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bcc: Verveer, Jennings, Ricchetti

THE WHITE HOUSE

WASHINGTON

August 31, 1993

The Honorable David Pryor
Chairman
U.S. Senate Special Committee on Aging
SD-G31
Washington, D.C. 20510-6400

Dear David:

Thank you so much for advising us of your priorities with regard to pharmaceutical coverage and cost containment issues. As you well know, I greatly appreciate your guidance on all matters. However, having the benefit of your years of experience on the many complex issues regarding pharmaceuticals is particularly helpful.

David, because the cost estimates for all the various elements of the health reform package have not yet been finalized, the President has not made final decisions on all the issues related to prescription drugs. Having said this, I would like to take this opportunity to outline for you, on a confidential basis, my sense of where the elements of the proposal related to pharmaceuticals are likely to go.

Prescription Drug Costs and Managed Competition

We believe that the negotiating practices utilized most frequently by managed care purchasers have great potential to contain escalating prescription drug prices. In recent years, we have witnessed the new found ability of these purchasers (primarily hospitals and HMOs) to obtain more reasonable prices by negotiating and managing costs with formularies, prior authorization requirements, physician and consumer education programs, drug use review, and other techniques.

While managed care purchasers have been able to generally contain their pharmaceutical cost increases, they have had little success in managing the costs of new drugs that have no therapeutic alternative. Moreover, it is likely to take several years before pharmaceutical purchasing that utilizes managed competition techniques will be developed sufficiently enough to buy and manage the costs of prescription drugs for all Americans.

As a result, it has become clear that we must develop an interim and a long-term pharmaceutical cost containment strategy. Moreover, to ever have a realistic chance to contain these costs, it has become evident that we will have to assure that all Americans have private or public coverage for prescription drugs.

Prescription Drug Coverage

It is our belief that providing prescription drug coverage for all Americans is essential to assuring that everyone has access to affordable and frequently cost-effective medications. It is our hope and expectation that there will be a Medicare prescription drug benefit that parallels the coverage that we will require all Americans under the age of 65 to receive. We share your belief that all Americans, particularly the elderly, are in desperate need of protection from the high costs of pharmaceuticals. While we have not finalized exactly what the cost sharing components will be, we do believe it will be at or close to your suggestion of a $250 deductible and a 20 percent copayment.

Interim Cost Containment Strategy

Under any scenario, consumers will need to be protected from price increases over the inflation rate until there is much greater coverage of prescription drugs and there is a widespread ability -- using managed competition methods -- to negotiate on behalf of consumers. We are, therefore, now considering accepting the offer of many in the pharmaceutical industry to voluntarily constrain their prices to the general inflation rate. Consistent with your recommendations, this policy would assure that retail purchasers would have the same inflation protections as everyone else.

Cost Containment for Under-65 Population

The short-term cost containment provisions that we are contemplating should help assure that the under-65 population will not be subjected to significant price increases for pharmaceuticals now on the market. Moreover, the growing movement towards managed competition purchasing principles should achieve substantial savings as well. However, we share your concern about the potential for a continuation -- or even escalation -- of the trend of excessively high prices for new drugs, particularly those that have no therapeutic alternative.

With the above in mind, we believe it is advisable to direct that the National Health Care Board envisioned in our current draft be charged with reviewing the prices of new pharmaceuticals. While the Board would not have the authority to regulate or set prices, it would have the responsibility for evaluating the cost effectiveness and therapeutic value of new medications. In undertaking this responsibility, the Board would then be required to disseminate information to both public and private purchasers of prescription drugs.

Cost Containment for the Medicare Program

No Medicare benefit can be established without a realistic and serious cost containment component. No one knows this better than you. We anticipate that the Medicare cost containment provisions will meet with your approval, since they are very close to your recommendations.

More specifically, since the Medicare program would become the world's largest single purchaser of prescription drugs, we believe the program merits a reasonable price. To achieve this, we believe that Medicare should receive a discount that is at, or close to, the percentage discount that the Medicaid and other public programs are now receiving. Moreover, to assure that excessively priced new drugs do not bankrupt the Treasury, we believe it is advisable to provide the Secretary of Health and Human Services the authority to negotiate Medicare drug prices with manufacturers. Lastly, I believe we should provide incentives for greater use of generic drugs and for more widespread use of patient and physician counseling.

Equitable Treatment of Pharmacists

Finally, it has become clear that community pharmacists are having great difficulty in accessing the degree of discounts that other purchasers have achieved. It remains unclear to us exactly why this is the case. The retail pharmacists argue that it is blatant discrimination by the pharmaceutical manufacturers; the HMOs and hospitals say they earn these discounts because they can push volume in ways the retail pharmacists -- with few exceptions -- have not yet been able to master.

We have been working for months on this complex and controversial issue. It is our hope to find a policy approach that assures that no one receives a particular discount just because they are one particular purchaser or another. We want to make certain that discounts are given to those who earn them. In the upcoming days and weeks, we will be working closely with your and other offices to attempt to find a way to achieve this goal.

David, the contributions of you and your staff to the pharmaceutical coverage and cost containment policy we are developing have been invaluable. It is my hope and expectation that after reviewing this letter you will conclude that we are meeting your policy priorities. However, if you have any questions, concerns or further suggestions, I urge you to give me a call. Once again, thank you for all of your assistance.

Sincerely yours,

Hillary

Hillary Rodham Clinton

from the office of

Senator Edward M. Kennedy

of Massachusetts

FOR RELEASE: September 15, 1993
CONTACT: Theresa Bourgeois
Kevin Winston
202-224-4781

**STATEMENT OF SENATOR EDWARD M. KENNEDY
ON THE INTRODUCTION OF THE REPUBLICAN HEALTH PLAN
BY SENATOR JOHN CHAFEE**

I want to commend Senator Chafee and his Republican colleagues for the hard work and commitment they have shown in developing the health reform proposal that they announced today. This proposal, along with comprehensive proposals previously introduced by Senator Jeffords and Senator Kassebaum, shows that there is commitment to reform on both sides of the aisle.

I am pleased to see that the plan introduced today has many points in common with the plan that President Clinton will announce next week.
Both proposals share the same goal of universal coverage and affordable health care for all Americans. Both proposals encourage the use of market forces to control health care costs. Both proposals provide assistance to low income Americans. Both proposals enable small businesses and individuals to join purchasing alliances to obtain coverage at an affordable cost. Both proposals include measures to prohibit abusive insurance company practices. Both proposals simplify reporting and data requirements, and reduce the paperwork and red tape that plague the current system and make it so wasteful and inefficient.

Both proposals include measures to reform medical malpractice liability, to provide greater flexibility in the application of the anti-trust laws to health care, and to improve the quality of care.

The shared goals and the many points in common between President Clinton's plan and the Republican proposal are a positive sign that bi-partisan cooperation is not only possible but probable in this all-important debate that is now underway, and I look forward to working closely with Senator Chafee and other Republicans on legislation to achieve our goals.

At the same time, there are significant differences between our two approaches that need to be addressed as we work towards a reasonable and realistic compromise.

I am particularly concerned with the approach to achieving coverage in the Republican plan. The requirement on individuals to purchase coverage without any sharing of responsibility by employers, coupled with a government subsidy, will encourage many businesses to drop coverage and shift an even heavier financial burden onto middle class families and the taxpayers.

I am also concerned that the failure to back up steps to improve the market with strong limits on spending does not provide adequate assurance that health care will be affordable for businesses and average Americans. Medicare beneficiaries would be asked to accept substantial benefit cuts without steps to fill current gaps in coverage such as long-term care and prescription drugs. The proposal to limit the deductibility of health insurance benefits could result in a tax increase and higher health care costs for millions of middle class Americans.

And the proposed benefit package does not provide sufficient specificity to assure citizens that all their essential medical needs will be met when serious illness strikes.

Nevertheless, the Republican plan is a major step forward. It augurs well for our ability to work closely together in the months ahead, and to develop a truly bi-partisan bill that meets the increasingly urgent needs of the American people and the nation.

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93/107

ASSURING PATIENTS' ACCESS TO QUALITY, COST EFFECTIVE CARE AT FEDERALLY DESIGNATED CANCER CENTERS IN A REFORMED HEALTH CARE SYSTEM

Executive Summary

The National Cancer Program enacted by Congress in 1971 has as its mission to improve our ability to prevent, detect, diagnose, and treat cancers. The National Cancer Institute (NCI) has designated comprehensive cancer centers (CCC) in different parts of the country, nine of them freestanding facilities.[1]

Memorial Sloan-Kettering Cancer Center is taking the lead to establish a network of federally designated comprehensive cancer centers. These NCI-designated cancer centers are the cornerstones for deepening the understanding of the causes of cancers, for setting the standards for cancer prevention, diagnosis and therapy, for applying this knowledge to clinical practice, for disseminating this knowledge and to contain the costs of care. As the network develops, it would be designed to include centers and providers across the country that can meet the established standards of care and costs.

The role of these national health care resources and the continued success of the National Cancer Program require for their special mission health care reform legislation that provides:

- Patients in managed care programs with guaranteed access to the NCI-designated cancer centers.

- That a global budget and/or cost controls accommodate the services and patients of the exempt cancer centers. (Current law provides nine freestanding cancer centers special status under the Medicare reimbursement system because of their atypical services and patients.)

- Patients with cancer access to qualified and appropriate clinical trials that substitute for generally available, possibly less effective, therapy.

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[1] The nine are: M.D. Anderson Cancer Center, Houston, Texas; City of Hope National Medical Center, Duarte, California; Dana-Farber Cancer Institute, Boston, Massachusetts; Fox Chase Cancer Center, Philadelphia, Pennsylvania; Fred Hutchinson Cancer Research Center, Seattle, Washington; Arthur G. James Cancer Hospital and Research Institute, Columbus, Ohio; Norris Comprehensive Cancer Center, Los Angeles, California; Memorial Sloan-Kettering Cancer Center, New York, New York; Roswell Park Memorial Institute, Buffalo, New York.

The Cancer Centers Are National Resources

As part of the National Cancer Program, the NCI was directed to designate certain cancer centers to establish standards of quality of care; to develop new treatments for cancer and introduce them into clinical practice; and to develop regional programs for prevention and early detection. These state-of-the-art clinical programs and research activities offer the greatest hope for successful control and cure of cancers. Research is the driving force that allows these cancer centers to develop new innovations that replace less effective approaches to prevent and treat cancers. The most cost effective approach to cancer care is prevention and definitive, curative therapy. Cancer is a human burden and requires very costly care if it becomes a chronic or incurable disease.

As the centers develop new methods for treating, preventing, and detecting cancer, they can demonstrate their effectiveness through treatment of patients at the centers and disseminate information on these developments so that they can be incorporated into clinical practice throughout the country.

These cancer centers have played pivotal roles in developing and advancing treatments for childhood leukemias which previously were often fatal and are now highly curable; safely substituting lumpectomy for mastectomy in many breast cancer patients; originating limb preservation techniques that minimize disability and disfigurement; developing bone marrow transplantation to cure previously untreatable cancers; and perfecting ambulatory cancer treatment for large numbers of cancer patients, thereby effecting major health care cost reductions. The work continues, as the cancer centers innovate in such areas as early detection when cancers are most likely to be cured, prevention by innovative trials and new, increasingly effective therapies.

A report from the United States General Accounting Office to the Chairman, Subcommittee on Health environment, Committee on Energy and Commerce, and House of Representatives on "Cancer Treatment 1975-85: The Use of Breakthrough Treatments for Seven Types of Cancer" in January 1988, the latest available GAO report on this subject, evaluated seven treatments which by various criteria were considered state-of-the-art. This report found that "a considerable group of patients among those who had the seven cancers we examined--20% of those with Hodgkin's Disease, 25% with one type of lung cancer, 60% of those with rectum cancer, 94% of colon cancer patients--did not receive what NCI considers state-of-the-art treatments. This is especially troubling in that all these treatments have been proven to extend patients' survival in controlled experiments, many of which were concluded 10 or more years ago."

Health care reform must not deprive patients access to or undermine the work going forward in these comprehensive cancer centers.

Paul A. Marks, M.D.
Memorial Sloan-Kettering Cancer Center
6.11.93

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release September 16, 1993

STATEMENT BY DR. ARTHUR FLEMMING

"As the former Secretary of Health, Education and Welfare in the Eisenhower Administration, I would like to express my strong support for President Clinton's health care reform proposal. The proposal he is about to present to the nation is comprehensive, thoughtful, workable and fair -- a proposal that will lead us on the road to a nation where health security with quality care is guaranteed for all Americans and health care costs are brought under control.

I have worked for health care reform for the better part of four decades, and I have seen other health care reform efforts start with high hopes and fail. But I believe this is different. The President has presented us with a historic opportunity, and we must seize the moment. Let us get a plan on the books and begin to learn from experience, instead of engaging in endless rhetoric.

As a former U.S. Commissioner of Aging, I am particularly enthusiastic about the plan: because this proposal will mean a stregthened Medicare program -- providing greater security and expanded benefits for older Americans.

Under the President's proposal, older Americans will receive all the benefits they do today. In addition, Medicare will be expanded to cover prescription drug benefits, and there will be a new long-term care program to cover home- and community-based care. Nearly all Americans will still have to pay only 25% of the total cost of the Part B benefits they receive -- including the new drug benefit. Any increase in the premium will be consistent with the increase in benefits. Only the wealthiest Americans -- those people earning $100,000 or more -- will pay the full actuarial value of the benefits they receive. Finally, Medicare funds now being wasted to cover fraud and overcharges will be used to pay for these new benefits.

Over the next several months, there will be likely many attempts by those opposed to reform to scare Americans about the effect of the President's plan.

But older Americans should know that President Clinton's proposal will mean greater security and expanded benefits. And I hope that older

Americans -- and Americans of all ages -- will join in getting this plan on the books."

Dr. Flemming was Secretary of Health, Education and Welfare from 1958 through 1961. He was Chair of the White House Conference on Aging in 1971 and U.S. Commissioner on Aging at HEW from 1973 to 1978. Currently, he is Chair of the National Citizens' Board of Inquiry into Health in America, Co-Chair of Save our Security Coalition.

-30-30-30-

House of Representatives

Committee on Post Office and Civil Service

Washington, DC 20515-6243

TELEPHONE (202) 225-4054

October 21, 1993

Mrs. Hillary Rodham Clinton
White House
Washington, D.C.

Dear Mrs. Clinton:

I am writing to express my great frustration and deep anger concerning a decision by the Administration to break an agreement with the Committee on the timing of the enrollment of Federal employees and retirees into the state regional alliances and the final dissolution of the Federal Employees Health Benefits Program (FEHBP).

The Administration has proposed that Federal employees be enrolled in state regional health alliances. While the Committee has so far reserved judgement on the threshold issue of whether Federal employees should be enrolled, the Committee felt that if that were to happen, the FEHBP should continue serving its enrollees until all fifty states have begun operating regional alliances; only then would Federal employees and retirees be enrolled in the alliances and the FEHBP abolished. If Federal employees were to be enrolled as each state regional alliance commenced operation, OPM would have to administer the FEHBP for the remaining enrollees with a ***rapidly declining and unstable risk pool.***

The phase-in transition the Administration is about to propose would make the FEHBP ***unadministrable***. FEHBP rates could be very unstable and, in some instances, could skyrocket. Administrative expenses would be spread over fewer and fewer enrollees. A shrinking risk pool will make it difficult for some FEHBP plans to remain viable enough to continue operating; their enrollees could be subjected to steep premium increases and a decline in service, in addition to the unnecessary disruption from being moved into the government-wide service plan during the transition period. Even the viable plans would have difficulty establishing their rates and may defensively price their premiums upward.

On Wednesday, September 29th, the Committee Staff Director and Deputy General Counsel met with Mr. Ira Magaziner, among others, to discuss this and several other issues. After a discussion of this particular point, ***Mr. Magaziner agreed to include a provision in the Administration's health care reform bill that provided that FEHBP enrollees would enroll in regional alliances only after all of the state regional alliance systems had become fully operational.*** His agreement to the provision sought by my staff was unambiguous and

unqualified. A second provision requiring OPM to offer supplemental benefits to FEHBP enrollees to avoid any diminution in benefits or increase in out-of-pocket costs under the new system was agreed to as well.

This afternoon, my staff was formally notified that the Administration has reneged on its agreement with the Committee and will proceed to propose the phase-in integration of the FEHBP into the new system. In addition, we were notified that the bill will authorize, but not require, OPM to offer supplemental benefits to Federal employees and some retirees.

The Administration's proposal to enroll Federal employees and abolish the FEHBP on a phase-in basis is unacceptable to the Committee. It further complicates an already difficult situation for me. To begin with, I already have very grave concerns over the whole idea of abolishing a generally well-run program that serves 9 million people. So if the program is to be abolished, I want to ensure that it is done right -- that is, dissolved in the least disruptive, most rational and most orderly manner. I would also point out that Federal employee organizations view the possibility of a phase-in transition with the same degree of concern and trepidation as I do and will be communicating those views to you.

Therefore, unless the decision is reversed and the agreement reflected in the legislation, I may be forced to oppose outright the Administration's proposal to integrate the FEHBP into the state regional alliances. Given both my desire to work with you and the President on solving the Nation's health care crisis and to keep an open mind on the President's proposal to dissolve the FEHBP, being forced to take this course of action would truly be regrettable.

In closing, I respectfully urge you to reverse the Administration's decision and include in the bill the agreement entered into between the Committee and Mr. Magaziner on both the timing of the integration of the FEHBP into the new system and the provision of supplemental benefits for Federal employees. I would like to meet with you on Monday to discuss this matter further.

Sincerely,

William L. Clay

WILLIAM L. CLAY
Chairman

cc: Melanne
Steve R.

United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

October 19, 1993

Mrs. Hillary Rodham Clinton
The White House
Washington, DC 20500

Dear Hillary:

Many thanks for your call last night. I'm looking forward to the introduction of the bill, and with a little Irish luck, we'll have Jim Jeffords and a strong representation of Democrats on the Labor Committee as sponsors--even the single-payers!

I wanted to follow up with you on two issues I raised during our conversation--funding for academic health centers and funding for public health. In both cases there are some issues on which I would appreciate your assistance as the Adminstration bill becomes final.

Academic Health Centers

In general, the Administration has done a good job of designing a structure that will enable academic health centers to compete effectively without jeopardizing the research, training, and tertiary care that have made them such a national resource. The problem is the proposed sixty percent reduction in their indirect medical education (IME) payments under Medicare.

A cut this deep is unjustified on policy grounds, according to the Prospective Payment Review Commission, and could be a very serious problem for the centers--particularly since this cut would be on top of the Medicare reductions they'll absorb along with other hospitals. The cut also jeopardizes the support of institutions that can credibly and

effectively make the case that the President's plan will maintain and improve quality of care.

I hope this reduction can be set at the level the Prospective Payment Assessment Commission has said is reasonable. The current 7.7 percent factor would be reduced to 5.6 percent instead of 3.0 percent. A cut at this level would be acceptable to the institutions and would still save $1.2 billion annually.

Public Health

All of us agree that expanded public health services are essential to realize the full potential of health reform and to assure that vulnerable populations actually have access to the services to which the health security card entitles them. For the new funding in the President's plan to be meaningful, it should be mandatory, and not subject to the budget cap on discretionary spending or available for deficit reduction.

I am not suggesting an entitlement in the form of an open-ended commitment. What is needed is a limited, controlled form of directed spending that would not be subject to the discretionary caps. Short of such a requirement, the likelihood of actually funding the new public health initiatives is small. As in the case of other mandatory spending programs, no dedicated tax or premium is necessary, as long as the total spending in the Administration bill is deficit neutral.

In addition to these two concerns, I hope that the proposal is carefully drafted to maintain traditional Labor and Human Resources Committee authority over public health programs and to provide an appropriate role for the Committee in non-Medicare funding of academic health centers. To avoid distorting established authority, funding for these two functions must come from general revenues and not from dedicated taxes, premiums or a government trust fund, pool, or special account. In addition, in the case of academic health centers, Medicare funding must be included in the Medicare title and be separate from private sector funds.

I have attached a short drafting guide on these topics which may be helpful as the bill-writing team puts the final touches on the legislation

With respect and warm regards, and I'm most grateful for your consideration of these requests.

All the best—

Ted—

Concerns About Premium Surcharges (for Funding Academic Health Centers, New Public Health Programs, and Other Purposes)

In general:

(1) Spending should be mandatory, not subject to discretionary caps

(2) Language imposing premium surcharges that will be used to finance federal spending must be written in a separate title by itself or in a tax title

(3) Funds collected from premium surcharges must go into general revenues, not into a segregated account, pool, or trust fund

(4) Payments for these purposes must come from general revenues

A. Academic health centers

(1) Medicare's contribution to funding academic health centers should be written in separate Medicare title

(2) Premium surcharge contribution:

a. For corporate alliances:

(i) surcharge should be written in separate title or tax title

(ii) surcharge should go to general revenues, not trust fund, pool, or special account

b. For regional alliances:

(i) surcharge should be written in separate title or tax title, as for corporate alliances

(ii) alternatively,

(a) surcharge can be included with other surcharges paid to regional alliances, e.g., bad debt.

(b) in this case, surcharge should not be sent to Washington but should be retained at alliance and offset against subsidies or other Federal payments

(3) Private payments to academic health centers must come from general revenues, not from trust fund, pool, or account

B. New Public health spending

(1) Spending should be mandatory (not subject to discretionary cap)

(2) Any surcharge to finance public health spending must go to general revenues under separate title or tax title

(3) Spending must be from general revenues, not pool, trust fund, or separate account

cc: Melanne, Steve R.

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

October 22, 1993

Mrs. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Hillary:

I understand that a new option has come under serious consideration in the last few days for funding expanded public health service activities and possibly academic health centers as well. This option would create a separate "receipt" account for this purpose, which would be financed by a premium surcharge or some other dedicated funding source. Because it is a receipt account, it would be outside the discretionary caps.

You asked me to let you know if there were any aspects of the President's program that would distort normal jurisdiction. For many years, all Public Health Service Act programs, including community and migrant health centers, nurse training programs, Centers for Disease Control programs, and the National Institutes of Health, among others, have been the exclusive responsibility of the Labor and Human Resources Committee.

Standing alone, the new public health funding would unquestionably be within the jurisdiction of the Committee on Labor and Human Resources. But the receipt account option would shift it to the Finance Committee. The Senate Parliamentarian has informed us that the account would be considered a trust fund for jurisdictional purposes, and the Finance Committee has clear jurisdiction over trust funds used for health care.

I also understand that the receipt account option would create a sixty vote point of order for the legislation under the Budget Act, because

it would be viewed as an attempt to circumvent the discretionary spending caps.

I would like to propose an alternative approach to achieve the Administration's goals without creating jurisdictional problems or violating the Budget Act. Under this approach, Public Health Service funding would be treated as capped, mandatory spending. Such spending is outside the discretionary caps but is carefully controlled and limited by the authorization amounts. There are already ten such programs in existence (list attached).

As I understand it, the rationale for the receipt account option is the importance of avoiding the appearance of creating any new open-ended entitlements. But that objective can just as easily be achieved under the approach I have proposed.

Because the amount of capped, mandatory spending is specified in the law itself, it cannot be higher than the law allows. It does not change with the economy, number of beneficiaries, or any other factor. Thus, it has nothing in common with the open-ended entitlements. None of the concerns involving entitlements has ever been raised, to my knowledge, about the existing capped mandatory spending programs. Indeed, the only major difference between a capped mandatory program and a regular appropriated program is that the authorizing committees, rather than the appropriations committees, control the funding level.

I hope you will give serious consideration to the alternative I have proposed, which is of great importance to me. Many thanks for considering this request, and I look forward to next week's unveiling.

Sincerely,

Edward M. Kennedy

List of Capped Entitlements/Mandatory Spending Authorities

1. OBRA 81: Social Services Block Grant (Title XX of the Social Security Act)

2. OBRA 86: Section 9414: Medicaid Respite Demonstration

3. OBRA 89: Section 6407: (Medicaid) Demonstration Projects ...

OBRA 90:

4. Section 4711: Home and Community Care for Functionally Disabled Elderly Individuals (Section 1905(a)(23) of the Social Security Act)

5. Section 4712: Community Supported Living Arrangements Services (Section 1905(a)(24) of the Social Security Act)

6. Section 4745: Demonstration Program to Study the Effect of Allowing States to Extend Medicaid Coverage to Certain Low-Income Families ...

7. Section 4747: Demonstration Project to Provide Medicaid Coverage for HIV-Positive Individuals

8. Section 5081: Grants to States for Child Care (Section 402(i) of the Social Security Act)

Newly Enacted in OBRA 93:

9. Section 13761: Social Services in Empowerment Zones and Enterprise Communities

10. Section 13711: Family Preservation and Support Services

CAROL MOSELEY-BRAUN
ILLINOIS

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS
JUDICIARY
SMALL BUSINESS

United States Senate

WASHINGTON, DC 20510-1303

October 13, 1993

Hillary Rodham Clinton
The White House
Washington, D.C.

Dear Mrs. Clinton:

I applaud your commitment and that of the President to health care reform. I share your dedication to improving our health care system and look forward to working with you and my colleagues in Congress to achieve the comprehensive health care reform our nation so desperately needs and deserves.

I realize the legislative detail is enormous in an initiative of this magnitude, but I believe the contribution of children's hospitals should be recognized in the final bill language under development. The draft plan does not adequately acknowledge the contributions provided by children's hospitals. Generally, sick children requiring complex or long term care receive that care from children's hospitals. Other community and private hospitals do not typically care for sick children.

Language in the current plan would require health plans to contract with essential community providers during a five year transitional period. In keeping with the proposed health plan's emphasis on primary and preventive care as well as its commitment to maternal and child health it is essential that the vital role of children's hospitals in caring for chronically ill children be acknowledged. I would like to recommend that the legislative language define "essential community providers" to include children's hospitals.

As the President noted in his speech, a children's hospital literally can perform miracles. Children's hospitals all around the country have been performing miracles every day for millions of children. I hope we can work together to insure that the important work of children's hospitals can continue.

Thank you very much for your consideration. I will call you later in the week to follow-up on this issue.

Yours truly,

Carol Moseley-Braun
United States Senator

cc: Ira Magaziner

CMB\fc

√cc: Melanne

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

JOHN D. DINGELL
CHAIRMAN

October 12, 1993

PAM OCT 14 1993

Mrs. Hillary Rodham Clinton
The First Lady
The White House
Washington, D. C. 20500

Dear Mrs. Clinton:

I have sent the attached letter to all the members of the House Democratic leadership, and I thought it would be of interest to you. The concerns expressed are sincere, and I would welcome an opportunity to discuss them if you think it would be helpful.

With best wishes.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Enclosure

cc: Mr. Thomas F. McLarty III
Mr. Howard Paster

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515-6115

October 7, 1993

The Honorable Thomas S. Foley
The Speaker
U.S. House of Representatives
H-204, The Capitol
Washington, D.C. 20515

Dear Mr. Speaker:

As an outspoken supporter of the President's health care plan and one who has advocated broad health reform throughout my career in the House, I write to express my deep concern over a potential procedural problem that seriously threatens our chances of passing meaningful reform next year.

To date, no coherent procedural strategy has been discussed or devised for processing the President's bill. In the absence of such a strategy, the process for consideration of the bill will become so chaotic as to destroy any opportunity to develop, consider, or pass a serious bill next year.

The Administration has promised to deliver a bill to the Congress within two **weeks**. When that occurs you will face two broad choices: a joint referral to all affected committees without time limitation; or a structured referral designed to produce a coherent piece of legislation in a timely fashion through sequential consideration of the bill's parts. The former is a recipe for disaster; the latter is the sine qua non for delivering the promises of the President's bill to the American people.

The first option guarantees a Tower of Babel approach in which conflicting claims and provisions yield a health care system even more irrational than today's. It would essentially require the Rules Committee to discard all the Committee-reported bills and have the measure redrafted in its entirety. This is not an outcome that we should design or allow to happen except in the most desperate of circumstances.

The second option requires early planning and consultation, but has the virtue of allowing orderly consideration through a process that members know and understand.

Major legislation has always demanded weeks or months of planning, including discussions about such matters as jurisdiction, timing, and collaboration. This must precede formal consideration of the bill, and perhaps even its drafting, if chaos is to be avoided. Remarkably, as we endeavor to receive perhaps the largest and most important piece of legislation this body has considered in recent times, no discussions have occurred and none seem planned.

The House through its Committee structure is well equipped to process this legislation. However, a bill of this magnitude will require order and discipline among Committees and individual members, which must be imposed following consultation and negotiation. I believe that unmanaged competition is no more appropriate here than in the health field.

The easiest procedural course in the short run is often the worst and hardest in the long-run. I know we all care deeply about passage of this legislation. I urge you, together with the other Members of the leadership, to call together immediately the chairmen of the three committees with the dominant jurisdictional interests in the bill to provide suggestions to you for a process by which this legislation can be enacted during the 103rd Congress.

I am sending an identical letter to each member of the Democratic leadership and look forward to the leadership's early response.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

cc: The Honorable William D. Ford, Chairman
Committee on Education and Labor

The Honorable Dan Rostenkowski, Chairman
Committee on Ways and Means

cc: Jia, Melanne, Chris

PETER HOAGLAND
2ND DISTRICT, NEBRASKA

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Congress of the United States
House of Representatives

COMMITTEE ON
WAYS AND MEANS

SUBCOMMITTEES:
TRADE
SELECT REVENUE MEASURES

August 27, 1993

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

Dear Mrs. Clinton:

In our recent telephone conversation I expressed concern regarding the impact that *exclusive* Health Alliances would have on my constituents within the Second Congressional District of Nebraska. Among those constituents are a number of health insurance carriers that employ approximately 15,000 individuals in the Omaha metropolitan area. During our call you requested that I follow up with written observations on the issue.

I want to make clear that I support your objectives for comprehensive health care reform, particularly in terms of universal access and cost containment. However, I believe some critical issues need to be resolved. A pressing issue relative to my district is the proposed exclusivity of Health Alliances. I would like to address my concerns in terms of the negative impact on both health care consumers and indemnity insurance carriers in my district. Also, I will present some overall concerns I have regarding the concept of exclusive Alliances; concerns I believe have validity beyond my district.

Structure of Health Alliances and Accountable Health Plan

It is my understanding that one or more Health Alliances will be created within each state, acting as a "benefits manager" for individuals and employers. The Alliances would contract with Accountable Health Plans (AHPs) which would offer a standard benefits package. *In an exclusive arrangement,* all individuals and employers situated within the boundaries of a Health Alliance will be required to obtain their coverage through the Alliance.

Members of the Task Force have argued that an exclusive arrangement is an absolute prerequisite for managed competition to be successful, the hypothesis being that if insurers can market outside the Alliance, they would select the healthiest persons. That issue can be resolved by establishing the same ground

rules for insurers offering plans through the Alliance and those marketing directly to consumers; specifically, by requiring guarantee issue in a mandated environment, and by implementing risk adjusters so that no insurer can benefit from a higher proportion of healthier persons, nor would any carrier suffer as a result of adverse selection.

Impact of Exclusive Alliances on Consumers in the Second District

From my perspective as a Representative of a predominantly rural State, I can identify several deficiencies in the concept of exclusive Alliances.

- Individual health insurance is an important source of coverage for persons in small towns and rural communities. Exclusive Alliances would force them to change their current coverage, potentially terminate long-term relationships with physicians and sever ties with insurance agents and companies even though they may be entirely satisfied with their current service and coverage.

- A premise of Health Alliances is the competition among several closely-managed health plans; many rural areas and small towns would be unable to support even one AHP. Certainly some limited aspects of AHPs, such as formalized peer and referral links, created by integrated delivery systems, could be viable in non-urban areas. However, competition and capitation, which are central to the concept, would not be feasible in sparsely populated areas.

- Exclusive Health Alliances do not permit the use of personal agents to assist persons in assessing needs and purchasing insurance. This is particularly crucial in rural areas where consumers have traditionally relied upon agents to assist them. With the removal of the employer resource and the agent, where will individuals go for personal assistance? *As with other government entities, I think it is reasonable to predict that Health Alliances will represent the collective interests of purchasers, with neither the capacity nor incentive to meet individual needs or provide personal service.*

- Exclusive Health Alliances could severely limit the choice of AHPs for my constituents if they are required to participate in only those plans sanctioned by a Health Alliance. The limitation of choice issue is discussed in greater detail later in this letter. Individuals and employers should have the choice of purchasing coverage through a Health Alliance or outside a Health Alliance, through an agent, broker or directly from an insurer.

Impact on Insurance Carriers and Jobs in the Second District

With 11 insurance companies headquartered or having a significant presence in the Second District (see attachment), Omaha has been called the "Hartford of the Midwest." Approximately 15,000 people within the Second District -- five percent of the non-agricultural workforce -- are employed in the health insurance industry.

Considering this presence, any provision of the proposed health care package which could negatively impact those jobs is of great concern to me. Although the *concept* of exclusive Alliances as currently presented would theoretically allow for all players, the *reality* is that exclusive Health Alliances could *totally eliminate* the individual market, thus effectively canceling the policies of 18 million Americans.

A health care delivery system structured around exclusive Health Alliances would have a natural bias toward group managed care products. The Alliance would not be conducive to indemnity free-choice plans either by overt exclusion by the Health Alliance, or due to an absent or ineffectual risk adjustment mechanism (as persons with serious health conditions typically prefer indemnity "free choice" plans). Therefore, I believe the exclusive Health Alliance as currently structured would eliminate jobs within the health insurance industry and ultimately limit insureds' choice of plans, physicians and hospitals.

Many of the companies on the attachment are smaller, indemnity carriers. Nevertheless, they collectively provide coverage and service to millions of people. They are quality-oriented, cost-effective companies that have every right to exist and remain competitive in a free-market system. These companies welcome every opportunity to compete with other insurers and health plans on the basis of cost, productivity and service. The effect of a mandated Health Alliance is effectively to legislate them out of business without the opportunity to prove their value.

Global Concerns about Exclusive Health Alliances

Though my overriding interest is the needs of my Second District constituents, I wish to offer some overall observations about the disadvantages of exclusive Health Alliances.

- An exclusive environment establishes the framework to shift away from a competitive environment. There is a need for an area outside the Health Alliance in which small, emerging health plans can develop, innovate and build the capacity to bid as Health Alliance participants. Without this "proving ground," AHPs will become concentrated, the relationship between Health Alliances and AHPs will get cozy, and the effort to achieve quality and cost-effectiveness will become regulatory as opposed to market-based.

• An exclusive environment removes any fall-back system if the concept proves unsuccessful. If an Alliance turns out to be unresponsive, inept or politically motivated, consumers will have no alternative for coverage or service. Citizens living in poorly run jurisdictions will feel betrayed. At the same time, Alliances will have no incentive to meet performance standards, other than the threat of regulatory penalties, which in itself requires another "watchdog" bureaucracy.

• The massive challenge of launching Health Alliances that can immediately begin serving millions of enrollees suggests that such Alliances should be piloted first, and that those pilots should not be exclusive. This will help assure continuity of care and prevent disruption to millions of Americans.

These more global concerns only serve to reinforce the projected negative impact of exclusive Alliances on my constituents within the Second District. I am anxious to be a proponent of the health care plan enacted by Congress. And I believe that with diligent attention to such issues as exclusive Health Alliances, the resulting package can be one that works for all Americans. I thank you for the opportunity to present my thoughts to you on this matter and I look forward to working with the Administration on a health care package that will benefit all Americans.

With warm regards,

Sincerely,

Peter Hoagland

enclosure

HEALTH INSURANCE CARRIERS
LOCATED IN
SECOND CONGRESSIONAL DISTRICT

Central States Health & Life Company
Continental General Insurance Company
Guarantee America Life Company
Guarantee Mutual Life Company
Medico Life Insurance Company
Mutual of Omaha Companies
Mutual Protective Insurance Company
Physician's Mutual Insurance Company
Principal Health Care of Nebraska
Woodman Accident and Life
World Insurance Company