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S. HRG. 103-575

ROUNDTABLE DISCUSSION ON THE ECONOMICS OF HEALTH CARE

HEARING

BEFORE THE

JOINT ECONOMIC COMMITTEE CONGRESS OF THE UNITED STATES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

APRIL 21, 1994

Printed for the use of the Joint Economic Committee

80-466

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON: 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-9328
ISBN 0-16-044513-2

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[Created pursuant to Sec. 5(a) of Public Law 304, 79th Congress]

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ROUNDTABLE DISCUSSION ON THE ECONOMICS OF HEALTH CARE

THURSDAY, APRIL 21, 1994

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to notice, at 10:15 a.m., in room 2359, Rayburn House Office Building, Honorable Lee H. Hamilton (Member of the Committee) presiding.

Present: Representatives Hamilton and Saxton, and Senators Dorgan and Craig.

Also present: Patricia Ruggles, George Foy and Morgan Reynolds, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE HAMILTON, MEMBER

REPRESENTATIVE HAMILTON. The meeting of the Joint Economic Committee will come to order. We are having another in a series of round table conversations that the Joint Economic Committee is holding with prominent economists to discuss the state of the economy and economic policy.

Today's topic, the Economics of Health Care, is certainly one of the more important economic policy issues of the 1990s. We are pleased to have as our guest, Mr. Henry Aaron, Director of Economic Studies at the Brookings Institution.

Over the years, Mr. Aaron has made important research into the areas of property taxation and social security, tax reform, and most recently health care. He is the editor of the Brookings Institution 1990 book, *Setting National Priorities, Policies For The 1990s*, and he has written of course extensively on health care.

We are pleased to welcome you, Mr. Aaron, and look forward to a good discussion with you. We will let you proceed with whatever opening statement you would like to make and then we will turn to questions.

STATEMENT OF HENRY J. AARON, DIRECTOR, ECONOMIC STUDIES, THE BROOKINGS INSTITUTION

MR. AARON. I will try to be brief. Thank you very much for inviting me. It is a privilege to have this opportunity.

Conversation entails a two-way exchange, so I am going to be brief in my opening statement.

The health-care debate has passed through the initial phases during which the various parties put forward their ideal plans. None of the plans can command a majority in either House of Congress in my view. Regardless of what our personal preferences for the best of the candidate plans, compromise is going to be essential.

In my view, compromise is possible, specifically a compromise that would enable most of the supporters of the major health-care reform proposals to join together in a signing ceremony in the Rose Garden and declare victory, declare that they have achieved the major purposes of their health-care reform bills.

I turned in a brief outline, which is headed, "Draft Specifications of a Compromise Plan." It was put together with that express purpose in mind.

There are many centers of ideas on health-care reform. I focused on four of what I regard as the more important and larger groups in Congress. Of course, President Clinton's plan has its supporters, and Senator Chafee's proposal enjoys considerable support, particularly in the Senate.

Congressman Cooper's proposal has bipartisan support in the House of Representatives, and although I think many members of the fourth group would acknowledge that they have little chance of triumphing in the end, a very sizable fraction of the House of Representatives favors what is sometimes called the single-payer or Canadian-style approach to health-care reform.

In the end, in my view, most members of those four groups are going to have to join together and be prepared to vote for a bill that the President can sign.

The draft proposal that I put forward was assembled with that express goal in mind. Let me run very briefly through the main provisions of it, and I will try and point out where specific elements of the proposal link up with what seem to me to be preeminent objectives in each of the four groups, starting with an employer mandate.

The President's plan embodies it. It is the instrument by which he assures that all employees and their families will be covered by insurance, and not unimportantly, that those funds now being spent by businesses remain in support of health insurance.

Nonetheless, there is powerful and very effective opposition to the employer mandate from the small business community and from some larger companies that operate through small outlets—fast food chains, for example.

Provision one would impose an employer mandate, but only on firms exceeding a certain employment size. Furthermore, the mandated share of health insurance costs that employers would be required to pay I suggest at a lower level than that contained in the President's plan. I use 50 percent as an illustration, but obviously that is not anything but a person's suggestion.

Furthermore, I suggest reintroducing what is clearly a loophole that used to exist in the tax law with respect to the corporation income tax. There was a provision enacted some years ago called the Thom McAnn rule, which was designed to prevent large corporations that consist of many separate outlets from organizing to take advantage of the lower corporate tax rate on the first few dollars of corporate earnings. The Thom McAnn rule required corporations to consolidate.

My suggestion is that with respect to health insurance, that rule not be applied so that large collections of small outlets—fast food operations— would be regarded as collections of small businesses, and the mandate would not apply to them.

As you will see, however, when I come back to certain later provisions, I believe that the financial incentives will confront even such businesses with offers for incentives to sponsor and pay for insurance that they will not be able to resist.

Purchasing cooperatives perform many important functions in three of the four major groups' plans that I described: Senator Chafee's, Congressman Cooper's, and President Clinton's. Nonetheless, the particular formation of alliances or cooperatives that President Clinton proposed has run into intense and, I think, overwhelming opposition.

Accordingly, the second element of what I suggest proposes an alliance structure that is looser and less prescriptive in many ways than President Clinton's.

A public alliance in a geographical area, much like that proposed by President Clinton, would be created, but it would not have monopoly authority. Other groups containing, again, an illustrative number, at least 5,000 members, could form alliances of their own. There would be no prescription as to which organizations could band together to do so.

I suggest that one not leave to State legislatures the task of trying to draw alliance boundaries, the reason being captured, I think, in a quip that somebody made about alliances. The joke was that alliances are redistricting to meet school finance needs.

The political difficulties of drawing alliance boundaries, I think, could be sufficient to derail implementation of a proposal by itself. For that reason, the second element of this cooperative or alliance structure would be the use of some already existing federal boundary system, Federal Reserve districts, Health and Human Services region, census districts, I am not sure what, but adopt some such boundary structure presented to Congress much as base closing legislation was presented, up and down.

If the alliances want to negotiate with one another, all right, they can write treaties. It is voluntary among themselves, but you have something to go with at the outset, and it doesn't entail a monopoly.

The most innovative part of this compromise proposal concerns the subsidy structure. The Clinton bill has been, in my view, rightly criticized for the subsidy structure applied to businesses. Low, average-wage small businesses are eligible for subsidies, not others.

That creates incentives for outsourcing, for reorganizing businesses to qualify for subsidies. It also doesn't deal with the disemployment effects that might arise if one mandates expensive health insurance in large companies.

Accordingly, subsidy structure at the business level should be keyed to workers, not to businesses. My suggestion is that whatever share of health insurance cost business is required to bear, it be capped at a certain percentage of the worker's earnings, say 10 percent. That would put the added cost of health insurance for those businesses not currently sponsoring and paying for health insurance at about the magnitude of actual increases in the minimum wage that have been enacted.

Studies indicate that the disemployment effects from those increases in the minimum wage have been trivial. For that reason, I think we delay a side concern about the disemployment effects.

But the key part of this is that the amount of subsidy paid on behalf of any family to help them buy insurance shouldn't be based on the average earnings of their employer. It shouldn't be based on the wages of any one household member. It should be based on family income.

That truth, I believe, lies at the heart of the Chafee proposal.

Accordingly, each year at year end, the employer, on the W-2 form that every employee receives, would have another box that would report how much the employer had paid for health insurance. The employee's family would, on the annual tax return, have a one-page added with a table, based on family income and family size, one would read off the dollar amount of premium that household is required to pay for health insurance, subtract what the employer has paid already. The household owes the difference or, in special cases, if more has been withheld than the family owes, the household receives the refund. This minimizes subsidy cost because you use the right index for targeting aid, family income, not an inaccurate measure, earnings or average wages in a business.

It is a simple system that would be easy to incorporate into withholding so that people on an ongoing basis pay for their health insurance. One could use the withholding framework much as we now use it to enforce the personal income tax.

The final element of the subsidy structure that comes back to provide, I would say, a very powerful incentive for small businesses to sponsor and pay for health insurance is that employer payments for health insurance, as under current law, would be tax exempt, not excluded from personal income tax. The payments made at the house-

hold level would not be deductible. That means that every worker knows, first of all, he or she is going to be covered by health insurance, is going to have to pay a certain dollar amount based on family income—no getting away from it. If the employer pays for it, you don't have to pay taxes on it. If the worker pays for it, they do have to pay taxes on that income.

That means that every worker is therefore transformed into a lobbyist with his or her employer to urge that employer to sponsor health insurance and pay for the employer's share of the cost.

That situation does not exist today, because if the employer doesn't sponsor, the worker doesn't have to buy health insurance. For that reason, I believe this arrangement would encourage strongly mom and pop grocery stores, McDonald's, and everybody else, to enter the market voluntarily for health insurance.

The fourth element is the benefit package. The President's plan is relatively generous. Congressman Cooper's is unspecified. I don't think you can get away with an unspecified benefit package leaving that to subsequent administrative action.

Congress is going to want to know what it is buying, but I believe it is possible to meet the President's commitment to universal coverage, without which he says he will not sign a bill, and I believe him, with a smaller benefit package.

One could raise cost sharing. One could trim back certain benefits, many of which are desirable, and actually I would like to see in health insurance. I would buy it if it was available to me. But they raise the cost of health insurance and make it more difficult for Congress to put together a fiscally coherent package.

If you could trim the package back from about the 50th or the 60th percentile of major corporate plans, which is where the President's plan is now, to say the 15th or 20th percentile, you could knock about 15 percent off the overall cost of the plan, and while that may not seem a lot, it has a big bearing on subsidy costs and on the initial premiums that companies not now sponsoring insurance would face.

Fifth, slow down implementation. I suggest that both for administrative and budgetary reasons. Implementing national health insurance through whatever mechanism is a monumental job. We don't have a lot of the data. We don't have a lot of the administrative apparatus.

I think we need somewhat more time than contained in the President's proposal.

Finally, not a gesture, but a genuine movement to Congressman Cooper and supporters of managed competition, a big debate out there was whether changed incentives will actually suffice to slow the growth of health-care spending.

I think the overwhelming majority of Americans would be just delighted if, by changing incentives, we could slow the growth of health-care spending sufficiently and do away with the need for prescriptive administrative rules there.

There may be some junkies who love administrative rules, but I don't know any.

On the other hand, there is broad skepticism that simply modifying incentives will cut spending adequately or fast enough. The last element of what I suggest is, I call, the put-up or shut-up approach to managed competition. That is to say, one sets up the rules for purchase of insurance, then changes the tax rules in some ways I haven't gone into here that are in the brief statement to encourage cost conscious buying on the part of households.

One establishes targets for spending and a period of time over which one is going to give managed competition a fair run. If at the end of that period spending is within target levels and you can't set the targets unreasonably slow, they have to be modified back in view of my expenditures, then you declare victory and you stick with the incentive structure. No need to call into effect the regulatory devices.

If they fail, however, you enact a regulatory device the same time you pass the bill initially, and you have an administrative apparatus ready to go.

In a nutshell, that is what I think could be the basis of a compromise plan all parties favoring major legislative modification could endorse. It has the employer mandate and universality for President Clinton. It has, in the end, subsidies based on households for Senator Chafee. It has a fair run for managed competition for Congressman Cooper, and for those who advocate the single-payer approach, as with many of the proposals, it should have a state cutout. If any state wishes to adopt a straight Canadian style approach, as long as they meet certain federally established performance standards, they should be free to do so.

[The prepared statement of Mr. Aaron, together with an attachment, starts on p.38 of Submissions for the Record:]

REPRESENTATIVE HAMILTON. Mr. Aaron, thank you very much.

We will begin with questions. I will begin with you, Senator Craig. We will move along under a loose five-minute rule.

Senator Craig, please proceed.

QUESTIONS BY SENATOR CRAIG, MEMBER

SENATOR CRAIG. My time is going to require that I clearly stay under five minutes, Mr. Chairman. I do have to leave. Thank you.

REPRESENTATIVE HAMILTON. You go right ahead.

SENATOR CRAIG. Mr. Aaron, in your concept where you develop the purchasing cooperatives or the alliances, do I understand you to say that you permit voluntary alliances, but I say establish public alliances. Are you looking at two different types?

MR. AARON. The principle here is that there exists a public alliance, which is, if you will, an alliance or a cooperative of last resort. Business that has more than 5,000 employees, as in the President's plan, is automatically permitted to form its own alliance.

A voluntary private organization that wishes to form an alliance, as long as it has a minimum—I selected 5,000—a minimum number of members, is permitted to organize.

Now, if one does this, there is an additional layer of administration that has to be brought into existence. In particular, in order to avoid groups of low-cost patients from banding together in order to get special deals and——

SENATOR CRAIG. Game the system.

MR. AARON. Game the system. One needs to have risk rating over alliances, and that would have to be done presumably at either the state or at the national level, but it would permit people to join different alliances.

SENATOR CRAIG. My next question, you did not speak to insurance reform as a part of your mechanisms, and you mentioned the gaming of the system or types of groups coming together that have unique health-care needs, or lack thereof.

MR. AARON. That is an important point, and I am glad you raised it. I tried to keep it short and readable. One of the functions of the co-operative or alliance, in my view, should be enforcing the rule that any insurer who offers coverage through one alliance must offer insurance on the same terms through all. That means at the same premium. That means community rating.

Now, whether community rating is defined over just the classes that President Clinton has proposed—really three or four, depending on how you treat couples versus single people with children—is a separate issue. Many people who generally favor community ratings say that there should be some age variation, nonetheless, so that one could have a single community rate for people under the age of X and a different one for people over the age of X. I have not gotten into that. That is a highly technical issue.

One really needs actuaries and model builders who deal with the gradations of community rating.

SENATOR CRAIG. The reason I react to that, I come from one of the lowest cost states in the Nation, and we don't want to have to pay for New York's problems.

MR. AARON. I know that. The lowest?

SENATOR CRAIG. To be very straightforward about it, Idahoans are very fearful that a more uniform system, as proposed by the President, is going to level the field and we will go up, while others may not come down, but we will be forced up to other standards. And if you go to community ratings, you can capture the culture and the environment of a given area, and it ought to be allowed that——

MR. AARON. I agree. In fact, Idaho is the lowest cost state. Massachusetts is the highest, and Idaho spends half per capita——

SENATOR CRAIG. That is right.

MR. AARON. ——of what is spent in Massachusetts. So I can understand your sensitivities fully.

SENATOR CRAIG. Thank you, Mr. Chairman. Thank you, Mr. Aaron.

REPRESENTATIVE HAMILTON. Mr. Cox, please proceed.

QUESTIONS BY REPRESENTATIVE COX, MEMBER

REPRESENTATIVE COX. Thank you, Mr. Chairman. It has been pointed out often in the course of this health-care debate that the United States is nearly unique among nations of the world in not having a system of national health.

The good news implicit in this observation is that Congress has many models to look to in designing our own system and choosing which model to emulate.

Which country's system would you say your compromise plan most closely resembles?

MR. AARON. One can learn a great deal from other countries, mistakes they make, things that work. I think it is important, especially in the area of health care, not to see the reform process as one of adopting one or another country's plans.

Health insurance arrangements emerge from enormously complex historical patterns, differences in the delivery systems, wars, value structures, cultural and ethnic divisions.

No country's system is exactly like any other's and ours is not and never will be, in my view. What I have described would allow the Canadian system—if Vermont's legislature changes its mind and wants to adopt it, or some other state followed that model. It would allow the managed competition structure in California or Minnesota, if those states wanted to rely on that mechanism for cost control.

In the end, requiring employers to pay for a part of health insurance, not all, usually around 80 percent, that is a system that is widely used in many countries.

I don't think the system that I have described neatly lines up with that of any other country. It is an evolutionary variation on the system that exists in the United States.

REPRESENTATIVE COX. If that is the case, is it true that the elements of the proposal then are untested, that they have not proven to work in some other country, or can we point to another country where they do work?

MR. AARON. All health-care reforms are untested in the United States. None has been tried. We have tried the current system, and we know it is falling apart in a variety of ways.

Costs are rising at grossly excessive rates, in my view, and in the view I think of many others. The market for private insurance is imploding, so the issue of trying something untested, in a way, that is almost a recommendation. Ones that have been tested here are not working.

The various elements of this kind of a proposal, I think, have been tested and tried in different places. Employers are required to pay for a portion of health costs in Germany and some other European countries. Subsidies are implicitly or explicitly provided to households in the systems of all countries for families who have low incomes.

Setting rules for the marketing of insurance and the use of community rating—certainly in the latter community rating—certainly exists in most countries that rely on some kind of an insurance system.

We are unique, I think, in allowing the exquisitely attuned underwriting practices that have come into existence in the United States. So I think it is safe to say that no element of what I have described is untested or untried. The package is different.

It is a package that pulls together components of major reform proposals now on the table. The only thing in this proposal that I think is new is the subsidy structure, which is a way of linking an employer mandate to keep those employers now paying for insurance in the game, mostly at levels below what the vast majority of employers are now doing. So the bite of the mandatory part of this is really quite slight, linking that to a system of family-based subsidies, such as Senator Chafee has proposed. That is the really the only new part in this proposal.

REPRESENTATIVE COX. Taking the one country that you have listed, Germany, as an example, it has used a requirement to employers pay a portion of health care, has that worked satisfactorily as far as you are concerned?

MR. AARON. I think that health-care systems all over the world are under enormous stress today. To characterize any system as working well today requires a loose use of terminology.

REPRESENTATIVE COX. Let me be very specific. You cite Germany's example of a country that uses an employer mandate. Has the employer mandate worked in Germany?

MR. AARON. Generally, yes.

REPRESENTATIVE COX. The effects on unemployment, job creation?

MR. AARON. You have probably heard about this from other folks. In general, labor markets in Europe have a degree of rigidity far greater than that in the United States.

I don't think this particular provision significantly contributes to that rigidity, and we have in the United States and in other countries lived with a variety of mandates on employers. Employers don't like them many times, but they have not stopped the U.S. labor market from being remarkably flexible.

That holds true for the vast majority of companies that now do sponsor health insurance. There is no reason in my view to think that if a modest additional number phased incentives that encouraged them to pay for a portion of health insurance, the flexibility of U.S. labor markets would be significantly modified in any way.

Let me just add one thing. In fact, I think the availability of insurance, in general—and this is a point not new with me obviously, and President Clinton stressed it, correctly—we are concerned about job lock today. That is a major element of rigidity in current U.S. labor markets that I think none of us really likes very well. Health-care reform would loosen that and thereby facilitate mobility of the workers among jobs.

REPRESENTATIVE HAMILTON. Mr. Saxton, please proceed.

QUESTIONS BY REPRESENTATIVE SAXTON, MEMBER

REPRESENTATIVE SAXTON. Thank you, Mr. Chairman.

Mr. Aaron, I read with some interest, actually very early this morning, some of the things that you had written, and I came across an editorial that you wrote, which appeared in the *Plain Dealer*.

I think a similar one also appeared in the *New York Times,* where you were analyzing the economics of the Cooper health plan and its effect on the behavior of lower income people. And I think, in a general sense, you came to the conclusion that the Cooper plan would be counterproductive, in terms of encouraging positive economic growth, because of the way the plan was structured, and that people would be discouraged and it would be a disincentive for people to work to get above the poverty level. Is that a fair analysis?

MR. AARON. I was concerned about the work disincentive effects of the subsidy structure of the Cooper bill, yes.

REPRESENTATIVE SAXTON. So this is certainly a recognition—and you have mentioned this morning, as well—that there is a place for incentives. In reading, I didn't see anything that addressed what incentives or disincentives would result from the employer mandates that you and Mr. Cox were just talking about, relative to what type of behavioral effects employer mandates might have on employers, and I think you just said you didn't think they would be significant.

I find that a little bit strange in light of the fact that you recognized in other places that these types of economic changes do have effects on people's behavior.

MR. AARON. As in many issues, we can agree on the sign of an effect. The question is the magnitude. In this case, Congressman Cooper's bill, if enacted in its proposed form, would confront workers over a substantial range of the earnings' distribution with tax rates in the vicinity of 75, 80 percent.

That would mean that if you earned an additional dollar, you got to keep 20 or 25 cents of it. That is a big test. We could all agree about that and for that reason I was concerned about the effect on work incentives.

That tax rate came from the intersection of personal income tax rates—well, actually not personal—phase out of the earned income tax credit, the substantial rate at which subsidies for health insurance were phased out over this income range and various other taxes. You can't

get away from the phase-out of the earned income tax credit, and Congress isn't going to be legislating about payroll taxes for Social Security when it is dealing with health insurance. What it can do is limit the rate at which subsidies are phased out as income rises.

The approach that I described would have a much lower rate of phase out for the subsidies for health care than the Cooper bill called for, although any tax, let's be honest about it, has some effect on work incentives. Can't get away from it, the magnitude of the tax implicit in the proposal I described is much lower than that in Senator Cooper's—I was anticipating the election—Congressman Cooper's——

REPRESENTATIVE COX. President Cooper.

MR. AARON. He hasn't announced for that in his proposal, and so I could not go into it. I did not analyze lots of aspects of it. Let's stipulate that if one phases out subsidies—that is an implicit tax—that it is going to have some work incentive effects. They are just smaller.

REPRESENTATIVE SAXTON. So you and I agree that there are behavioral changes that might occur, that would occur vis-à-vis an employer mandate. We just would have to talk about what the effect of those changes in work incentive might be.

MR. AARON. I think one has to talk about the behavioral effects of the entire package, the payment structure, the availability of health care.

Let me mention one other effect that I think many economists would argue was more important than the one we are focusing on right now.

Under current law, to get health insurance, you have to go to work pretty much, unless you are poor enough to be eligible for Medicaid, or old enough to be eligible for Medicare, or rich enough to pay for it on your own, and that is really quite a challenge these days. You get health insurance by going to work.

If health insurance is available uniformly for everybody as a matter of more or less entitlement, then you don't have to go to work in order to get health insurance. So there is going to be work incentive effects from that. There are going to be work incentive effects that arise from the termination of job lock, which will be a plus.

There are going to be changes in relative competitive balance among companies and their ability to compete for different kinds of workers if you get health insurance everywhere. So there are a whole lot of effects, and I would urge careful attention to the work incentive effects pervasively through the proposal.

REPRESENTATIVE SAXTON. Thank you. Let me change to another issue that concerns me a great deal. In any plan we have identified—and I say we collectively—there are a finite number of sources of funding for any plan.

In the Clinton plan, for example, we identified, and I suspect this is true of most any plan, new mandated premiums in the area that we are already extending. There are other private health insurance expendi-

tures that are currently being made, which is another source in the total universe of monies available to pay for a plan.

There are currently some federal health expenditures, you just mentioned them basically—Medicare and Medicaid—and there are some monies currently being spent by state and local health expenditures, and finally out-of-pocket expenses that people pay themselves, basically five sources.

One of the major sources that the President calls on to help with the funding of his plan is the Medicare fund where he would reduce Medicare expenditures in the current universe by a very significant amount. I have forgotten the exact number, $118 billion over the five or six-year period of time.

There are some hospitals in the United States that, under the current plan, rely very, very heavily on Medicare, to the extent that 65 to 70 percent of their patient load are Medicare reimbursable expenditures. The people who are responsible for maintaining services through those hospitals are suggesting very strongly to some of us that there is no way they can meet their obligation to the older Americans they serve with those kinds of cuts in the Medicare plan.

REPRESENTATIVE HAMILTON. And keep the quality up.

REPRESENTATIVE SAXTON. And keep the quality up, exactly. In fact, they say unless something different is done, we have to close. I didn't want to be that extreme in my question, but that is the thrust of it. What is your reaction? I am sure you have looked at this.

MR. AARON. I have. You mentioned the article in the *Cleveland Plain Dealer*. Last September, I also had a piece in the *New York Times* on the Clinton proposal, in the course of which I raised my concerns, and they resonated, I think, with some other people, regarding the magnitude of the cost containment built into the calculations of the financing of the President's plan. Part of that are the economies projected for Medicare.

Economies of that magnitude become imaginable, desirable if one believes that in a relatively brief period of time, a few years, one can squeeze out a great many inefficiencies from the U.S. health-care system. That such inefficiencies exist, that we provide a considerable amount of wasteful care, that much of care has very low benefits, I think is beyond dispute. But I raise questions as to whether it is possible to do this as fast as President Clinton's calculations suggest. I remain concerned about that, and I think Congress should be concerned.

There is capacity for achieving economies and of course it is always in the interest of those who would be subjected to the rigors of controls to emphasize the pernicious effects that would arise from such controls.

Nonetheless, the financial course of health-care reform, which I hope passes, will be safer from a variety of standpoints, safer from the standpoint of the availability of services, safer from the standpoint of the fiscal risks confronted by government, Federal Government and

State governments, if we do not rely so heavily on severe presumed cutbacks in spending for currently available services as is embodied in some of the proposals.

REPRESENTATIVE HAMILTON. Let's pursue that a minute. Is the $118 million phony?

MR. AARON. I don't think it is phony at all. I think it is real. It is certainly possible for Congress to curtail legislatively, and actually to reduce Medicare spending by the magnitudes contained in the President's numbers and in the CBO affirmation of them.

The question isn't whether it can be done. The question is what happens if it is done. If costs, in general——

REPRESENTATIVE HAMILTON. The question is whether we do it.

MR. AARON. That is a different issue. That is something you can speak to. I can't. I mean, whether you do it, I believe, will depend on what you think the consequences of doing it would be.

If you were convinced that you would get rid of a lot of waste, fraud and abuse and not harm the delivery of services, you would embrace it enthusiastically. The concern is that either of two things will happen. Quality will deteriorate, or very large cost shifts could occur to the private sector. Those are the two concerns.

REPRESENTATIVE SAXTON. Let me tell you something that concerns me, and I am just trying to find the answers like we all are to these questions. You wrote in the *New York Times* on September the 22, 1993, the following words, I believe—correct me if these are not correct.

> So it is clear that most savings would have to come from changes in medical practice. Physicians would have to administer fewer tests, hospitalize less often, do less surgery and prescribe fewer medications.

That sounds an awful lot like rationing to me.

MR. AARON. It is rationing to the extent that the services curtailed provide significant benefits. If they are not useful services, as some observers believe, then it isn't rationing.

My own view is that it is going to be a slow process of education and research for us to identify where savings can be achieved.

It takes a very peculiar view, I think, of American exceptionalism to believe that we must spend 4 to 6 percent more of our gross domestic product than do other developed, civilized, humane countries with health indicators as good as our own.

Many factors contributed to those health indicators. It is not just the health-care system. So it might be that we need to spend a lot to offset risks that people in our society face.

I don't think you can account for the differences in outlays between the United States and France on that basis, but that's the question, in my mind, and I think it is one that is not a partisan issue. This is one, I think, members of both parties can grapple with and try and reach an unpartisan judgment. Can the culture of health-care delivery in the

United States be modified? That it can be, I think, is quite likely, but it is going to take time, sir.

REPRESENTATIVE HAMILTON. Jim, may I interrupt one moment?

REPRESENTATIVE SAXTON. Sure.

REPRESENTATIVE HAMILTON. I want to go back to this $118 billion that the President has. That is over what?

MR. AARON. Five years.

REPRESENTATIVE HAMILTON. Five years in his program, $118 billion. What if we took $60 billion out of Medicare. We had Medicare cuts a few years ago. Now, you have $118 billion, as Jim says here. With all of the people in the hospitals, this just can't be done. We can't get the savings.

You have looked at it carefully. Do you think that under the Clinton plan, you can get $118 billion of savings over a several year period?

MR. AARON. You can certainly get $118 billion in reduction in federal spending. Whether hospitals will reduce spending on the Medicare population by that dollar amount, I think is more problematic.

REPRESENTATIVE HAMILTON. And you can do it without loss of quality?

MR. AARON. You may sustain quality and shift costs to the private sector. That is the way we have been doing it.

Just a week ago, for a completely different purpose, I did something that is really rather perverse. I went back and looked at old trustees' reports of the Medicare system. I have a collection of them dating back to 1982.

I looked at the projected outlays under Medicare for the year 2005. The projected outlays in the year 2005 in the 1982 trustee's report were approximately—I will give you rough numbers—6.5 percent of payroll. That is the standard test.

In 1987, the projected outlays were about 3.7 percent of payroll for the year 2005. The projected outlays in 1994 are about 4.8 percent of payroll for the year 2005. My point is that projections of what we are going to be able to do seven years in the future differ sensitively according to policy.

Congress has drastically curtailed federal outlays on Medicare. It pushed back, without raising Medicare payroll taxes at all, the date at which the fund was supposed to run out of money that was the 1982 projection to 2001. That is today's projection.

Now, while that has happened, CBO and others have been doing studies in which they calculate that the proportion of total cost for patients in hospitals covered by reimbursements has diverged between private and public payers. Private payers are about 130 percent of cost. Medicaid is about 80 percent. Medicare is about 90 percent. So you have saved the money on budget.

Outlays have also been reduced. Lengths of stay in hospitals have gone down by about 30 percent, total number of hospital days, pardon

me. Combination of hospitalization rates and lengths of stay since the early 1980s. Those are not confined to Medicare. They are general medical events. But there has been cost shifting to the private sector.

Now, one practical question is whether it is desirable to say that for more federal savings by cost shifting——

REPRESENTATIVE HAMILTON. Excuse me, Jim.

REPRESENTATIVE SAXTON. I guess, I would ask this question. I understand the cost shift that we have done in the past. That has taken place because there have been third-party payers to shift to. If we adopt some kind of a plan that is somehow regulated in terms of how much money there is to be spent, either in terms of an universal budget or in terms of reimbursements for services, who do we cost shift to, then, if we reduce Medicare costs?

MR. AARON. That is a fair question. The cost shifting won't occur if there is a general retardation in the projected growth of spending. Can there be a general slowdown in the growth of spending? That depends upon how fast one can modify the culture of the medical delivery system in the United States.

I don't know the answer to that. That is one reason why I prefer a more modest presumption regarding the degree of cost control to be built into the financing of the system.

If you want to spend more on additional services—I hate to use the word—but you find the tax increases or the expenditure cuts elsewhere to pay for it. I would personally, as an economist, favor something close to pay-as-you-go on financing health-care reform, and using cost savings to fund deficit reduction down the road.

Could I say one other point that I wanted to mention when you were describing the hospital situation? Keep in mind that we do have way more hospital beds than we need. It is easily possible to exaggerate the savings from closing an unoccupied hospital bed because most of the costs associated with when a person is in the hospital and using services.

Nonetheless, they cost something and if financial reform led to the closure of some hospitals, it would not be a bad thing.

Now, having said that, I am not referring to the single hospital within a 100 mile radius in a modest-sized town. I am referring to the low occupancy rates that exist in many large American cities where we simply are badly over bedded.

REPRESENTATIVE SAXTON. If I can just conclude——

REPRESENTATIVE HAMILTON. Jim, you go ahead with your questions. I will run off here and vote and get back as quickly as I can. We will keep the hearing going as much as we can.

REPRESENTATIVE SAXTON. Thank you. I just wanted to conclude my question in the hearing. Then, I will pass the ball to Chris if he has some questions, but I will just conclude by making this observation.

Based on what you have said here, there are basically two ways to deal with the Medicare reduction. One would be to find efficiencies

and the other would be to continue the practice of cost shift, and with regard to the efficiencies, you have indicated in the *New York Times* that the best way to define efficiencies to the magnitude we have, talking about these numbers at least, most savings would have to come from changes in medical practice, and the next sentence is reduce the amount of services that we provide.

MR. AARON. Also rates of reimbursement to providers. Physicians in the United States are exceedingly well paid compared to average earnings, better paid than are physicians in any other country for which I have seen data.

I think we could continue to attract top quality talent even if the rate of remuneration weren't quite so high.

REPRESENTATIVE SAXTON. Now, three things, reduce costs, I guess, in salary accounts, and finally by the cost shift, keeping in mind that if we are going to have a system that works, we would have to have a system that you could cost shift within.

Some of these programs that we are talking about here would have that opportunity, while others might not. Is that fair?

MR. AARON. I think it is basically fair. Let me be clear, I am not advocating cost shifting as a means of financing health care. It strikes me that one of the goals, one of the stated purposes of major health-care reform plans, certainly the President's plan, is to prevent further cost shifting.

Whether that is the consequence of the specific proposals, you folks are going to have to decide, but nobody wants anything to increase public obligations on the backs of private payers through surreptitious means.

REPRESENTATIVE SAXTON. Are you familiar with the report that the Republican staff did here on this Committee, with regard to the Clinton proposal?

MR. AARON. I am not.

REPRESENTATIVE SAXTON. Let me ask a general question. It concluded that there was a significant gap between what the program would actually cost and the total funds that would be available to pay for it.

CBO did a similar study with different results. They too said there would be a gap between the amount of money available to pay for it and the services outlined.

Do you have an estimate as to whether or not you think that is right and if so, what that finance gap is?

MR. AARON. I will be completely honest with you, my answer is, no, I don't, because this is not a solo operator's game. In order to make cost estimates of these health plans, one needs a large staff, the ability to manipulate many diverse data sources and a considerable variety of expertise.

I will say that I think Congress, in its wisdom, created the Congressional Budget Office, perhaps because it appreciated that the President— whichever party is in the White House—always has an interest

in bending assumptions favorable to itself and groups speaking for one party or another in Congress have similar incentives.

The goal was to try and create a detached nonpartisan group to mediate these disagreements.

I have read the CBO report. They have done their best to be careful. They certainly didn't buy everything the Administration said. They indicated that the proposal would marginally add to the deficit, not reduce it as the President had claimed, but it would reduce national health-care spending significantly by the end of the period for which they did their projection.

I know the people involved and I think it was a careful, very professional, and down the middle effort.

REPRESENTATIVE SAXTON. Thank you. Currently, we are watching this process, I guess called a political process, and I don't mean R&D political process. The process through our political system of trying to arrive at a conclusion as to what we are going to do, and it seems to me that we started this debate some time ago, and since that time, we have developed a whole series of options, starting with options with a great deal of governmental influence and a whole spectrum of ideas that end up perhaps on the other end of the spectrum, with proposals that would have a minimum of government or maybe no government influence much at all. I guess that is probably an overstatement.

A minimum of government influence. And we started talking about, I think it is fair to say, a single-payer system, which most people refer to as the Canadian system or one like it, and then we move from that to maybe something like what President Clinton proposed, where there was a good deal of government influence in terms of regulation and budgeting and global budgeting, and regional groups that would do a great deal of control. Then, we move one step further to Cooper, which we have had a lot of discussions about, where there is some government influence in terms of setting it up, but much less than Clinton. So it seems to me that the debate has moved from a lot of government control to maybe not so much government influence and control. Now, the debate is almost on the other side of the spectrum, or moving in that direction, at least, and I think that I heard you say that one of your six areas to talk about in one of your proposals was to slow growth in costs by modifying incentives.

It seems to me that that is one of the areas that we are headed toward, and I am interested to know how we can do that .

MR. AARON. Let me quibble a bit with the history of the debate. I don't think this has been an unidirectional process moving from prescriptive government involvement to the use of incentives, but the efforts going on at various times by people with different points of view on these issues.

Congressman Cooper's bill, in fact, predated President Clinton's and then the Clinton proposal emerged. The single-payer approach has been around for 40 years, and I think if nothing is done, it will be

around for another 40 years, because there is a core group of supporters of that who believe strongly in it.

How does one use incentives to control the growth of spending? Well, the standard approaches that have been advocated by supporters of managed competition, which is what I tried to incorporate, in effect, by reference in what I put as my put-up or shut-up approach, consist of certain rules regarding marketing of insurance.

All insurers have to market a standard plan so that people can compare prices readily. If you tell me two plans differ, one has differing mental health benefits and differing cost sharing, there is no way I can compare prices between those two bills, so I don't know which is really more extensive per unit of service.

They want to cut through that. You get a standard plan, you know the price, end of story.

They also propose a provision under which the cost difference between different plans has to be met with before-tax income, so the excludability or deductibility of health insurance premiums doesn't in effect transfer part of the cost to the public budget and off the shoulders of private payers.

The expectation on the part of advocates of managed competition is that if these changes, and perhaps some others as well are made, individuals through their purchase of insurance will bring to bear on health-care providers a degree of financial pressure that will drastically slow the growth of spending.

This view has widespread support. It has never been tried. It also confronts widespread skepticism. I am a skeptic. I don't personally believe that. I could go into a lengthy explanation of why, which I will spare you. I think the chances that it will succeed are not great, but I don't know. We have not run the trial. None of us has God-like wisdom on this subject, and as I said, if they are right, if through insurance market reform and changed tax rules one could slow the growth of spending sufficiently, we should all celebrate the need and the ability to avoid——

REPRESENTATIVE SAXTON. I hate to do this because the Chairman wanted us to continue on through, but these votes are a fact of life, and so I guess maybe we can take a five-minute recess until the Chairman comes back, or until I get back.

Thank you.

[Recess.]

REPRESENTATIVE COX. [Presiding.] In the sixth element of the outline of your proposal, you describe the taxes that will be necessary to cover subsidy costs and recommend that they be enacted at the front end.

What kinds of taxes are we talking about?

MR. AARON. I did not want to express a specific preference about which taxes would be increased, and I think I would prefer to pass on that now.

REPRESENTATIVE COX. So would everyone in Congress.

MR. AARON. The principle that was embodied here, and this is one that I wouldn't pass and I regret that members have and I think the President has, there is a deep financial dilemma in any health-care reform plan.

The savings from costs containment comes slow. They build and become large. The costs of universal coverage hit quick and don't grow, but that means that health-care reform is a deficit increaser in the short run, even if it is a deficit reducer in the long run.

Now, that creates, as you know, a very difficult problem. You can't, I think, credibly come forward with a plan that raises the deficit significantly in the short run. One can pay for coverage by projecting much faster achievement of cost savings. The President did that.

One can cut other spending programs. The President, Congressman Cooper, Senator Chafee all do that, or one can raise taxes. The force of the Chairman's question or comments, and indeed of Mr. Saxton's, were that there may be leaner pickings in Medicare than is projected in the President's plan. I am prepared to believe that.

I also believe that the savings from cost containment may well come slower than projected in the President's plan. I am a deficit hawk and I am also a health-care reform hawk, and that means in order to make the books balance, you have to be prepared to vote higher taxes.

It could be, and indeed in a Brookings book, Charles Schultz and I advocated using a value-added tax to pay for health insurance. It could be a payroll tax. It could be an income tax surcharge, but the key principle—which I believe is important to admit to the debate at least—is that health-care reform should not add to the deficit in the short run and, if necessary, taxes should be enacted to pay for it. It is too important not to do. It may even be worth raising taxes to do.

REPRESENTATIVE COX. Accepting that premise, the Congress will have to move beyond the general to specific in rather short order. As you know, Ways and Means is presently considering this very legislation. They will finish it and indeed so too will Education and Labor, and so too will Energy and Commerce, so even before the August recess, the House of Representatives will vote on a package that either combines or rewrites all of the foregoing bills.

In addition to all of the things that you mentioned you are, you are also an economist, and presumably can provide us some insight into which of the VAT, a payroll tax or an income tax surcharge, will fall on the respective elements of the economy in least disruptive fashion.

MR. AARON. The purpose of some taxes is meant to disrupt. The purpose of a cigarette tax is meant to disrupt consumption.

REPRESENTATIVE COX. I will state the question anew. I accept the criticism of the question. Which of the VAT, payroll tax or income tax surcharge, which of the three that you mentioned as possibilities will be least harmful to the economy in the purposes we are seeking to achieve?

MR. AARON. Done badly, any of them can be harmful. Done well, none of them is going to be seriously disturbing. If Congress in its wisdom were to decide that another trend of deficit reduction was in the cards, as well as health-care reform, I would suggest serious consideration of the value-added tax.

But I wouldn't suggest it unless Congress was prepared to acknowledge that it was going to raise a lot of money, because introducing a new tax is disruptive, it is divisive and it raises transition problems.

Eventually it is a perfectly administratable tax as every other country has demonstrated, but it is not something you do lightly and it is not something you do for $30 or $40 billion. It is something you do if your targets are very much higher than that.

If your targets are lower, then use some combination of extended excise taxes. There has been discussion of cigarette taxes. Alcohol and tobacco and firearms taxes are additional candidates, particularly with respect to health-care reform, and I don't know whose toes I may be treading on at any given time, but I still think some recourse to one variety or another of energy taxation is a serious consideration.

REPRESENTATIVE COX. We are probably not talking about a gas tax since we just did that again. What do you have in mind?

MR. AARON. I was not dismissing it. The last gas tax was certainly at the low end of the spectrum of rate increases. It still leaves the United States' tax rates on gasoline relatively modest by international standards.

We don't have to have the taxes as high as other countries. We are a larger country. We depend more on the automobile, but I think one certainly could go back to that well.

REPRESENTATIVE COX. If we selected an income tax surcharge, what would be the best way to design it?

MR. AARON. The simplest approach is as a surcharge directly as a certain percentage of liability. That is simplest, but in my view, not best. The income tax base remains flawed in a variety of ways.

Additional revenues could be raised through any number of particular reforms, some of which incidentally would be quite progressive in their distribution, some of which would be rather more regressive in their distribution.

As examples, perhaps of the most progressive, the transfer of capital gains at death, the restatement of basis strikes me as a provision that is difficult to defend, and eliminating it would be highly progressive in its revenue impact.

REPRESENTATIVE COX. I am sorry. Just to understand, the proposal is to eliminate the step-up of basis to death?

MR. AARON. No, I would constructively realize a death subject to averaging rules and cutouts for certain small family-owned businesses.

MR. AARON. The limitations on the use of itemized deductions, for example, by setting floors or ceilings on applicable specific deductions

could be extended. That would have more of an effect on middle class taxpayers. Some additional——

REPRESENTATIVE COX. I just want to understand that. We would have a specific dollar amount as a cap on the total amount of itemized deductions that one could claim?

MR. AARON. As an example, the deduction for state and local taxes, one possibility would be to set a floor, to say that deductibility for state and local taxes is allowed to the extent that state and local taxes exceed a certain dollar amount.

That would have two effects. It would raise revenue. It would also simplify tax filing for some filers who would be moved into the ranks of standard deducters by such a provision. The taxation of Social Security continues to be much more liberal than the tax treatment of private pensions.

Congressman Rostenkowski has made some proposals along these lines. I would go even further. The case for the threshold, it seems to me, to be difficult to sustain from the standpoint of tax policy, although I certainly do understand the political basis for the $25,000 and $32,000 thresholds.

I use these just as illustrations. My point is that one could go to one's usual handbook—the CBO shin-kicker list that they put out annually—as ways to reduce the deficit and find any number of structural modifications in the income tax law that would be good and any one could contribute to this.

As a practical matter, I suspect that if it came to financing something like health-care reform, one wouldn't want to complicate the politics of the debate by having to address each of these specific issues, and one would have recourse to some broader-brush device, such as a surtax if one was going to go to the tax route at all.

REPRESENTATIVE COX. Is your recommendation that we do this at the front end?

MR. AARON. I believe it is important to make sure that we don't get an unpleasant budgetary surprise from health-care reform, and the way to do that is to pay for it upfront, and when the good news comes in the form of cost containment, that is deficit reduction.

REPRESENTATIVE COX. You also mention, in addition to an income tax surcharge and a value-added tax, a payroll tax. If that is an option to cover additional future subsidy costs, I take it that that payroll tax would then go beyond the 50/50 cost sharing that we have already imposed on the employer, or perhaps it would not. Perhaps it would be also a further tax on individuals. How would that work?

MR. AARON. It could be a direct payroll tax, or one could set the financing up so that with respect to some employees, the maximum contribution was based on a calculation of a premium that exceeded the actual premium, so in effect there is an extra contribution made on behalf of those workers.

But I think it is simplest to think of it, if one is going to go the tax route, and use a payroll tax simply as an explicit tax so that people see it and understand it.

REPRESENTATIVE COX. My colleague has shown up, and I yield to you for further questions.

REPRESENTATIVE SAXTON. I have an observation and a question. You are an economist, but you are also very knowledgeable obviously about these health-care proposals and health reform, generally.

I saw an article in the *Post* yesterday said that Chairman Rostenkowski had made a proposal to increase the Social Security wage tax. Is that the kind of a thing that we are talking about? If we are talking about a wage tax, I assume that we are talking about something in addition to what we currently have, and possibly in addition to what Chairman Rostenkowski has suggested might be a good idea.

MR. AARON. Congressman Rostenkowski's increase in payroll tax for Social Security would occur about 20 to 25 years in the future for the first bite, and approximately 50 years in the future for the second bite. It is part of a larger set of proposals, including benefit reductions, designed to deal with the long-run deficit in the Social Security system.

The short run looks just dandy for Social Security, but the long run doesn't, and what Congressman Rostenkowski proposed, I think, is a relatively balanced collection of benefit reductions and tax increases, the effect of which would be to put the 75-year projections back in the balance.

I think that is important to do. The United States is unique in making 75-year projections and paying a lot of attention to them, which is really a breathtaking exercise of faith. Where else do we believe projections even a year or two in advance, much less 75 years, but I think it is sound. It has caused Congress over the life of Social Security to run the program in a very conservative fashion, from a financial standpoint.

One may disagree about the benefit structure, a lot of other things, but up until very recently, Congress has followed the rule that it kept the system within close, long-run actuarial balance plus or minus 5 percent relative to revenues. Costs never were more than 5 percent of revenues.

Currently, it is more in the vicinity of 15 percent or thereabouts, the long-run deficit, and I think it is desirable and admirable that Congress take those long-run projections seriously and enact changes now that will act to restore public confidence—well justified, in my view, that the system is being carefully managed.

That is a different issue. The taxes are in the future. We are talking now about financing of a reform that, if you folks agree to do it, will happen this year, so I don't think they are going to stumble all over each other, at least in the short run.

REPRESENTATIVE COX. Will you yield for just a moment, on this wholly different topic that is not the subject of our hearing?

MR. AARON. I love Social Security. I wrote my Ph.D. dissertation on it, so——

REPRESENTATIVE COX. I serve as a member of the President's Entitlement Commission. We are going to report in December.

Does Brookings have numbers that you have generated on your own on these subjects, projections and forecasts? Because if you do, I would love to get my mitts on them and read them.

MR. AARON. We did work on the deficit problem as part of the studies we have done on setting national priorities, and then later we got more modest and called it setting domestic priorities. I and two colleagues did a study some years ago on the long-run financial condition of the Social Security system and what it would take to put it back into balance, what economic effects of either allowing the deficit to continue or closing it would be on future productivity.

I would be glad to make those available to you. I should acknowledge that the study that Gary Burtless, Gary Bosworth, and I did on Social Security was done at a time when the long-run projected deficit was smaller than it is today, and so you will have to multiply various numbers mentally to come out with the right story, but I think qualitatively the structure we have got holds, and the model we used, if your staff wanted to adapt it, could, I think, relatively readily be updated and used for analytical purposes.

REPRESENTATIVE COX. Thank you very much. I will give you a fancy business card.

MR. AARON. Okay.

REPRESENTATIVE HAMILTON. Let me just ask some broader questions on health care generally. What is driving up health-care costs?

MR. AARON. The major factor, in my view, is the breathtaking pace of scientific advance in medicine. I did some calculations and Joe Newhouse, who is an economist at the Harvard Medical School, subsequently did some calculations attempting to decompose growth of health-care spending into various factors over a relatively long period of time.

We know health insurance has expanded and that reduces the price of medical care at the time people demand services. That increases use. We know there have been some increase in compensation of medical workers relative to other workers in the economy and identify that.

We know the population has gotten older; we can calculate that. When you are all done, you don't explain much of the story.

What we do know is that the list of services provided within hospitals is almost completely different today from what it was a generation ago. Somebody—I don't know on what empirical basis—quipped that the half life of medical knowledge was five years.

A co-author of mine, a physician, now at the University of Southern California, has spent about a year carefully examining and interviewing medical scientists in 10 or 12 different medical subspecialties. He has

identified a series of innovations about to debauch from the medical laboratories into clinical practice.

The cost projected for just these technologies comes, according to his calculations, to on the order of $50 billion a year once they are fully implemented. The story is the medical technology.

REPRESENTATIVE HAMILTON. So you think because the march of technology goes on, these costs are going to continue to rise? If you tried to slow down——

MR. AARON. No, we haven't. What we have had is a slowdown of the growth of premiums reported by a certain subgroup of companies. There has been a very modest slowdown in the Consumer Price Index for health care, an index that is a very good candidate for being the most meaningless statistic issued by the Federal Government.

I can get into that in more detail if you want, but the real gross domestic product spent on health care grew in 1993 at almost the same rate as it did in 1992, and that was faster than it had grown in earlier years.

REPRESENTATIVE HAMILTON. So the argument that is sometimes made that market forces are beginning to correct the problem of rising health-care costs is not accurate?

MR. AARON. Not yet. Whether it will be tomorrow, there are people who have very strong beliefs that it will be and they can cite a lot of anecdotes and specific cases that seem to support their case. But the aggregate numbers are unsettling.

REPRESENTATIVE HAMILTON. The impact of this rise in health-care costs is what, with respect to wages?

MR. AARON. Standard economic theory, which is a phrase that is sufficient to cause many defense walls go up instantly, but I believe that standard economic theory holds that after an adjustment period, perhaps, workers pay for their health insurance, even if the ostensible payer is the employer.

That means very rapid growth in health-care spending is depressing the growth of money wages and as you know from others who have testified, I am sure, actual wages are now lower than they were a couple of decades ago, in real terms.

REPRESENTATIVE HAMILTON. We hear all the time about the health-care costs being, what is it, 14 percent of GDP?

MR. AARON. Yes.

REPRESENTATIVE HAMILTON. It used to be 6 percent or so back in 1965. Is that something we ought to worry about?

MR. AARON. I think so, yes, I do.

REPRESENTATIVE HAMILTON. Why?

MR. AARON. Not, I would suggest, because it makes the United States a poor competitor in international markets, but because——

REPRESENTATIVE HAMILTON. It doesn't have that effect?

MR. AARON. I do not believe so. If workers pay for added health-care costs in the form of lower wages, then it isn't reflected in product prices.

What it is reflected in is a reduced capacity to consume other goods and services. In other words, it in effect hit on our standard of living.

Let me just add, if we thought health-care spending, every dollar of it, was being well spent, we would celebrate it. The reason we are worried about it—all of us from personal experience—is that we believe a lot of money is not being well spent.

REPRESENTATIVE HAMILTON. Let me ask a few questions about this employer mandate. How do you get to universal coverage? What are the options in front of us?

You have the single-payer system, obviously, that would get us there. You have the employer mandate. Would that get us to universal coverage?

MR. AARON. The President's plan is an employer mandate plus an individual mandate. It is an employer mandate for workers and their families and individual mandate for everybody else.

REPRESENTATIVE HAMILTON. Why is an employer mandate better than an individual mandate?

MR. AARON. It is not. It just happens to be where we are—not employer mandate, but employer coverage happens to be where we are. And there is a lot of concern, and I think legitimate concern, that if one has only an individual mandate without an employer mandate, well, lots of people can't afford it, so you have to give subsidies to many low-income households.

Many of those low-income households now receive coverage through work, but employers would then have an actual positive incentive to get out of paying for insurance, because if they get out of it, then the government will pick up part of the costs of the health insurance.

So you would have the effect of shifting onto public budgets a large part, or some part, of currently privately financed health insurance that, as an economist, I can tell you that if it happens relatively gradually, people have time to adjust, not to worry, you shouldn't be concerned. I don't know of anybody who has to face voters and worry about the size of the public sector who agrees with that position.

REPRESENTATIVE HAMILTON. Now, if you have an employer mandate, are you going to have a lot of job losses? Are you going to have a lot of wage reductions?

MR. AARON. You could. Just to give you, I think, a crude number, which tells you what is at stake, family benefits cost $5,000 a year, more or less. Full-time, year-round employment, 50 weeks a year, 40 hours a week is 2,000 hours. That is $2.50 an hour.

If you mandate employers to pay $2.50 an hour for a family who previously hasn't been paid for, that is enough to cause disemployment effects. So nobody requires it, even those who go for an employer mandate.

President Clinton insulates low-wage, small-wage firms. There is a 7.9 percent of payroll cap on liability, and that removes a significant part of the disemployment effects at the price, I might add, of creating incentives to reorganize companies who get all your low-wage workers into small low wage companies where they qualify for subsidies.

REPRESENTATIVE HAMILTON. Now, Senator Chafee's plan, Congressman Cooper's plan, Senator Gramm's plan, they don't have the employer mandate.

MR. AARON. That is correct.

REPRESENTATIVE HAMILTON. Do they get universal coverage?

MR. AARON. Senator Chafee's plan gets it on a contingent basis. That is, he is committed to the principle. The achievement of it hinges on the payment of subsidies to low-income households and the payment of those subsidies is contingent upon achieving adequate savings elsewhere in the budget, particularly in Medicare and Medicaid.

Congressman Cooper has no mandate and, in my view, would not reach universal coverage, nor would Senator Gramm's proposal.

REPRESENTATIVE HAMILTON. Where would you get money for healthcare reform? The President gets it out of savings on Medicare largely and the tobacco tax. Is that the best place to get it?

MR. AARON. I think the tobacco tax is a good way to go and savings can be achieved without significantly affecting the quality of care.

I suspect you can't get enough to cover the costs of universal coverage, and that means that other taxes need to be considered.

REPRESENTATIVE HAMILTON. You think that under the Clinton plan, other taxes are going to have to be considered if you enacted the Clinton plan today? Would you have to have other taxes other than what he has recommended; that is, other financing than he has recommended?

MR. AARON. No, if you enacted the Clinton plan. The question is, what would be the consequences of the Clinton plan when it was implemented.

Judgment is that some of the consequences would lead to reconsideration of the implementation schedule and of certain provisions in it, but if you enacted the Clinton plan, I believe the Congressional Budget Office calculations are about as close to being an accurate prediction as we are likely to get in this bail of tiers and inadequate information. They indicate that we could live without financing beyond what the President has proposed, if you enacted, carry it through and implement it as proposed.

REPRESENTATIVE HAMILTON. I want to get into that a little more. In your plan, you cut back on the benefits from the President.

MR. AARON. I do, yes.

REPRESENTATIVE HAMILTON. How much?

MR. AARON. I think one can achieve, in terms of the premium cost, reduction on the order of 15 percent, perhaps 2o percent, but probably not.

REPRESENTATIVE HAMILTON. What kind of benefits are you cutting now?

MR. AARON. I am raising cost sharing, deductibles, and copayments.

REPRESENTATIVE HAMILTON. From what to what?

MR. AARON. I think I mentioned earlier, in order to really do refined specification of provisions, one needs a small army, maybe not 500, but one needs a small army of cost estimators. I do not have those resources. The cost of about a 20th percentile corporate plan is on the order of 15 percent less than that of the President's plan, and one could achieve that in a variety of different ways.

REPRESENTATIVE HAMILTON. You do not think you can get universal coverage without a mandate of some kind?

MR. AARON. Yes.

REPRESENTATIVE HAMILTON. Is that correct? You have to have either an employer mandate or an individual mandate.

MR. AARON. Yes.

REPRESENTATIVE HAMILTON. Or the single-payer plan, in order to get to universal coverage?

MR. AARON. Yes.

REPRESENTATIVE HAMILTON. It can't be done otherwise.

MR. AARON. I do not believe so.

REPRESENTATIVE HAMILTON. You cannot do it with incentives and subsidies?

MR. AARON. This is not an opinion question. The Robert Wood Johnson Foundation has run a variety of demonstrations and experiments in which they offered exceedingly deep subsidies to encourage employers to offer insurance. When I say deep, I mean 50 percent in the aggregate. They got a very slight take-up in large segments of the currently uninsured commercial world.

REPRESENTATIVE HAMILTON. You are saying to me that it is broadly accepted among the experts here that you cannot get universal coverage without employer mandate, individual mandate or single payer? Is that what you are talking about?

MR. AARON. Yes.

REPRESENTATIVE HAMILTON. You can't get there another way?

MR. AARON. Yes.

REPRESENTATIVE HAMILTON. Okay.

Chris.

REPRESENTATIVE COX. Just one quick clarification. I think I heard you say that you believe that the CBO estimate on the Clinton plan is as good as any out there, and that you are willing to rely upon it.

MR. AARON. No, I didn't say that. I said that I think they have done as good a job as it is possible to do with available information and called it down the middle.

If you asked me how much reliance I would place on any particular estimate right now, I would say slight, I guess, in a word.

The reason I say that is that the health-care reform of the magnitude the President or Senator Chafee has proposed entail enormously far-reaching changes in our institutional arrangements. We are going into an environment that we haven't lived in before. As the statisticians say, we are predicting out of sample. We are reaching into an area where we hope our models are right, but we haven't seen the world work this way.

We don't know how people are going to behave in this new environment. That is one reason I think that it is important to make sure that the financial risks are protected against at the outset.

REPRESENTATIVE COX. That is to say that we should front-end the tax increases?

MR. AARON. We should pay for whatever we do and not do it on the come, so to speak.

REPRESENTATIVE COX. All right, let me shift a moment to premium caps, which you recommended on the deferred basis, implementing them five years henceforth, implementing them, if I understand your outline correctly, in advance of five years if targets are not met. Is that what you intend?

MR. AARON. Again, it is an approach I am describing. I don't have any hard numbers to include in this. Specified period of time over which the incentives of managed competition will be given free rein.

At the start, set certain cost control targets, which, if achieved, one will conclude that managed competition was successful and if they are not met, that it was not.

At the front end, enact the regulatory framework that will be called into play if managed competition does not succeed, but under no circumstances implement it for a period of time—three years, five years.

I don't have a firm judgment as to what that would be. But I think it is important and it is a fair challenge to the advocates of managed competition to say, look, you have a new idea.

It has many attractive theoretical features, lots of people are skeptical that it will work, but we are going to give it a run. If it works, we all celebrate because nobody wants the regulations to go into effect if we don't need them. If it doesn't work, this is too expensive a mistake to allow it to go on.

REPRESENTATIVE COX. You have just used managed care as a shorthand, as you say, for the kind of environment in which health care will be conducted post-reform, and there certainly are incentives in your outline and in other proposals for that result.

Likewise, premium caps will serve as an incentive for insurance plans to prefer the kind of environment in which we have gatekeepers and other forms of cost control. Given that you are recommending a reduced benefit package, what will be the circumstance for someone whose illness isn't covered by the reduced benefit package when the gatekeeper doesn't let them in and they need to go somewhere for their medical care?

What will be available for them in this new environment to purchase it somehow, because it wasn't covered in their plan?

MR. AARON. What are the elements of a reduced benefit package? Any adequate insurance plan is going to cover physician, hospital, and essential pharmaceutical products associated with acute somatic illness. The degree of cost sharing will vary and that affects the generosity of the plan.

Any managed competition plan, any health maintenance organization that achieves a degree of cost control uses gatekeepers, and they do so today. How do people react today if they confront those limits? Well, in different ways. Some plans—so-called point of service plans—allow people to go outside the plan at a higher cost. More cost sharing, for example. Those kinds of arrangements could be and, I would expect, would be continued.

One could, and I expect would, allow people to buy supplemental coverage on their own. Some people would, some people would not. One would certainly allow, in my view, people to spend their own resources to buy health care directly. That is an option for which I can see no moral basis for any kind of limitation.

If one was talking about draconian cost limits, then one could, I think, conceive of serious dilemmas and problems of the kind you describe arising.

REPRESENTATIVE COX. I didn't describe a problem. I just asked what would be the circumstance if someone who finds that their malady isn't covered by the reduced benefit package——

MR. AARON. Well, I think a malady that isn't covered is a problem if it is a serious malady. If it is limited to relatively unusual or minor circumstances, which is all that would arise if the degree of cost control is modest as you move into it, then I wouldn't characterize it as a problem.

REPRESENTATIVE COX. Let's take an example from your outline. You said that we should narrow the benefit package for mental health.

MR. AARON. Yes.

REPRESENTATIVE COX. Let us say that we are on the other boundary of the narrowed benefit with a mental health problem.

How does a person or the family in that circumstance deal with the fact that their plan doesn't cover them? And in particular what I am concerned about is what will they find in the environment that has been created by a system of universal coverage in which everyone is

driven to an HMO-like mechanism, to use gatekeepers and other strict cost controls to live within the premium caps?

MR. AARON. I am not sure that everybody would be driven to that, but if my wife were here, she would be delighted that you asked this question. She is a psychotherapist, and we have gotten into a number of arguments about this particular element of my proposal. She doesn't like it at all.

The short answer to your question is a little better than they can deal with it today. Many people are bereft of mental health benefits altogether in their health insurance plans.

What I am describing here is a floor, not a ceiling, and therefore employers that wish to sponsor more generous coverage would be free do so, or individuals who wished to buy it would be free do so.

REPRESENTATIVE COX. But will the private practitioners be there from whom to buy the services?

MR. AARON. They are not going away and in any plan that is a floor, not a ceiling, is going to tend to rise, not fall.

Now, currently, mental health coverage tends to be very, very partial in many plans, and that means whole segments of society are completely cut off, even from crisis intervention. At a minimum, that needs to be part of any health insurance plan. Most HMOs do cover at least a minimum number of visits. Sometimes it will only be six or ten in the course of a year. Others have more generous coverage.

The President's plan, because I think members of his staff are well informed on the character of mental health problems in the United States, were relatively more generous in their design of this benefit provision than are many private-sector plans today.

All I am saying is, if the price of getting through a plan covering acute somatic illness is trimming back mental health benefits, it is a bargain on which you pay a price, but it is worth doing. I don't argue for these curtailments because I think they are desirable or because they are going to be free of the kinds of difficult choices you have described, but because there are economic constraints governing planners and if one can shrink the overall cost of the package, the possibility of finding a viable compromise, I think, increases.

REPRESENTATIVE HAMILTON. On this business of controlling costs, your plan sticks with the managed competition. You make a presumption that managed competition might work. What does the phrase "managed competition" mean?

MR. AARON. To me, it means a set of marketing rules for the sale of insurance that promote cost conscious buying on the part of purchasers.

REPRESENTATIVE HAMILTON. Does that mean you have to have those alliances?

MR. AARON. I think you need alliances, cooperatives, some entity that enforces rules for the sale of insurance.

REPRESENTATIVE HAMILTON. And without it, you don't get managed competition?

MR. AARON. Without it, it is much more difficult to get it. It is a loose term, and for different people, it means different things.

I read an article once that listed about 30 different components of something that one person or another called managed competition, so you paid your money and you take your choice, depending on who you talk to.

REPRESENTATIVE HAMILTON. If you talk with our constituents, the whole idea of choice is really central. They have to have the right to choose their doctor and their hospital.

How do you come out on that now? I would just like your reaction to the plans in general, which you identified first thing in your testimony, your own plan, analyze those plans for me in terms of impact on choice.

MR. AARON. The baseline is that many Americans have essentially complete choice, but many others do not.

REPRESENTATIVE HAMILTON. Let me stop you there. Is choice declining now in the present system?

MR. AARON. Yes.

REPRESENTATIVE HAMILTON. So more and more Americans are finding themselves with less choice under the present system?

MR. AARON. Correct.

REPRESENTATIVE HAMILTON. Okay, excuse me. I didn't mean to interrupt you.

MR. AARON. Well, that is important, because increasingly employers are limiting the number of plans and plans are having close panels of physicians or are imposing penalties if you go outside those panels, so the degree of choice is becoming circumscribed.

The Clinton proposal is, in fact, a very large expansion of choice, at a price. But if one is willing to pay for the cost of the fee for service, any willing provider plan that each alliance would have to offer, then one has total choice, and that would be available as a matter of entitlement to everybody in each alliance area.

REPRESENTATIVE HAMILTON. Costs you how much more?

MR. AARON. There is a limit in the Clinton proposal that would permit the alliance to disallow plans costing more than 20 percent above the regional average, but not requiring them to do so. Whether they would exercise that choice or not, I do not know.

The framework that I have described here is one that would have competing alliances in a given area and which of these alliances one elected to buy insurance through would be a matter of how they got organized.

The public alliance would be available to everybody and the rule that I suggested, which every insurer must offer through any alliance on the same terms, would thereby mean that the public alliance had available

to it all the plans operating in a given area. That is a high degree of choice. It is more choice than most people have today.

I believe that in the end, Senator Chafee's plan and Congressman Cooper's would provide a similar range of opportunity.

REPRESENTATIVE HAMILTON. Now, if your managed competition doesn't work and the costs, technology and other factors continues to explode and you run out the period—whether it is three to five or whatever years—what do you do?

MR. AARON. First of all, I wish you wouldn't say my managed competition. I am not a gung ho managed-competition person, frankly. I once referred to Alan Enthoven as a managed competition monotheist.

REPRESENTATIVE HAMILTON. Wait a minute. I thought you said you had a put-up or shut-up approach.

MR. AARON. That is correct.

REPRESENTATIVE HAMILTON. And you tried this, I thought, managed competition for five years.

MR. AARON. Three to five years. That is correct, and the reason I say that is not because I personally think it is going to work or believe this is the way to go, but I believe that Congressman Cooper has the allegiance for his approach of a significant minority of the House of Representatives and many Members of the Senate. They are going to need to be on board, and this is a way of getting, I hope, the support of many.

REPRESENTATIVE HAMILTON. So your view is that managed competition, as they perceive it, isn't going to work?

MR. AARON. I think it is a long odds proposition, but I don't pretend to be smart enough to know the answer.

REPRESENTATIVE HAMILTON. But at least give it a shot.

MR. AARON. Give it a shot?

REPRESENTATIVE HAMILTON. All right, if give it a shot, doesn't work, what happens?

MR. AARON. At that point, I think the regulatory apparatus suggested by President Clinton is probably the best practical apparatus now on the table.

REPRESENTATIVE HAMILTON. Premium cap?

MR. AARON. Premium caps, that is correct. I think having a little more time to collect the data, develop the administrative capability and learn how to implement it would not hurt, and so I think there is a plus actually for the regulatory approach, the likelihood that it could actually succeed in giving people a little more time to plan.

REPRESENTATIVE HAMILTON. What is the disadvantage of a premium cap? Spell that out for me. What is the downside of it?

The comment you would get from people, I think, in general, who are not the experts, would say it would lead to rationing. I don't know what else they would say about it, but that is one thing they would say about it.

MR. AARON. The downside of any cost control is rationing, and the question that the Nation is going to have to confront at some point is whether it is possible to squeeze out enough waste, fraud and abuse to reduce the growth of spending without rationing.

My own view is that in the end, after a while, we are going to discover, like the person who has been writing prose all his life and didn't know it, that if we do succeed in curbing the growth of spending, we are going to be rationing. Why do I say that?

You cannot think of any medical intervention of any significance today that is not in some cases beneficial, lifesaving, the information provided is extremely valuable. You would never want to forego it. But that same procedure is used in other cases where the benefits are negligible or zero. The name of cost control is trying to get rid of the latter without getting rid of the former.

Nobody will argue with pure waste, but suppose the benefits are positive, but very small. I can personalize this. I have had three magnetic resonance imagining examinations. One of them was the prelude to very accurate back surgery, from which I recovered really quickly. I was home in less than three days and back at work in a week.

Another case was to look at a brain abnormalities where the doctor said, and I quote, "You know, I think the chances that we will find anything are minuscule, and if we found anything, the chances we could do anything about it are smaller still, but you are insured, aren't you?" And I said yes. And he said, "Well, you will feel better and I will feel better if we just rule this out." So, at 7:00 p.m. the same night, I was in there and I had an MRI on my head with contrast media for $1,200 bucks, and I did feel better because it was negative.

But then you ask yourself, consider 10,000 people presenting with the same symptoms I had. I will pull a number out of the air, but it is not far off. Maybe you will find one treatable case. Ten thousand times $1,200 bucks is $12 million bucks for a treatable case.

Now, if you had a system that denied me that MRI, or more to the point, made me pay out of pocket for it, I call that rationing. That is beneficial care and it is rationing.

REPRESENTATIVE COX. Sir, if I might interject, it is price rationing, yes? In your example, it would be price rationing, right?

MR. AARON. No. Let me come back to it in a minute. Let me make one other point, and then I will come to that. I think I ought to have the right to buy the $1,200 MRI myself, but I don't think I should make you folks pay for it. The rationing that would occur if I was not given an MRI through my insurance plan is a kind of budget rationing.

REPRESENTATIVE COX. I am sorry. I was talking about the rationing that would occur if we required you to pay for it.

MR. AARON. If you required me to pay for it, then it is in the same category as fine cars and good dinners. That is correct, that is right. If one wants to use the word rationing for the purchase of automobiles and clothes, yes, but I think that is stretching the term beyond its nor-

mal use. Rationing usually means denying people access to things for which they have the capacity to buy.

REPRESENTATIVE COX. That is government rationing, but if you have many valuable things in a society with more people than there are such things, we have to find a means of allocating scarce goods, and we use price rationing?

MR. AARON. That is right. In that sense, everything is price rationed except medical care.

REPRESENTATIVE HAMILTON. These costs that you are going to put a premium cap on at the end of this period of time if managed competition doesn't work, what impact is that going to have on technology improvement?

MR. AARON. That is the hardest question of all. The reason it is the hardest question is that I believe we are in the midst ... I am saying this as an economist who talks sometimes to biological researchers. I think we are in the midst of a scientific revolution of truly civilization transforming character in biomedical research, and that slowing or aborting avenues of advance in this area would be a tragic loss. I am also an economist who understands that entrepreneurial capital invested in speculative research is going to be reduced if the significant cost control is put into effect.

The implications of that, I believe, are that as part of controls in the growth of spending, it is important for public support of research and development not to decrease, but to increase.

REPRESENTATIVE HAMILTON. Pretty hard to make any estimates about that, I suppose.

MR. AARON. Yes.

REPRESENTATIVE HAMILTON. I wanted to ask you about the unlimited exclusion of the employer-sponsored health insurance from your employee's taxable income.

MR. AARON. Yes.

REPRESENTATIVE HAMILTON. How important is that in the scheme of things here? That is not in the Clinton plan. I guess he phases it in.

MR. AARON. He phases in limits, 10 years hence.

REPRESENTATIVE HAMILTON. Okay. All right.

MR. AARON. There are two aspects to the tax incentives that are on these two pages.

First of all, the excludability from personal income tax from employer-financed premiums is the mechanism that creates an incentive for small businesses and current nonpayers to get into the game. I think that is very important.

The second tax element is a way of turning on its head certain financial incentives that are part of managed competition proposals. The Cooper bill would deny deductibility at the business level to health plans more costly than a certain basic level.

I believe there are serious administrative problems with that idea, but that is a separate issue.

This approach is analogous, I think, to the old practice of gasoline companies charging people a surcharge if they wanted to pay with credit cards. People got very upset about that. It aroused a lot of opposition. So gas companies discovered that they could do the same thing if they gave people a discount for cash. Same effect.

I suggest that you try to apply that example to the financial incentives for being price-conscious shoppers. If you buy a less expensive premium plan that your employer makes available, then the worker is entitled to receive the difference in cost tax free.

Price incentive is exactly the same as in the penalty variance, but it looks different and it is a reward rather than a penalty. It is a reward for being price-wise rather than a penalty for being prodigal.

REPRESENTATIVE HAMILTON. Chris, go ahead.

REPRESENTATIVE COX. I will just ask one question along those lines. In order to get individuals to be more cost conscious, both in terms of the health care that they consume and in terms of the insurance policies that they are interested in obtaining, we are often directed to the problem created by the employer exclusion for health-care premiums.

From my standpoint, working for an employer that provides health insurance, I have a disincentive—a pretty strong one—to go out and shop for something else, because I get it with before tax dollars here at work.

If, on the other hand, we went back to the status quo of not that many years ago, when you did your income tax, medical expenses were deductible. Indeed, if I could deduct as an individual my medical expenses and my medical premiums, wouldn't I suddenly become indifferent to whether or not I did this with before tax dollars at work or outside of work?

MR. AARON. In my view, one shouldn't be protected from the financial consequences of choosing a premium plan, relative to a less costly plan.

That is an individual choice, much as if you decide to buy a $400 suit instead of a $200 suit, that is up to you. The government doesn't subsidize that decision for you. I don't think they should in the case of health care.

So it seems to me that the desirable direction to go is the other way. Politically it has been very controversial. President Reagan proposed it in the early 1980s and had a hard time finding a sponsor in either House of Congress to introduce it. It is now much more widely discussed.

REPRESENTATIVE COX. Yet, you keep the employer exclusion from gross income as part of your system?

MR. AARON. I do so in order to encourage employers to stay in the game, but if the individual buys a less costly plan than some premium

standard that would be defined within an alliance area, they receive the difference.

They don't have to pay tax on the difference in the cost, and that introduces the same price incentive as would arise if you fed it all through and made households pay tax on what their employers did.

REPRESENTATIVE COX. Well, I am not certain that is the case because the individual isn't buying the insurance. The individual is collecting from the limited menu offered by his or her employer, a less expensive employer-provided plan than he might otherwise be entitled to obtain.

But what we are not empowering this individual to do is to go off on his or her own and buy whatever is cheapest.

MR. AARON. The——

REPRESENTATIVE HAMILTON. Excuse me. May I interrupt? I apologize for interrupting. Chris, I am going to have to go on. I am scheduled to testify before the Rules Committee.

REPRESENTATIVE COX. I didn't have lunch myself, and I think Mr. Aaron has been more than generous with his time.

MR. AARON. I will answer your question by mail, because I think I can show in writing—and probably can't do so over the table—that the financial consequences of what I have described get you the same result as you are describing.

Under the arrangements that I am describing and in the President's plan, you would be shopping for insurance yourself. You would be buying it from a cooperative or an alliance, and they would have a menu of options available to you.

What I will show in the example is that if, under the incentives I have described, you pay for the difference, or you reap the reward, out of after-tax income, the incentive is the same as if you got rid of the exclusion.

REPRESENTATIVE COX. If you would respond in writing, take into account that the number of choices that I will be given from the alliance will be far less than the number of choices——

MR. AARON. No, I don't think so.

REPRESENTATIVE COX. Let's say that I get a dozen choices from my alliance, a very, very healthy number of choices.

I just checked with a couple of my local hospitals and they presently accept over 150 different kinds of private insurance, so the spread in the number of things that would be available to me is going to be much smaller if I am getting it through my employer rather than through an alliance.

MR. AARON. I have the choice of three plans where I work, and that is pretty generous coverage. Some places only have one. Very few people have choices of 150 plans, federal employees being an exception.

REPRESENTATIVE COX. Nobody does. President Clinton is precisely right when he says you are not losing that much from an alliance compared to what you get from an employer.

But my point is, if you liberated the employee from a slavish appearance to a limited choice offered by an employer in an alliance and let him or her go out and shop from hundreds, if not thousands, of plans available nationwide, that would be a different competitive environment.

MR. AARON. That is different issue, but I will respond to the tax issue.

REPRESENTATIVE HAMILTON. Thank you very much.

[Whereupon, at 12:30 p.m., the Committee adjourned, subject to the call of the Chair.]

SUBMISSIONS FOR THE RECORD

PREPARED STATEMENT OF MR. AARON

Some Reasons Why Reforming Health Care Financing is So Difficult

The goals of health care reform are widely acknowledged to center on the achievement of universal financial access to health care, control of the excessively rapid growth of health care spending, and the maintenance of high quality care. Other goals are unimportant as well, but less central, including the extension of the supply of health care providers, and the achievement of specific standards of care for target groups, especially children and pregnant women.

If the goals are widely accepted, why are programs to achieve them so controversial and why is agreement so elusive? Several factors, apart from pure political cussedness, partly explain why.

First, the traditional divisions between those who believe markets almost always produce better results than government management and those who have a keen eye for market failures and a greater respect for the capacity of government policy to solve problems play a very large part in explaining divisions on health care reform. Since both parties agree that the current system is seriously flawed and major change is necessary (although they disagree on the specific diagnoses), most participants favor reforms that entail actions that go well outside past experience. Thus, solutions advanced by all of those who favor major reform rest on a large measure of faith. Advocates of market solutions believe that changing tax rules will induce large changes in behavior—greatly heightened cost consciousness, for example—while advocates of direct regulatory controls on health care spending doubt that behavior will change much or quickly.

Representative Cooper's proposed reforms, for example, embody a profound faith that changes in the tax code will suffice to control growth of health care spending. President Clinton expresses a belief that market reforms will help slow growth of spending, but his proposal includes tight regulatory limits on premium growth should changed tax incentives do less than their advocates think likely.

Similar disagreements arise with respect to other issues. In each case, some evidence is available, but not enough to overcome deeply held prior beliefs.

A second factor concerns the relative weight attached to the various goals of health care reform. President Clinton has declared that unless a health care reform bill assures universal coverage he will not sign it. This seemingly hard-edged commitment is not so rigid as it may seem, since he has not clearly specified what coverage people must be assured to win his approval, and he has not indicated how fast universality must be achieved. Nevertheless, universal coverage is the central goal. His proposal assures universal financial access to care without qualification, regardless of fiscal surprises.

In contrast, Senator Chafee, who also embraces the principal of universal coverage (although by means different from those President Clinton proposes) declares that universal coverage must wait until sufficient savings have been achieved in other government programs to pay for it. Universal coverage is not so preeminent an objective for Senator Chafee. Representative Jim Cooper declares that he favors universal coverage and expresses the belief that his plan, which contains subsidies to help low income households buy insurance,

will achieve it. But the subsidies, like those of Senator Chafee's plan, are contingent on the realization of sufficient savings in government programs to pay for them. Furthermore, his plan does not actually guarantee universal financial access, and few other observers actually believe that universal coverage will result from it.

These three approaches embody a different ranking of the importance of universal coverage and insurance against fiscal surprises.

Apart from fiscal surprises, designers of health care reform must grapple with one vexatious fiscal certainty. The costs of universal coverage come fast; the savings from control in the growth of health care spending come slow. But neither step is possible without the other.

Universal coverage raises *the level* of federal spending because many of those now without coverage cannot afford to buy it and because all of the methods of achieving universality shift some additional costs to the federal budget. These costs must be incurred just as soon as universal coverage is achieved but do not rise thereafter as a share of federal spending.

Cost control entails reducing *the rate* of growth of health care spending—private and public below the rate that would otherwise occur. If growth is slowed from 5 percent annually—the actual rate, adjusted for inflation, that has prevailed for many years—to, say, 3 percent annually, the savings in spending are approximately 2 percent the first year, 4 percent in the second year, 6 percent in the third year, and so on.

Eventually, the savings from a successful program to reduce the rate of growth of spending will exceed the one-time increases in the level of spending from universal coverage. But that takes time. This simple arithmetic fact, leads to the central and inescapable fiscal and political fact about health care reform: in the short run, It must raise federal spending and tends to raise the deficit, while in the long run, it tends to reduce the deficit.

Because Congressional procedures put large obstacles in the way of deficit-increasing legislation and public resistance to such legislation is widely believed to be strong, proponents of health care reform must find some way to offset this central fact. Unfortunately, all the ways are unpleasant. They include cutting other federal programs, raising taxes, or claiming very *large and very rapid* reductions in health care spending.

Fashioning a Viable Compromise

Although all the major health care plans contain many provisions, each embodies certain core principles on which its supporters cannot or will not compromise. Such core principles are not, of course, clearly demarcated or fixed in stone. There are, no doubt, important areas of potential compromise even on core principles. Despite these qualifications, which make identification of core principles difficult and judgmental, the fate of health care reform hinges on identifying them.

Although many bills have been submitted on health care reform, I believe that one can identify four broad approaches: the employer mandate for workers combined with an individual mandate for nonworking families, the individual mandate for all households, full national health insurance (the "single-payer" option), and managed competition without any mandate.

Each of these approaches embodies very far reaching change. Some members of Congress, particularly in the conservative wing of the Republican party, reject such far reaching modifications. In my view, few from this group are likely to support any legislation that would have any chance of winning presidential signature, and I shall not consider these approaches further.

The President has declared clearly that any bill he will sign must assure universal financial access to comprehensive benefits, but that he could compromise on almost anything else. Presumably this willingness to compromise includes the requirement in his proposal that all companies must pay 80 percent of the cost (subject to various caps) of health insurance for their employees and their families.

Senator Chafee and supporters of his bill declare opposition to employer mandates and would rely on a requirement that all individuals and families show that they have health insurance coverage. Although opposed to an employer mandate, there is reason to think that they would not regard a mandate limited to large companies, virtually all of which already pay for health insurance for their employees, as unacceptable. In short, they seem to be opposed to any mandate that would force large numbers of businesses to do something other than what market incentives seem to dictate.

Representative Cooper's primary objective is to change the nature of the market for private Insurance by altering the conditions under which people buy insurance. He would establish marketing cooperatives to reduce the capacity of insurers to compete by selecting low-cost patients and to increase cost consciousness of insurance buyers. The goal is to obviate the need for government regulations to control growth of health care spending. Cooper and many of his supporters are likely to insist that managed competition be given a chance to show that it can control costs.

Representative McDermott and other single-payer supporters favor an integrated reform that would assure universal coverage and cost control. The approach cannot be programmatically divided. but it stands no chance of enactment nationally. Some states might be willing to adopt the single-payer approach, if given the chance under national legislation that established performance standards. Accordingly, the irreducible requirement for support by single-payer advocates must be that states have the option to follow this approach if they meet national performance standards.

The compromise plan, an outline of which is attached, is designed to meet the minimum requirements of these four groups. While fully satisfactory to none of the groups, all could participate in a signing ceremony for such a bill and honestly proclaim that, while they were forced to make compromises they would have preferred to avoid, the bill contains the elements they deem most important and meets their irreducible demands.

Draft Specifications of a Compromise Plan

1. ***Employer Mandate***

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

2. ***Purchasing Cooperatives [Alliances]***

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

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

3. ***Subsidy Structure***

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

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

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

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

4. ***Benefit Package***

   Reduce benefit package from 50th percentile of corporate plans to (say) 15th to 20th percentile, by increasing deductibles and (perhaps) cost

sharing and by narrowing benefits (child dentistry, mental health, substance abuse, or other elements).

5. ***Calendar***

Full implementation of mandate by 2000 to 2003.

6. ***Cost Control***

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

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