Both simplify administration and reduce paperwork. We also agree on the need to control costs. We also provide states with the flexibility to adopt a single payer plan for their citizens.

But we cannot support the McDermott / Wellstone bill because, among other reasons, it would require raising and redistributing as much as half a trillion dollars in new federal taxes. Not only would this approach add further strain to our recovering economy, but it doesn't make sense to change our health care system so radically when it is possible to build on our current system -- to take the finest private health care system in the world and make it work better.

A New Half A Trillion Dollar Tax

Of the Americans that are covered under today's system, 9 out of 10 receive their coverage through the workplace. While we agree there are major problems with the current system that need to be addressed that there are many positive aspects as well. We believe that our goal should be to change what's wrong while preserving what's right. Our plan is uniquely American plan rooted in the private sector. Asking Americans to support a half a trillion dollar tax hike to support a system whose costs are already out of control is unfair. Without an effective mechanism for containing costs, their plan would compromise the quality of American health care and would limit consumer choices.

Government Dream? Providers Nightmare?

While single payer advocates claim that their system would be simpler, providers say that our current government programs are a bureaucratic nightmare. Doctors and nurses must deal with an ever-growing set of regulation, a blizzard of paperwork and multiple layers of reviews, inspections and oversight. In a government-run health care system with no competition, there aren't any incentives to increase efficiency, to develop systems that works better and improves quality.

We believe that the government should set standards, guarantee security then get out of the way. It will simplify the system, reduce paperwork, and streamline government oversight. Doctors and nurses will be able to spend less

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time filling out forms and fighting bureaucrats and more time taking care of patients.

A One Size Fits All Approach

The McDermott/Wellstone bill is based on the premise that "one size fits all" -- that a single health plan would meet everyone's health needs and work as well everywhere. Our plan recognizes the unique differences of our states. What works in New York, may not work in New Mexico. Our plan allows states the flexibility to tailor their reform plan to meet the needs of the citizens of their state.

Ineffective Cost Control

The McDermott/Wellstone plan contains costs by setting fee schedules -- controlling the cost by controlling the payment rates for doctors and other providers. Under this approach, its easy for providers to game the system by ordering more tests and more procedures. Canada's health care costs are rising as fast as ours. We do not believe that Americans should be asked to spend their money on a system with skyrocketing costs with a containment mechanism that is ineffective.

Our plan is based on proven approaches -- here and around the world -- that are successful in containing costs. Costs will be controlled by bringing competition to the health care marketplace, strengthening the buying power of consumers and businesses by pooling them into large groups to bargain for lower prices. It will put consumers in the driver's seat by providing them with the information they need to choose plans on price and quality