J. OLDER/DISABLED AMERICANS

POLICY BRIEFS:

AMERICANS WITH DISABILITIES
LONG-TERM CARE
PRESCRIPTION DRUGS

Q & A

- Prescription Drugs
- Use of prescription Drugs as incentive to draw Medicare beneficiaries into HMO's
- containing costs under Medicare -- PRO
- ~~CC~~ " " - CONCERNED ABOUT current Specs
- "Black listing" Drugs for Medicare coverage & Research Impact

POLICY BRIEF

DR

AMERICANS WITH DISABILITIES

Americans with disabilities are a large and diverse population. Of the estimated 35 to 43 million people with physical or mental impairments, a significant portion are of working age. For many, their disability status, compounded by the lack of available and affordable assistance, renders them unable to get health insurance, and disadvantages their job prospects.

In a health insurance industry that competes by insuring only the healthiest people, Americans with disabilities are often discriminated against, dubbed "high risk" applicants because they may have higher health care costs. Those who are able to obtain insurance are often forced to pay the highest rates in the market, and are still faced with a lifetime limit on benefits. After that, they're on their own.

Americans with Disabilities Guaranteed Comprehensive Insurance:

- Under health reform, all Americans -- including those with disabilities -- are guaranteed access to comprehensive insurance coverage at the agreed-upon community rate. Like all other Americans, persons with disabilities will be able to choose their doctor and health plan.

- The benefits they receive will include not only acute-care services, but also covered rehabilitative services in both inpatient and outpatient settings.

- There will be no lifetime limits on care -- a change that will free many Americans with disabilities to go to work without the fear of losing the health benefits they now get through Medicaid or to live without fear of losing their private health coverage.

Community-Based Long Term-Care Will Provide New Assistance:

- A new community-based long-term care benefit will aid Americans of all ages with severe mental or physical disabilities, without regard to income. This will benefit 840,000 Americans.

- Children under the age of six with a severe disability or chronic medical condition would otherwise require hospital or institutional care will also be able to receive this home and community-based assistance.

- Personal assistance will be part of the array of services offered. Through the new home and community-based program, a broad range of personal assistance services will be available to children and working age adults with severe disabilities.

- States will have the flexibility to design their own approaches to community-based care and to expand its reach beyond personal assistance. States may include case management, homemaker and chore services, home modifications, respite services, assertive technology, adult day care, and rehabilitition services.

- For low-income persons with lesser levels of disability, states will be able to continue their home and community-based programs under Medicaid.

New Tax Credit for Workers with Disabilities:

- Under health reform, employees with disabilities who require personal assistance with daily tasks will be eligible for new tax credits covering 50 percent of their personal care service costs up to a maximum of $15,000 each year.

Improved Access to Health Care for Americans with Disabilities:

- The sum of these benefits, protections from discrimination in health care, and new services will substantially improve access to health services for Americans with disabilities.

Sep-93

DRAFT

LONG-TERM CARE

The current long-term care system is inadequate to meet the needs of the elderly and disadvantaged. Too often, many seniors and people with disabilities enter nursing homes and other institutions when they can, and prefer to, be cared for in their own homes. Not surprisingly, too many families must exhaust their savinngs in order to pay for needed care and to qualify for public assistance.

The Health Security Act creates a new long term care program through Title XV of the Social Security Act and expands existing ones. Aimed at providing more flexibility and greater choices to disabled Americans needing long-term care, the program will include the following components:

A New Program for Home and Community-Based Services:

- The Health Security Act will dramatically expand home and community based services to individuals with severe disabilities, without regard to income or age.

- States will have flexibility to design and define their community-based service system and may elect to offer vouchers or cash directly to eligible individuals.

- Home and community-based service programs will be funded through a federal/state partnership.

- At a minimum, states will be required to make a standardized assessment and an individualized care plan will be developed for those eligible.

- Individuals will pay co-insurance to cover a portion of the cost of services, based on to a sliding scale.

Medicaid Institutional Coverage Expanded:

- States will establish a medically needy program for residents of a nursing home or intermediate care facility for the mentally retarded.

- The living allowance for residents of nursing homes and intermediate care facilities for the mentally retarded will be increased from $30 to $100 per month.

- Residents will also retain up to $12,000 in personal assets -- up from $2,000 -- in determining eligibility for Medicaid coverage.

Private Long-Term Care Insurance Improved:

- The quality of private long-term care will be improved by establishing minimum standards for long-term care insurance products and requirements for monitoring, enforcing and regulating the sales of such products.

- Long-term care policies will include group and individual annuities and life insurance policies, rider or certificate that primarily offer supplemental coverage.

- Excluded are life insurance policies that provide accelerated payment of benefits and a lump-sum payment in which neither the benefits nor eligibility are based on the need for long-term care services.

Tax Treatment:

- Employed disabled individuals may obtain a tax credit for 50 percent of their costs, up to a $15,000 maximum per year.

- Tax treatment of premiums will include an itemized medical expense deduction, and an exclusion from taxable income of amounts paid for services or as cash payments.

Demonstration Studying Integration of Acute and Long-Term Care:

- Secretary of HHS will conduct a demonstration program for integrated models of acute and long-term care services for individuals with disabilities and chronic illnesses.

Sept. 93

DRAFT

PRESCRIPTION DRUGS

Prescriptions drugs are frequently the most cost effective intervention to treat medical conditions. However, these potentially life-saving products are often inaccessible because there is inadequate insurance coverage for Americans and because the cost of pharmaceuticals have far outpaced the general inflation rate. Until very recently, prescription drug price increases dwarfed percentage increases in the rest of the economy. Between 1980 and 1992, while the general inflation rate increased by 22 percent, drug prices increased 128 percent. New medications, especially biotechnology drugs -- although full of potential to advance medical treatment advance potential, are extremely expensive.

Almost 25 percent of Americans under age 65 do not have any type of public or private prescription drug insurance coverage. As a result, expensive, frequently taken medications (like antibiotics for children) become such a financial burden that many vulnerable populations go without.

The high cost of prescription drugs and their heavy reliance on medications, cause a significant financial burden for Older Americans. Since Medicare does not cover outpatient prescription drugs, only 46 percent of all drug costs for seniors are paid for by public or private insurance plans. As a result, prescription drug costs are the highest out-of-pocket medical costs for 3 out of 4 older Americans. A recent AARP study found that nearly 8 million Americans over the age of 55 report that they must choose between buying food and paying for prescription drugs.

Coverage for Prescription Drugs Included within the Comprehensive Benefit Package:

- All health plans for the under 65 population will be required to cover outpatient prescription drugs. Under the low-cost sharing option plan, the beneficiary will pay $5 per prescription. Under the high-cost sharing option plan, the beneficiary will be covered for 80 percent of his/her prescriptions after a $250 deductible is met. The insured person's copayments will count towards the overall out-of-pocket $3,000 cap.

Provides a New Medicare Outpatient Prescription Drug Benefit:

- Like the nationally guaranteed package, Medicare beneficiaries will have 80 percent coverage for their medications after a $250 deductible is reached. In addition, a $1,000 annual cap is placed on out-of-pocket prescription drug costs. Costs above this amount will be fully covered.

Drug Costs for the Under 65 Population will be Controlled:

- The national guaranteed benefit, offered by private sector plans, will use managed care purchasing mechanisms to hold down the rate of growth of current drug prices. For new drugs, private purchasers will have the benefit of information provided by the National Health Board about the appropriateness of prices. The Board cannot regulate prices.

Provides for Cost Containment of Medicare Prescription Drug Benefit:

- The Medicare program, which will become the world's largest purchaser of medications, will receive a discount for prescription drugs currently on the market. Without the authority to use parallel private sector purchasing tools, the Secretary of Health and Human Services will be given authority to negotiate the price of new drugs for the Medicare program.

Patient Counseling by Pharmacists:

- To help avoid unnecessary, inappropriate and expensive hospitalizations, pharmacists will be required to provide patient counseling.

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QUESTIONS AND ANSWERS

PRESCRIPTION DRUGS

BACKGROUND QUESTIONS

What was the philosophy in structuring the Medicare drug benefit? Aren't we starting a new entitlement we cannot afford?

- All very good questions. There is a lot of misinformation already out on the streets that need to be cleared up.

- First, because of the costs, the lack of coverage of prescription drugs, and the potential cost effectiveness of pharmaceuticals, the President has always been committed to providing some type of prescription drug coverage for all Americans. Drug costs represent the highest out-of-pocket medical cost for 3 out of 4 elderly. The President concluded it was a problem we literally could not afford to ignore.

- We consulted extensively with the industry. They thought the private sector managed care purchasers were now quite effectively containing health care costs through the use of formularies and other negotiating mechanisms. They encouraged us to, as quickly as possible, establish incentives to integrate the Medicare system into these privately managed plans. That way, they argued, we could expand coverage and contain costs in a way that was acceptable to them. We did just that.

- By requiring any non-fee-for service plan to also contract out with the Medicare program as an alternative option to Medicare beneficiaries, we will be dramatically expanding the elderly's access to privately administered, managed care plans. They will be attracted to join these plans by small copayments for medications and other expanded benefits over and above what Medicare now offers. And, as you may know, we are providing for additional <u>options</u> for Medicare beneficiaries to retain or obtain private sector coverage.

- However, for those Medicare beneficiaries who do not wish to give up their current fee for service option, we could not advocate not giving them access to any drug benefit. That would not be fair. So, we developed a drug benefit that largely parallels the fee for service benefit for the under-65 population.

Why not use prescription drugs as incentive to draw Medicare beneficiaries into HMOs? (Sen. Chafee)

ANSWER:

- We're already doing that, and we will continue to do so. In fact, under reform, we will be significantly expanding access to Medicare HMOs and other managed care private settings.

- These HMOs and other alternative plans will provide even better coverage than we are talking about with the new drug benefit. This is the case, as you know, because many of these HMOs offer drug benefits with no or very little deductible and a very low copayment.

- However, did not want to set up a false choice between having access to their fee for service doctor (the highest priority of the elderly) and having access to needed drug coverage (their highest out-of-pocket cost.

- Having said this, there may be better ways to set up incentives and to structure the benefit package. We are certainly open for suggestions and look forward to discussing this with you.

KEY INFORMATION:

- Some HMOs currently provide prescription drugs for Medicare enrollees at no additional charge, and some Medicare beneficiaries do enroll in those HMOs in order to get the prescription drug benefit.

CONTAINING COSTS UNDER MEDICARE -- PRO

(THIS MIGHT BE A PRYOR-LIKE QUESTION)

QUESTION:

The Administration has already given into the drug industry on a number of fronts. First, the National Health Board has no regulatory authority whatsoever to contain the costs of prescription drugs in the private sector. Second, you have dropped your plans for short term price controls for pharmaceutical companies. Lastly, as I understand it, you have agreed to the industry's request to not allow Medicare formularies to be used to contain drug prices. Why have you done this and are you going to be hang strong on the few other provisions you have now to contain at least Medicare drug prices? Already there is an onslought of drug company lobbying going on?

ANSWER:

- There are many wide ranging opinions on this issue. We believe it is essential to contain prescription drug costs for the Medicare program and for all purchasers. We believe our proposal represents a solid middle ground from all sides of the debate.

- We have no plans to significantly alter these provisions at this time. The Congress has many opinions on these subjects and we look forward to working with you and your colleagues in the weeks and months ahead.

CONTAINING COSTS UNDER MEDICARE -- CONCERNED ABOUT CURRENT SPECS

QUESTION:

How are you going to contain costs for the Medicare drug benefit? I hear you are going to ask for large rebates and, for new drugs, actually have the authority to arbitrarily "blacklist" drugs you conclude are too expensive.

ANSWER:

- First, the President, as well as the Secretary, has a fiduciary responsibility to the taxpayer and the Medicare beneficiary to ensure the program has access to reasonable drug prices. After all, Medicare will now be the largest single purchaser of medications in the world. We deserve some level of discount; no one disputes that.

- Second, in response to the drug industry's vehement opposition to the concept of Medicare being able to use formularies, we decided to not give the authority to the Secretary to utilize these private sector purchaing techniques. (The industry argued that a Medicare formulary would drive all other formularies in the nation.)

  In the absence of this authority, we had to ensure that the program had access to affordable pharmaceutical prices for drug products currently on the market. We came up with a formula that ensures that the Medicare receives a discount of about 15-17 percent. (In actuality, many other private sector purchasers now get a much greater disount.)

- For new drugs, since we would not have the authority to exclude a particular drug -- like the private sector can using its formulary -- it became clear that we needed to have some authority to negotiate the manufacturers over price.

- It is important to note, however, that is not a new, radical concept. **The Congress just gave the Secretary the same authority to do just that with drug products used for immunizations.**

- Lastly, it is also important that you know that there are Members of Congress on both side of this debate. Some feel strongly that we did not go far enough in our drug cost containment provisions; others feel we went too far. We are willing and looking forward to listening to all sides of this debate.

"BLACKLISTING" DRUGS FOR MEDICARE COVERAGE AND RESEARCH IMPACT

QUESTION

Won't all your prescription drug cost containment mechanisms -- particularly the Secretary's "blacklisting" authority kill all incentives for investment in research for medications for the elderly and the disabled?

- No, because the Secretary would rarely use the authority and all the investors know it. For example, if there was a new drug treatment for Alzheimer's, how many Secretary's -- or Presidents for that matter -- would stand in the way of Medicare coverage. (DO NOT SAY BLACKLISTING -- THAT IS THE INDUSTRY's WORD).

- The reason the Secretary has the authority, however, is to have a fall-back negotiating mechanism in case the Medicare trust fund and the taxpayers who support it become at risk because some bad apple drug industry representative prices a product at an unreasonably high level. We hope and expect that the industry is now more sensitive to launch drug prices.

- We have discussed ways to better define how and when the Secretary could use this authority. As with all issues, we are open for suggestions from all sides of this debate.

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K. MEDICARE

POLICY BRIEFS:

MEDICARE

Q & A

- Medicare Savings

POLICY BRIEF

DRAFT

MEDICARE/OLDER AMERICANS

Older Americans will see little difference in where, how or from whom they receive their health care under the Health Security Act. This proposal does not involve cutting Medicare-- it involves spending Medicare money differently, and increasing benefits for older Americans.

What older Americans pay -- their share of the cost of health premiums -- will actually decline as growth in the cost of Medicare comes under control, reducing annual cost increases not only for Medicare but also for Medigap policies.

Medicare benefits will be expanded to cover the costs for prescription drugs, as well as home- and community- based long-term care. The expected savings in Medicare will be rechanneled into those new benefits.

Controls Spending without Shifting Costs or Cutting Benefits:

- The plan to slow the growth in Medicare by $124 billion over five years is comparable to the most serious entitlement caps called for during the budget process, but because it is done within the context of comprehensive health care reform, it will not shift costs to the private sector and will be part of a plan, that will, in fact, increase health benefits to older Americans.

No Cost Shifting to the Private Sector:

- Calls for strict entitlement caps on Medicare outside of health care reform would have led to a hidden tax on private sector premiums. Outside of the health care context, if Medicare payments were simply cut -- so that a hospital was paid $100 for a service that they used to pay $150, the hospital is likely to simply charge everyone else $50 more, rather than try to control costs. Under reform, providers cannot simply pass on costs because of limits on private sector premiums growth.

A New Prescription Drug Benefit:

- Under the new drug benefit, Americans eligible for Medicare will automatically enroll in the new prescription drug benefit when they enroll in the Part B benefit, which 97 percent of eligible individuals do. Part B premiums will increase to cover 25 percent of the cost of the new benefit, the standard level of beneficiary contribution for Part B under the current program.

- The new drug benefit carries a $250 annual deductible before coverage begins. Beneficiaries also pay 20 percent of the cost of each prescription up to $1,000. Prescription costs in excess of $1,000 are fully covered by the new benefit. The prescription drug benefit covers all drugs and biological products, including insulin, approved by the Food and Drug Administration and prescribed for medically accepted indications.

Integrating Medicare Into The New System:

- The Medicare program will continue primarily as a fee-for-service health program until the new system is running smoothly. However, the Medicare program will offer beneficiaries a wider range of choices of health plans, including health maintenance organizations and preferred provider networks.

- After a state's system has been established, newly eligible individual Medicare beneficiaries will have the choice to remain in their health plans through the alliance or join Medicare.

- Once a state's system is successfully up and running, they also will have the option of integrating all their citizens, including Medicare beneficiaries , into their alliances or single payer systems.

- States must submit a plan to the Secretary of Health and Human Services and guarantee that all eligible beneficiaries have equal or better coverage than under Medicare, at no additional costs to the Medicare program.

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QUESTIONS AND ANSWERS

UNTIED

Medicare Savings

How is it possible to accomplish $124 billion in Medicare savings without reducing the benefits of Medicare beneficiaries?

Medicare savings must be viewed in the context of overall health reform.

Without overall health policy reform we would oppose savings of this magnitude, because there would be no way to protect Medicare beneficiaries from serious risks of benefit reductions.

During the budget debate the Administration opposed an "entitlement cap" for this very reason. The cap would have forced reductions in the Medicare program -- whether or not we accomplish overall health care reform controlling private sector health care costs -- and whether or not beneficiaries could be protected.

In the context of health reform Medicare beneficiaries can be protected.

Health care reform will protect against two factors which now make it difficult to contain Medicare costs without hurting beneficiaries: cost shifting that results from uncompensated care and price pressures arising from the difference between private and public reimbursement rates.

Universal coverage will make it unnecessary for providers to look for ways to shift costs for uncompensated care to paying customers -- which includes Medicare as well as private insurance.

Controlling private sector health costs will bring public and private reimbursement rates closer together. By restraining the growth in spending on the private side, it is possible to restrain the growth on the public side while at the same time reducing the risk that providers will elect not to treat Medicare patients in favor of patients with private insurance.

The health plan will not reduce Medicare spending. It will only slow the rate of growth from three times inflation to twice inflation. In the context of universal coverage and corresponding private sector cost restraint, there is no reason why this reduction in the rate of growth should harm beneficiaries.

In contrast to other proposals, the Administration only supports Medicare savings of this magnitude in the context of health reform.

43 Senators voted for the entitlement cap without a corresponding cap in private health care costs, and without any assurances about the impact on Medicare beneficiaries.

Other health care proposals call for Medicare savings comparable to or greater than ours, but fail to meet the critical test of protecting beneficiaries because they fail to provide universal coverage (and therefore put an end to uncompensated care) or to

control private health care spending (and therefore reduce the differential between private and public reimbursement).

The Clinton Administration only supports Medicare savings of this magnitude in the context of health reform that removes these risks that beneficiaries will be hurt. The Chafee/Dole plan, in contrast, would result in comparable Medicare savings [$111 billion]. However, the Chafee/Dole plan would not guarantee cost controls in the private health care system and it would not guarantee universal coverage or expanded Medicare benefits.

Reform and Competition will reduce Medicare costs.

Competitive forces will reduce the cost of health care for people over 65 as well as for people under 65. With cost differentials of 300 percent between Miami and Wisconsin, there is much room for savings from competition.

Streamlined administrative procedures will reduce the costs to providers of caring for Medicare patients.

Health reform plan will specify detailed policies to achieve Medicare savings.

Unlike proposed "entitlement caps" which leave the difficult task of finding specific savings to be determined in the future, the health reform plan will propose specific policies to achieve $124 billion in savings over five years.

If Congress believes that other specific measures are more appropriate, we will work with Congress on designing alternative savings measures.

The Administration is firm on the amount of Medicare savings that are necessary. If the specific measures that are enacted fail to meet the projected spending levels, we are prepared to work with Congress on streamlined procedures to ensure that policies are put in place to achieve the spending targets.

Medicare savings will be used to provide new Medicare benefits.

Savings from Medicare will be used to finance prescription drug benefits and long-term care benefits for Medicare recipients.

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L. MEDICAID

POLICY BRIEFS:

MEDICAID

Q & A

POLICY BRIEF

DRAFT

MEDICAID

Medicaid, the joint federal-state program that provides health coverage to low-income Americans, is a mixed blessing for those it serves. Medicaid coverage can serve as a disincentive to join the workforce. Employment means forgoing Medicaid benefits but obtaining an entry level position which increasingly does not include health coverage. A Medicaid card, however, does not guarantee care. Low reimbursement rates and the stigma attached to the program have caused many providers not to accept Medicaid patients.

Medicaid Beneficiaries will be Full Participants in the Health Care System:

- Medicaid recipients will carry the same health security card that other Americans carry.

- Medicaid patients will choose among health plans offered by regional alliances, just as all other Americans will choose.

- The Health Security Act will remove the stigma attached to obtaining health coverage through Medicaid.

Medicaid will Contribute to Alliances for Coverage of Beneficiaries:

- Under the Health Security Act, Medicaid will continue as a separately funded program for persons receiving cash assistance (either AFDC or SSI). Non-cash assistant recipients of Medicaid will now obtain coverage through alliances based on their employment status. As state health alliances begin operations, Medicaid patients will move into health plans offered through regional alliances, integrating care now delivered under Medicaid into the new system of universal health insurance coverage.

- Just as private sector employers make payments to the alliance to cover the health insurance costs of their employees, the Medicaid program will make payments to the alliance to cover the health insurance costs of Medicaid, cash assistance recipients.

- Health plans will receive the same payment from the alliance regardless of the enrollee's Medicaid status -- so that health plans don't treat Medicaid patients any differently than anyone else-- promising an end to two-class medicine.

Benefits not Covered by Comprehensive Benefits Package Continue:

- Medicaid will continue to offer additional benefits not covered in the comprehensive benefits package -- such as transportation, language interpretation and child care during clinic visits.

Integration of Medicaid will Provide Relief to States:

- Integration of Medicaid into the new health care system will provide substantial fiscal relief to state and local governments. Non-cash recipients of Medicaid will now receive coverage through the alliances, based on employment status.

- For non-cash assistant Medicaid recipients, coverage will be provided based on their employment status, like everyone else's. This move will bring significant relief to states.

- Medicaid will make capitated payments to health plans on behalf of AFDC and SSI cash recipients based on prior levels of spending for these populations in the state. Payments to alliances will be tied to the rate of growth of the budget rather than the much higher levels currently projected without reform. This will free up state resources for other pressing concerns.

Reform will Reduce Disincentives to Work for Medicaid Recipients:

- Reform will also benefit Medicaid recipients and public sector budgets by reducing welfare lock. Many women cannot afford to go to work because of the threat of losing health care coverage for themselves and their children. Health reform will free these welfare recipients to pursue work and economic independence without the threat of vulnerability to a medical crisis without health coverage.

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M. FINANCING

POLICY BRIEFS:

FINANCING SUMMARY

Q & A

POLICY BRIEF

SUMMARY OF FINANCING FOR HEALTH SECURITY PLAN

I. THE MAIN WAY WE PAY FOR HEALTH INSURANCE IS BUILDING OFF THE OUR SYSTEM OF PRIVATE SECTOR FINANCING THAT WORKS BEST.

Under our current system, most people are covered through their employers. Currently, 90% of Americans who have private insurance through their employers.

Yet, some do not pay, which is bad for millions of families without insurance who live in fear, and bad for those of us with who end up paying for the costs of the uninsured, because when they get sick we don't turn them away, we give them care in emergency rooms and the rest of us pay the bill.

Because a fundamental premise of our plan is to build on the building blocks of our health system that work, our plan builds on the employer-based, private sector provision by making employers who do not provide insurance to their workers pay for comprehensive care for all of their workers. Some call this an employer mandate, but we think it is about responsibility, about ending the penalization of firms that do provide insurance for their employees.

Many people who are interested in financing have missed the basic fact that the substantial portion of the financing for health security comes from extending our current system. Currently, insured employees and their employers cover 140 million Americans. As you can also see today, 22 million receive inadequate coverage and 37 million receive no health insurance. The major piece of financing for those under 65 is the requirement that all employers and employees will be responsible for their health care. Indeed, of the funds needed to pay for proving all Americans health security, two-thirds comes from the simply making all American employers and employees who can bear responsibility for health care.

So the simple answer to the question, how can we cover so many people without a general tax increase is that we are asking every employer to be as responsible as the great majority of employers are today.

So while we believe that nearly every American will be better off through the Health Security Plan, there is no free lunch. Those who do not pay for health coverage for their employers or themselves currently, will pay more under our plan.

II. GOVERNMENT IS NEEDED TO PROVIDE PROTECT JOBS AND PROVIDE SECURITY WHEN AMERICANS LOSE THEIR JOBS:

A health plan could, of course, do nothing more than require all employers and employees to pay their fair share. If this were all we were doing we could rely solely on private sector financing, and our plan would affect only those who do not provide or get health coverage.

This system leaves three holes that are still left by even making this system.

First, we believed that it would be too hard on business and some low-income individuals to require those who do not provide to do so right away with no transitional help from government. We believe that everyone should be responsible, but we recognize that as it has not been that way, we must provide assistance to business -- particularly small business -- so that the cost of transition is manageable and will not hurt job growth.

Some have said our discounts to small business and to some large manufacturer have been generous -- and to this we plead guilty. But I think we need to find a way to have small businesses that create jobs and provide health care to their workers and I think we cannot ignore the harmful effects to our competitiveness and manufacturing base when a car made in America has $1100 more dollars due to health care than one in Japan.

Second, another key reason that an requiring all employers to provide alone would not be significant, is that this alone would not provide the core of our plan and the core of what we believe Americans most want -- health security. Employer coverage alone, does not provide every American with true security because it does not answer the question of what we do for Americans who lose their jobs, their health insurance and potentially all of their savings if they were to fall ill when they are unemployed.

So we need public sector funding if we are to say to every American that they will always be covered even when they are unemployed.

All together the subsidies and discounts needed to provide discounts to small -- and some large -- business, and to the working poor and the unemployed comes to $160 billion -- a $169 billion if you include the 100% deduction to the self-employed between now and the year 2000.

The third reason that we believe we need to look to benefits beyond full employer responsibility is that we believe that there are holes in the coverage we provide senior citizens. While Medicare works well overall, its costs rise too high and therefore means we spend such high rates on provider payments that we do not have enough funds to pay for benefits seniors very much need -- drug benefits and long-term care.

Therefore, our plan cuts provider payments on Medicare so that we can shift those funds to pay for the long-term care and drug benefits.

Unlike other proposals in the past, we won't do it with vague caps. We will do it with specific, scorable, line-by-line savings proposal.In the past it has also been difficult to achieve significant savings in the growth of Medicare or Medicaid for a few reasons:

First, because it was outside the context of health care reform, savings were assumed to be from the cuts in the middle class or poor. Let me be clear, this President has no intention of putting those beneficiaries at risk. Indeed, Medicare recipients will see their benefits increase through the President's plan.

For every $1 of savings we are calling for that affect Medicare beneficiaries, we are proposing $3 in increased benefits in long- term care and drug benefits.

Second, past proposals weren't reforming the private sector side, people rightly worried that costs would be shifted to the premiums of the insured middle class and small businesses who were already taking the worst hit, and

Third, this would create a differential between Medicare patients and others. In the context of a plan to bring down private sector costs, however, we can reduce Medicare savings without shifting costs or creating a differential.

The costs of the long-term care program over five years is $80 billion and the costs of the prescription drug benefit is $72 billion. As with the under 65 benefits, the financing of these benefits is straightforward and largely uncontroversial. 80% of the costs are paid for by $124 billion in Medicare savings. The rest is more than paid for by capping the amount of Medicaid spending by taking these Americans out of Medicaid and putting them with everyone else in the private, alliance system.

Now, many may not agree with our policies. Others may not think you can pass these many Medicare savings. Again, we disagree. But let's be clear. These are line, by line specific scorable savings in Medicare, and it is a disservice to public discourse for people to in any way say that these are not real.

Our plan and every Democratic and Republican plan that has been proposed recognizes that with national health care reform, we can save money in the rate of growth in Medicare and Medicaid. Indeed, the other serious proposal so far have comparable Medicare savings, and the Senate Republican budget proposal received 43 votes and received had at least as much savings -- with no offsetting benefits. You will debate how fast those savings can be achieved and how big those savings can be, but I think we all agree that there will be savings that will be our second major source of financing for health care reform.

PRIVATE AND PUBLIC NUMBERS ON HEALTH SECURITY PLAN

I. PRIVATE FUNDING OF HEALTH SECURITY PLAN

• Two-thirds of premium cost of ensuring health security for all Americans, comes from making all those who don't pay now, and can afford, start bearing responsibility for health care.

• That means in the first year (1994 dollars), the overall costs would be approximately $61 billion. $25 billion would be from business spending; $14 billion from households, and $21 billion from government.

[NOTE: The $21 billion government cost grows to average $32 billion a year, $160 billion over five years, because of inflation and of because of a $20 billion cushion built in as a contingency against uncertainty.]

II.SEVEN YEAR TOTAL FEDERAL COSTS FOR HEALTH SECURITY PLAN

USES OF FUNDS FOR HEALTH CARE REFORM:

Long-term Care	$80 billion
Medicare Drug Benefit	72 billion
Public Health/Admin Costs	29 billion
Discounts for Businesses and Workers	160 billion
100% Self-Employed Deduction	9 billion
Total For Health Care	$350 billion
Deficit Reduction	91 billion
TOTAL HEALTH CARE/DEFICIT REDUCTION	$441 billion

SOURCES OF FUNDS:

Medicare	$124 billion
Medicaid	114 billion
Reductions in Federal Programs	47 billion
Reduction in Growth of Tax-Free Benefits	51 billion
Sin Taxes/Corporate Assessment	105 billion
TOTAL	$441 billion

THE $259 BILLION SHIFT: The Clinton plan has inaccurately been described as calling for $700 billion more in government health care spending. The source of this confusion is the shift of $259 billion among federal programs, which amounts to an accounting change. Currently, under Medicaid, the federal government and the states reimburse providers. Now, rather than sending that money directly to providers, the government will send the same money to cover the same people through the regional alliances. If a company spent $1 million on employee health insurance through Insurer A, and then shifted to Insurer B, no one would see that company as spending $1 million more. The same is the case here. In addition, more Medicare beneficiaries who work will have employer-paid insurance as their primary payer, reducing costs to the Medicare program.

III. EVIDENCE AND EXAMPLES OF WHY THE CLINTON HEALTH SECURITY PLAN WILL BRING SAVINGS:

There are many people who doubt that we can save money when we reform our health care system. But evidence in this country and abroad shows that the kinds of changes we are proposing -- increased competition backed up by a limit on premiums -- can control costs.

1) **By reducing uncompensated care, we will achieve clear savings.**

Today, the government reimburses doctors and hospitals for $25 billion worth of "uncompensated care" -- care given to uninsured patients who can't afford to pay their medical bills. With universal coverage, that cost will disappear.

2) **Our international competitors control costs and provide security to all their citizens.**

Germany and Japan have been able to keep the growth in their health care costs down to GDP while ours have been growing at 9% and 10%.

3) **States that have tried reform have been able to control costs.**

Look at Minnesota. It has kept its annual rates of increase 2% below statewide trends for the last two years after reform.

4) **Health plans today that are cost-efficient, provide high-quality care, and emphasize prevention can control costs.**

The Mayo Clinic has kept its growth down to 3.9%.

In Northern California, Kaiser Permanente members have 25% fewer hospital days per capita than other residents.

5) **More information about health outcomes can point to potential areas of savings. More money spent doesn't always mean higher quality care.**

Open-heart surgery that costs $21,000 in one Pennsylvania hospital costs as much as $84,000 in another hospital in the same state. And, the lower-cost hospital had better outcomes.

The Central Florida Health Care Coalition persuaded hospitals to analyze why costs and quality of care differed for patients with the same illnesses. With this information, costs per hospital discharge fell 2%.

6) **Streamlining administration and cutting paperwork will save money.**

Under today's system, up to 30-40% of the premiums paid by small firms goes to administrative costs. Under reform, firms with 5,000 or fewer employees will join together to lower administrative costs.

A growing share of the health care dollar pays for processing paper. For every doctor hired at a hospital, there are four administrators hired. Under reform, a single claims form replaces the hundreds of different forms. One comprehensive benefits package, and standardized reimbursement rules, procedures and regulations will cut administrative costs.

7) **Putting consumers in the drivers' seat and forcing health plans to compete for their business will bring down costs.**

In California, when consumers joined together in a large purchasing pool, they received bids on one plan that were as much as 55% lower than the same plan offered by the FEHBP.

In Orlando, the 78-member Central Florida Health Care Coalition succeeded in negotiating better prices with regional hospitals that enabled the Orange County School Board to keep 20 teaching jobs it had planned to cut.

In Memphis, eleven employers, the Memphis Business Group on Health, commissioned a study in 1987 that found that some hospitals charged as much as 80% more for the same service. The group published the findings and took competitive bids for its business (25,000 employees). One hospital, Baptist, offered discounts of up to 20%, and the members of the coalition believe that they have saved tens of millions of dollars.

8) **Prevention will save money in the long-run.**

Look at Birmingham, Alabama. In 1983 the city government's health care expenses were rising at twice the national average. Officials launched a full-scale prevention program. From 1985 to 1990 the city's health costs did not rise, even as the price of care skyrocketed. By investing $3 million in health promotion, Birmingham officials estimate they saved $10.5 million over five years.

QUESTIONS AND ANSWERS

QUESTIONS AND ANSWERS ON FINANCING

Q: How can you cover everybody and maintain quality and give comprehensive benefits and add preventive care and new drug benefits and look at me with a straight face and say that you're going to pay for all that by cutting waste?

A: I'm glad you asked that because that's not how this plan will be financed. Let me tell you how we propose paying for health care reform.

There are three basic sources of funding.

1. First, we ask the 37 million people who don't have insurance and companies who don't provide it to their employees to take responsibility and contribute to the system. Right now, all of the rest of us are paying the price for the uninsured -- and that's just not right. But it's also not right to continue a system in which the vast majority of the uninsured -- 85% of them who are working people or their families -- can't afford health insurance. We're going to ask them to take responsibility to help finance the health care system, but we're also going to make sure they can afford to -- with discounts for low income workers, the unemployed, and low-wage and small businesses.

Two-thirds of the financing for premiums to ensure that all people are covered comes from asking employers and employees who don't pay now, to start taking some responsibility.

Now, there are a number of different proposals about how those 37 million should contribute to the system. We propose an extension of the current system where employers take the primary responsibility, but individuals share that responsibility. That's a pretty conservative idea which was first introduced by Richard Nixon. Others believe that primary responsibility should be only with the individual -- an individual mandate, not an employer mandate. Many fear that an individual mandate will disrupt the current system: that it will cause employers to drop people from their coverage. I assume that's a debate that Congress will have in the coming months.

2. Second, we are going to limit the growth of government spending. We all know that it's tough to stop government spending, but we do think we can slow it down. And unlike other proposals in the past, we won't do it with vague caps. We will do it with specific, scorable, line-by-line savings proposal.

In the past, we haven't been able to achieve savings in the growth of Medicare or Medicaid for a few reasons: First, because it was outside the context of health care reform, savings were assumed to be from the cuts in the middle class or poor. Let me be clear, this President has no intention of putting those beneficiaries at risk. Indeed, Medicare recipients will see their benefits increase through the President's plan.

For every $1 of savings we are calling for that affect Medicare beneficiaries, we are proposing $3 in increased benefits in long-term care and drug benefits. Second, past proposals weren't reforming the private sector side, people rightly worried that costs would be shifted to the premiums of the insured middle class and small businesses who were already taking the worst hit, and that third, this would create a differential between Medicare patients and others. In the context of a plan to bring down private sector costs, however, we can reduce Medicare savings without shifting cost or creating a differential.

Our plan and every Democratic and Republican plan that has been proposed recognizes that with national health care reform, we can save money in the rate of growth in Medicare and Medicaid. Indeed, the other serious proposal so far have comparable Medicare savings, and the Senate Republican budget proposal received 43 votes and received had at least as much savings -- with no offsetting benefits. You will debate how fast those savings can be achieved and how big those savings can be, but I think we all agree that there will be savings that will be our second major source of financing for health care reform.

3. Third, we're going to place a tax on tobacco. This plan has no broad-based tax, but I think it's appropriate when we're trying to encourage health in this country to put a tax on tobacco which everyone acknowledges will help discourage smoking and therefore promote good health. And finally, we're going to ask those large corporations that form their own alliances to help support the backbone of our health care system -- academic health centers and research.

Other plans that have been proposed suggest a different approach to taxes -- a tax on health care benefits above the comprehensive benefits package. Most of these proposals would call for taxing the benefits of at least 35 million American workers. We would prefer to raise around $100 billion through a cigarette tax and corporate assessment. Again, these are things that we can debate, but I think most of us agree that no broad based tax is needed and Congress will debate what new revenue sources are appropriate.

Those are the three primary sources of private and public sector funding that will pay for health security for every American. That will guarantee that every American has a comprehensive package of benefits that can never be taken away. We believe that it is a fair approach to financing: one that asks responsibility of everybody involved. It is also a conservative approach. We are not counting in cost savings that we believe will come from emphasizing prevention, and by encouraging competition in the health care system.

PRIVATE AND PUBLIC NUMBERS ON HEALTH SECURITY PLAN

I. PRIVATE FUNDING OF HEALTH SECURITY PLAN

• Two-thirds of premium cost of ensuring health security for all Americans, comes from making all those who don't pay now, and can afford, start bearing responsibility for health care.

• That means in the first year (1994 dollars), the overall costs would be approximately $61 billion. $25 billion would be from business spending; $14 billion from households, and $21 billion from government.

[NOTE: The $21 billion government cost grows to average $32 billion a year, $160 billion over five years, because of inflation and of because of a $20 billion cushion built in as a contingency against uncertainty.]

II.SEVEN YEAR TOTAL FEDERAL COSTS FOR HEALTH SECURITY PLAN

USES OF FUNDS FOR HEALTH CARE REFORM:

Long-term Care	$80 billion
Medicare Drug Benefit	72 billion
Public Health/Admin Costs	29 billion
Discounts for Businesses and Workers	160 billion
100% Self-Employed Deduction	9 billion
Total For Health Care	$350 billion
Deficit Reduction	91 billion
TOTAL HEALTH CARE/DEFICIT REDUCTION	$441 billion

SOURCES OF FUNDS:

Medicare	$124 billion
Medicaid	114 billion
Reductions in Federal Programs	47 billion
Reduction in Growth of Tax-Free Benefits	51 billion
Sin Taxes/Corporate Assessment	105 billion
TOTAL	$441 billion

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N. COST CONTAINMENT

POLICY BRIEFS:

SAVINGS
COST CONTAINMENT

Q & A

POLICY BRIEF

COST CONTAINMENT

The Health Security plan cuts the projected growth in health care costs plan by limiting the rate of growth in premiums paid by employers an consumers for health coverage. By the end of the decade, premiums will rise no faster than increases in the inflation rate. While some have questioned the ability to expand coverage while containing costs, these limits are reasonable and achievable, given reforms that:

- *enhance competition in the health insurance market,*
- *simplify the system and reduce administrative costs,*
- *empower consumers to make informed choices, and*
- *strengthen the negotiating power of employers and consumers through health alliances.*

Federal and state spending for Medicaid is similarly limited, with coverage for Medicaid recipients provided through regional alliances. Specific reforms hold Medicare to comparable, but slightly higher, limits.

The experience of other countries lend support to our cost containment targets. OECD countries spend, on average, 8% of GDP on health care, while our nation spends more than 14%. Of the other countries, Canada spends the most -- 10%.

Targeted Enforcement

- Competitive forces -- local negotiations between alliances and plans, and consumer selection of lower-cost plans -- should conrol premium increases. But in some cases, one or more plans may exceed the allowed rate of increase. In those cases, but if the average of the alliance as a whole remains within the the rate of increase, they will no budget enforcement.

- The budget enforcement process will focus <u>solely</u> on plans with excessive proposed rate increases. As a failsafe enforcement tool, these plans and their providers will face financial penalties in order to bring their rates down to the level required for the alliance to meet its overall target.

- Because these penalties are automatic and apply to both plans and participating providers, it is unlikely ever to take effect. Alliances,

plans, and providers will have an interest in negotiating beforehand to keep rate increases in line.

Setting Premium Targets

- The comprehensive benefits package will be paid for through employer and individual premiums, just like the premiums for health insurance today.

- The National Health Board will calculate a *national* target amount for the guaranteed comprehensive benefits package, which will include the increased cost of caring for the currently uninsured.

- The Board will use the national premium target to calculate a premium target *for each regional health alliance*, adjusting the national target based on current variations in health spending and the rates of uninsurance across regions.

Limiting Increases in Premiums

- After the initial premium base has been set for each regional alliance, the Health Security plan will limit how fast the cost of those premiums can rise. One current scenario calls for the following increases:

  1996: Increase in the Consumer Price Index (CPI) plus 1.5 percentage points.

  1997: Increase in the CPI plus 1.0 percentage points.

  1998: Increase in the CPI plus 0.5 percentage points.

  After 1998: Increase in the CPI.

- Since premiums paid by employers and consumers grow at the inflation rate, total health spending for the guaranteed benefits will grow at inflation plus increase in population.

- Limits on premium increases will apply **only after** taking account for increases in total health care spending to cover the uninsured and the under-insured.

Reducing Variations in Alliance Premium Targets

- Alliance premium targets will be set based on the current level of health care spending in each area, and will vary from alliance to alliance. The National Health Board will appoint an advisory commission to explore methods to reduce these variations over time.

Negotiating Premiums Over Time

- In each regional health alliance, health plans will bid annually to provide the guaranteed benefits package and negotiate with alliances to set premiums. Premiums will vary from plan to plan.

- If the average premium across all plans is less than the alliance's premium target -- that is, if premiums, on average, are increasing consistent with inflation -- then no federal enforcement will be triggered.

Enforcing Limits on Premium Increases

- Federal enforcement will be used if the average premium across all plans exceeds the alliance's premium target.

- Each health plan whose premium increase is higher than the allowed increase for the alliance as a whole will be required to "rebate" a portion of its premium. Rebates are calculated so that the average premium is lowered to the alliance's premium target, based on a formula set in federal law.

- A health plan may voluntarily lower its premium by the amount of its "rebate", and meet the lower premium by re-negotiating payments to providers or lowering administrative expenses and/or profits.

- If the plan does not lower its premium, then the rebate automatically takes effect. And, payments from the plan to its providers are automatically reduced across the board by the same percentage amount that the plan's premium has been reduced. The enforcement, therefore, applies both to the plan and its providers.

- In the first year of the plan, budget enforcement will be linked to the premium target rather than the limits set for premium increases. Plans that bid higher than the alliance's premium target will be required to rebate a portion of their premiums.

Corporate Alliances:

- Large employers forming corporate alliances are expected to comply with the same limits on premium increases as regional alliances. If premiums in a corporate alliance exceed the allowed rate of growth during two of any three years, the corporate alliance will be required to purchase coverage through regional alliances.

Sept. 93

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O. UNDERSERVED

POLICY BRIEFS:

RURAL COMMUNITIES
CHILDREN AND FAMILIES
ADOLESCENTS
AIDS/HIV AND CHRONIC DISEASE
AFRICAN AMERICANS AND HEALTH CARE REFORM
UNDOCUMENTED PERSONS

Q & A

- URBAN Health
- Rural Health
- Rural Providers

POLICY BRIEF

DRAFT

RURAL COMMUNITIES

America's rural communities pose special challenges in health care-- both for those who need services and those who provide them. The fragile economies of rural areas often mean that many who live there have little or no insurance, making it difficult for rural communities to attract and keep family doctors. Medicare pays both rural doctors and rural hospitals less than urban providers for the same services. The higher numbers of Medicaid recipients in rural areas also result in lower incomes for doctors.

And Americans living in rural areas have a harder time getting to the services they need. More than half of the rural poor do not own a car, and nearly 60 percent of the rural elderly are not licensed to drive.

The Health Security plan creates a system that meets the unique needs and circumstances of rural communities. The plan develops strategies for delivering and financing health care in rural areas, increasing the availability of care, and creating new opportunities for providers.

Universal Coverage Stabilizes the Financial Base for Rural Providers

- Universal coverage will channel significant new resources into rural health care and stabilize the financial base for rural health care providers.

Alliances Empowered to Remedy Rural Health Delivery Problems

- Alliances will be given specific responsibility and authority to remedy inadequacies in rural areas. They may sponsor the development of health plans in underserved rural areas, and may require urban health plans to serve rural areas within an alliance region. In addition, they may offer long-term contracts to health plans serving rural areas.

Telecommunication Technology Connects Rural Providers With Larger Urban Medical Centers

- Telecommunications links between remote rural sites and larger medical facilities will be funded. New video and computer networks will help create "group practices without walls," permitting easier consultation and coordination among rural providers.

Investments in Infrastructure Improve Access to Care for Rural Americans

- The Health Security plan's effort to develop an infrastructure and provide support for primary care capacity will help serve citizens and providers in rural areas. Fourteen million rural Americans will receive improved health care services as the Health Security plan targets areas in which more than half of all residents earn less than 200 percent of the defined poverty level income.

- Several hundred of the new health care facilities receiving assistance will be located in rural communities. A total of 10 million rural residents of underserved areas will be serviced by comprehensive primary care programs.

Expansion of National Health Service Corps

- Expanded efforts of the National Health Service Corps will place nearly 3,000 primary care providers in rural areas by the year 2,000.

Financial Incentives to Providers to Locate in Rural Areas

- Doctors, nurses, and other health professionals will be encouraged to locate in rural areas through tax relief and other incentives.

Federal Support for the Development of Community Networks

- Support for the planning and development of community-based health plans will help doctors establish new practices that are part of rural health care networks.

- Federal programs will provide technical assistance and capital necessary to help rural communities build networks and establish links with larger referral centers

Background Facts

- A total of 34 million people--half of them with incomes under 200 percent of poverty--live in rural areas with inadequate health care;
- Twenty-one million are without access to consistent primary care providers.[42]
- The population of younger rural physicians is not expanding to replace those who retire. Rural communities worry that current shortage of physicians will continue, and limit their access to care.
- Estimates in 1990 suggested a shortage of 45,000 registered nurses and nearly 1,000 dentists in rural areas.

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CHILDREN AND FAMILIES

Over the last decade, the amount the average American family has spent on health care has more than doubled, from $1,742 to $4,296. Health care costs are projected to double again by the year 2000 if nothing is done. In addition, family coverage through the workplace is rapidly eroding: only 33 percent of employer-sponsored health plans paid for health insurance coverage of spouses and dependent children in full in 1990--compared to 40 percent ten years ago.

- *Today 8.3 million American children have no health insurance.*
- *Thirty percent of all children under the age of two, and 50 percent of inner-city children, have not been immunized against preventable childhood disease.*
- *One in five American children had no contact with a doctor in 1992.*

Health care reform will include specific initiatives aimed at keeping children healthy.

Guaranteed Security for All Families

- The Health Security plan will guarantee every American family health insurance protection not linked to job, health, income or age.
- American families, and not their employers or insurance companies, will choose their own plans among those offered by the local health alliance or employers.

Preventive Care

- The comprehensive benefits package will include prenatal care, immunizations, regular checkups and preventive services for children, vision and hearing care, and preventive dental care for children.

Expanded Benefits for At Risk Communities

- The Health Security plan will continue to support specific services targeted at high risk communities, including, migrant health, family planning, and maternal and child health services.

ADOLESCENTS

Despite the physical and emotional stresses they face, adolescents rarely get the preventive care, counseling, or health education they need. The lack of pregnancy prevention initiatives and wellness education takes a high toll on teen mothers, leading to premature births and sicker infants. Habits detrimental to good health -- smoking, abuse of alcohol and drugs, irresponsible sexual behavior -- are often learned and ingrained during adolescence.

Targeting Teens At Risk

- The Health Security plan will create a new adolescent health program to provide primary care services with an emphasis on outreach, prevention, health education and health promotion, as well as mental health and substance abuse counseling.

- The program will be targeted to areas with high rates of poverty, adolescent pregnancy, sexually transmitted diseases, HIV, substance abuse, community or gang violence and unemployment.

School-Based Clinics and Community Health Programs

- The plan will build on school-based or school-linked health clinic demonstrations which have proven effective in reducing teen pregnancy, substance abuse, and truancy.

- The plan will aim to establish several thousand new health care clinics under the sponsorship of schools, community health programs, and social service organizations.

- Like today, reproductive health services will be provided either on site or arranged elsewhere -- according to community preferences.

- Health education in schools will be increased, leading to better understanding of healthy behaviors for American youth.

Sept. 93

AIDS/HIV CARE

An estimated 1 million people are infected with HIV in the United States. While the epidemic has continued to affect the gay community, it is also increasing among heterosexuals, persons of color, women, and adolescents. The Health Security plan will provide essential comprehensive health and prevention services for populations at risk.

Insurance Without Regard to Health Status

- Persons with HIV or AIDS will always be able to enroll in any health plan and receive the comprehensive benefits package at the same community rates paid by everyone within their area. The plan outlaws "pre-existing condition" exclusions, and prohibits plans from charging higher premiums for individuals with poor health status.

- The comprehensive benefits package will be portable, ensuring that people with AIDS and other chronic diseases can change jobs or keep their coverage if they lose their jobs.

No Annual or Lifetime Limits

- The plan guarantees comprehensive health coverage with no lifetime limits; Americans with serious, chronic disease will have the security of knowing that their medical needs will be met.

- The comprehensive benefits package includes coverage of: prescription drugs, home-care options and long-term care; and reasonable limits on how much patients can be required to spend out-of-pocket each year.

- The plan will limit how much patients can be required to spend out-of-pocket each year to $ 3,000 per family and $ 1,500 per individual.

- The package provides the complex mix of primary care and specialized services, and the capacity to respond quickly to emerging medical developments that AIDS patients require.

Enhances Current Research, Education and Prevention Efforts

- The Health Security plan will build on the existing structure and spirit of Ryan White programs for high HIV-prevalence cities and states, and

community-based clinics. Outpatient care, prevention, and treatment of substance abusers, and specialty sites developed for the HIV-infected community will be expanded.

- The Health Security plan will expand funding for research, education, and prevention efforts related to the spread of HIV; it will also continue funding for the Ryan White Care Act.

Provides Responsive Care

- Providing quality care for AIDS patients requires a complex mix of primary care and specialized services, with the capacity to respond quickly and with flexibility to emerging medical developments.

Supports New Public Health Efforts

- The Health Security plan will provide new resources for public health, aimed at helping people living with HIV or AIDS who frequently develop other infectious diseases such as tuberculosis. The clinical treatment of AIDS must include the need for referral of infected individuals into care programs as early as possible.

- By building new capacities and strengthening the nation's core public health functions, the plan will enable communities to reduce the spread of the HIV virus.

Sept. 93

HEALTH CARE COVERAGE FOR AFRICAN-AMERICANS

In many ways, African-Americans face a health care system stacked against them -- they are amongst those Americans most at risk of going without care and coverage today. Losing or changing jobs often means losing health insurance, and African-Americans have one of the highest unemployment rates in the country. The health of African-Americans is also aggravated by:

- *Homicide and legal intervention rates which are seven times higher among African-American males (61.5%) than white males (8.1%).*
- *African-American infant mortality rates are double (18.5%) those in white communities (8.1%).*
- *High mortality rates from preventable diseases -- including heart disease, cancer, and stroke .*

Guaranteed Comprehensive Benefits

- The Health Security plan will guarantee all Americans comprehensive health care benefits they can never lose. Health alliances and plans are prohibited from discriminating on the basis of race, ethnicity, gender, religion, or country of origin.
- Alliances are prevented from creating two-tier systems of care, and a system for redressing grievances quickly is required of all plans and alliances.

Community-Based Investments

- Community-based plans that can best address the needs of a particular community will be encouraged through special incentives, capital development programs, and public health initiatives.

Incentives for Providers

- New initiatives designed to expand access to care and encourage primary care will bring high quality medicine to millions of African-Americans who now live in medically underserved areas.

- The plan's health care workforce initiatives will increase funds for medical schools that train primary care doctors and expand the National Health Service Corp. The plan will increase the number of African-American physicians, nurses and other health professionals.

Community Input

- Alliances will have a Board of Directors composed of equal numbers of consumers and employers who purchase care in that area. Each alliance will reflect the communities it serves.

- Health plans will conduct annual consumer surveys and must seek out those in communities that have historically been denied access to high quality care.

Sept. 93

UNDOCUMENTED PERSONS

According to the INS, there were over 3.2 million "unauthorized individuals" living in the U.S. in 1992. Many do not have access to regular health care providers. Community health centers and migrant health centers are the main source of care. They often do not get preventive care and like other uninsured individuals rely heavily on emergency room care after their conditions deteriorate.

Undocumented Persons are Not Eligible for Guaranteed Benefits:

- Eligibility for the comprehensive benefits package is limited to citizens and legal residents. Undocumented persons are not eligible for guaranteed health benefits under the reform plan.

Continued Access to Emergency and Community Health Services:

- Individuals living in the United States without proper documentation may continue to use emergency and other health services as provided under current federal law.

- Community health centers and migrant health centers that serve a large number of patients who are not eligible for coverage will continue to receive federal funding to pay for care they provide to undocumented persons.

Employers Contribute for Undocumented Employees:

- All employers will be required to pay health insurance premiums for all of their employees. And, health alliances will not share information related to health insurance premiums with the Immigration and Naturalization Service.

Availability of Private Insurance:

- Any individual not eligible for the national benefits package may purchase coverage from a private insurance plan to the extent that such plans are available.

QUESTIONS AND ANSWERS

URBAN HEALTH

Q: How will this reform help people that live in cities get high-quality care?

A: First, by providing a comprehensive benefits package to all Americans that emphasizes primary and preventive care. In today's system, too many Americans end up in emergency rooms because they didn't get the primary care they needed. That's not right, it costs the system too much money, and we're going to change it.

Public hospitals in our nation's cities are the victims of the current system. They disproportionately serve non-paying uninsured populations and low-paying Medicaid patients. Under reform, all of these patients will be covered and will be compensated for at higher reimbursement rates.

The risk adjusters will insure that providers in urban areas receive greater compensation for their "sicker" populations.

If urban hospitals and community health centers are designated as essential providers, health plans are required to contract with them for a transitional period. During this time, they will have access to grants to improve their facilities and form their own community-based health care networks.

There will also be additional support for community and school-based clinics so that we really make an aggressive effort at prevention --keeping people healthy instead of waiting until they have to go to the emergency room.

RURAL HEALTH

Q: What are we going to do to get doctors into rural areas?

A: Right now, two-thirds of rural counties do not have enough doctors. It's no wonder. Rural doctors provide more charity care than any doctors in the country, and they often get paid late. In many cases, rural doctors can't even take a day off because there isn't another doctor for miles around.

The plan will include incentives for doctors to practice in rural areas. Specifically, it will expand the National Health Service Corps and their loan repayment program, increase incentives for medical schools to train more primary care doctors, and give states flexibility to develop programs that are more responsive to rural needs.

The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. By sharing skills through technologies like interactive video, it will give rural residents access to the kind of care once available only at major medical centers. And it will use nurse practitioners and other health profesionals to increase the availability of care.

In addition, the Health Security plan will give rural residents the bargaining power they need to get affordable coverage and access to high-quality care.

RURAL PROVIDERS

QUESTION:

How will rural facilities and health care personnel be affected under the plan?

ANSWER:

- I used to be very concerned about the impact of reform on rural areas. Now I feel that reform will benefit rural areas the most. Here's why:

- Under our current system, citizens and health care providers living in rural areas face some of the greatest health care challenges that confront our nation. These areas have too few primary care providers, disproportionate numbers of uninsured and underinsured populations, greater numbers of Medicaid patients who frequently are reimbursed at very low rates, and frequently have larger numbers of Medicare patients who are paid for at lower rates than private insurers.

- The reform's structural changes will ensure that rural providers and facilities finally have fully paying patients when they arrive at doctors' offices and hospitals. This will be the key to assuring that these providers not only survive, but hopefully flourish. Increased access to reimbursement will help communities attract and retain desperately needed providers.

- In addition, access to care is ensured for Americans who live in rural areas by designating independent health professionals and health care institutions as "essential community providers".

- During a five-year transition phase, health plans in underserved areas are required to contract with and reimburse established community-based providers that are designated as essential community providers.

- Finally, the reform proposal would provide new funds to underserved areas to support capacity expansion and to provide access to health care for low-income, underserved, hard-to-reach, and otherwise vulnerable populations.

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P. OTHER GOVERNMENT PROGRAMS

POLICY BRIEFS:

FEHBP
VETERANS
AMERICAN INDIANS AND ALASKA NATIVES

Q & A

- VETERANS

POLICY BRIEF

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

An estimated 10 million people, including Federal employees, retirees and their dependents, have health insurance coverage through the Federal Employees Health Benefits Program (FEHBP). In many ways, FEHBP has served as a model for the Health Security plan. Under reform, all Americans will enjoy a choice among high quality affordable health plans like federal employees and retirees do today.

However, the current FEHBP program is not without the problems that plague even the best models. Over the past tens years, premium rates have increased just as they have for other purchasers of insurance. These increases have ranged as high as 26% in a single year. Because FEHBP plans offer differing levels of coverage, some plans have had to withdraw from the program because they have attracted too many older and sicker workers and could not offer competitive premiums.

The variation in benefits also causes difficulties to federal workers and early retirees who are forced to make uncomfortable tradeoffs when selecting among plans that differ in price, services, coverage and choice of providers force federal workers into uncomfortable tradeoffs. Many are confused by these differences; information on how satisfied they are with their health plans is unavailable.

Guarantees Comprehensive Benefits

- Under the Health Security plan federal employees and early retirees will join with the other members of the communities in which they live and choose from among the health plans offered in their area.

- Federal employees and retirees will be guaranteed the security of knowing that if they change jobs, lose their job or move that they will still be covered.

- Those covered by FEHBP will continue to enjoy comprehensive health care since the benefits package provided in the Health Security Act are based on today's best plans, including those offered through FEHBP.

Helps Employees Make Informed Choices

- Federal employees and early retirees, not insurers, will still be in the driver's seat, but even better equipped to choose among plans on the basis of price and quality.

- A uniform comprehensive benefits and standard cost-sharing arrangements will replace the many different benefits packages offered in the FEHBP program today.

- Simple, easy-to-understand and up-to-date information about quality and providers price will help individuals choose among plans.

Increases Government Contribution

- The Health Security plan will increase the Government's contribution for federal workers to 80% of the average premium, up from an average 75% it contributes today.

- Under the Health Security Act, premiums will be based on regional prices, benefiting employees and early retirees in areas which do a good job in controlling costs.

- The slower rate of growth of health care spending under the health Security plan will mean that health care premiums will not take an ever-increasing bite out of their paychecks and pensions.

Protects Federal Retirees

- Under the Health Security plan, early retirees -- like active employees -- will be able to choose from the health plans that will be offered in their area.

- For federal retirees covered by Medicare, the Office of Personnel Management (OPM) will administer a Medigap option to provide the additional protection they currently receive.

DRAFT

VETERANS

Health care reform will honor the nation's commitment to bring health care to its Veterans. Reform will give Veterans more choices about how and where they receive care. The Department of Veteran Affairs health system will be preserved by giving the VA its own health plans, preserving veteran benefits, increasing veteran health care system flexibility, and maintaining their specialized services.

Disabilities and Low-Income

- Low income Veterans and those with service connected disabilities currently served by the Department of Veterans' Affairs will receive the benefits they do today.

Competitiveness

- The Department of Veterans' Affairs may choose to organize health plans to compete with other health plans for Veteran enrollment.

- VA hospitals and clinics will be provided with broad authority to enter into contract with other health plans to provide services to veterans and better compete with other health plans.

Specialized Services

- Under health reform, Congress will continue to fund specialized services, such as treatment for post-traumatic stress disorder. Low-income veterans and those with service-connected disabilities will have access to these specialized services whether or not they enroll in a VA health plan.

New Eligibility

- In areas where Veterans' plans exist, Veterans who are not currently eligible for care through the VA will have the option of enrolling in Veterans' plans to receive the nationally guaranteed, comprehensive benefits package.

- Veterans who enroll in a fee-for-service plan may obtain health care through the VA system. Under that arrangement, they will be responsible for any contribution required.

Funds

- Under reform, the VA will be permitted to retain funds recovered from third-party payers.

- VA managers will be allowed to control budgets without traditional restrictions of line-items or earmarked funds, and delegate more flexibility in hiring to managers of VA clinics and hospitals .

Less Paperwork

- Under health reform, unnecessary reporting requirements and inspections that currently burden VA institutions and providers will be reduced, freeing VA providers to concentrate on patients rather than paperwork.

Sept. 93

AMERICAN INDIANS AND ALASKA NATIVES

Health reform initiatives that affect Native American people will proceed within the framework of government-to-government relationships with over 500 sovereign Native American nations. Under the Health Security Act, the federal government will continue to pay for health care services to these populations, and will expand funding for these underserved groups. Tribal governments will have autonomy and flexibility in devising a health care system which is right for them.

The Health Security Act will not limit options currently available to tribes to control and operate their own health facilities under the Indian Self-Determination and Education Assistance Act.

- Indian Health Service clinics and hospitals, tribal health centers and urban Indian programs will operate outside regional health alliances.

- Public health service programs for American Indians and Alaska Natives are expanded to improve access to available services in the remote areas where reservations exist, and to provide health care that is sensitive to the diverse languages and cultures of these communities.

- An increase in medical professionals such as community health representatives, public health nurses, nutrition counselors and mental health and substance abuse professionals will lead to more and better prevention and treatment services.

- The Indian Health Service is expanded under new authority to expand their public health and prevention activities, and to cover Indian and non-Indian residents living on and around reservations.

- To recruit and train American Indian and Alaska Native health professionals, the Indian Health Scholarship Program and Loan Repayment Programs are expanded and given increased funding.

- American Indians and Alaska Natives may also enroll in health plans offered through the alliance, and are eligible for financial subsidies on the same basis as all other Americans.

- Likewise, an Indian Health Service center may serve non-Indians enrolled in health plans in the regional alliance on a contracted basis.

QUESTIONS AND ANSWERS

VETERANS

Q: I'm a veteran. What's going to happen to my health coverage?

A: You will get all the benefits you get today, and you will get the same comprehensive benefits package as all Americans. Veterans will have the choice of either joining the VA health plan in their area or a health plan used by non-veterans. The VA will have the option of organizing its hospitals and clinics into health plans.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: **< BLANK >**

From: Rick Kronick RK and Walter Zelman

Re: Comparison Between the Health Security Plan and 'Classic' Managed Competition

Date: September 27, 1993

There are six major differences between the Health Security Plan and the version of managed competition proposed by Alain Enthoven and others of the Jackson Hole Group.

Differences between the Health Security Plan and 'Classic' Managed Competition

	Health Security Plan	'Classic' Managed Competition
Global Budgets	Included in Plan	No Provision for global budgets
Size of Employer Required to Purchase Through the Alliance	5000 employees and fewer	Not well specified; probably 100 and below
Tax Treatment of Employer Contributions	No meaningful limitations for existing employers	Limited to premium of low cost plan
Alliance flexibility and regulatory powers	Limited alliance flexibility to choose and negotiate with plans	Alliance has substantial flexibility to respond to health plan strategies
Fee schedules for providers	Alliance 'negotiates' fee schedules with physicians and hospitals	No provision for alliance wide fee schedules
Provision for single payer option	States have option to adopt a 'single-payer' system	No provision for 'single-payer' option

The implications of each point of difference are discussed below.

Global Budget: The Health Security Plan provides for global budgets; 'classic' managed competition does not. Managed competition is supposed to accomplish two purposes:

1) Provide a market mechanism for determining what share of our income we want to devote to health care;

2) Create an environment in which providers have the opportunities and incentives to use available resources more effectively.

Our argument is that the savings we anticipate from health care reform are large enough that we do not expect the global budget to be binding. Our fallback position is that if all of the anticipated savings do not materialize and the budget does become binding, that the second goal of managed competition can still be realized: i.e., providers will still have incentives and opportunities to use resources more effectively.

Size of Employer Required to be in the Regional Alliance: Almost all managed competition advocates recognize that allowing all employers to choose to go in or out of the Alliance will create risk-selection problems. Some are nervous about requiring many medium and large employers to be in the alliance as well. Last year's CDF bill required employers of 1,000 and below to be in the alliance (if they purchased coverage); this year's draft reduces the threshold to 500, and consideration is being given to reducing the number further. Our reasons for proposing an alliance with all employers under 5,000:

We want to allow employers outside of the alliance to voluntarily opt in to the alliance. If the threshold for mandatory participation is low (e.g., 100 employees or fewer), the risk selection problems will be impossible to overcome, and we will be forced to prohibit employers above the threshold from voluntarily opting in. This will create further difficulties in regulating the insurance market for such employers.

Current non-cash Medicaid recipients and other low income persons will be part of the community rated alliance pool; to the extent that expenditures for such persons are higher than average (and the actuaries assume that they are), relatively small alliances will burden small businesses and their employees with the cost of 'subsidizing' these higher risk populations.

Department of Labor oversight is required on all employers outside of the alliance to assure compliance with the provisions of the Health Security Plan. Oversight of a large number of employers is extremely difficult.

Our Alliance, while large, will remain flexible and competition-driven. It has very little capacity to deny plans the right to compete.

Few firms of under 1000, and even under 5000 can do very much to lower their costs -- other then get good deals for having a less risky population. Only very large employers really have the resources, expertise, and market share to do

anything innovative to reduce costs.

Even at 100, the alliance will have such a large market share that few plans will be able to survive without an alliance contract.

Tax Treatment of Employer Contributions: The 'classic' managed competition model limits tax preferred employer contributions to the price of the lowest priced plan available. This proposed change in tax law would be a tax increase on tens of millions middle class Americans; almost all Americans would be paying more for the same benefits.

Our response to the arguments in favor of limiting tax free employer contributions:

The Health Security Plan dramatically changes the choice environment for individuals. Even without change in the tax laws we should expect substantial movement of individuals to lower cost plans and substantial change in provider behavior. Currently, approximately 45% of those with employer sponsored insurance have a choice of plans, and less than 30% of those with a choice face a cost-conscious choice. Under the Health Security Plan almost all individuals will face a cost-conscious choice (we require that if an employer is willing to contribute more than the 80% minimum contribution that the employer rebate the extra contribution if the employee chooses a less expensive plan). When large numbers of individuals face a cost-conscious choice, many will move to lower cost plans, and provider groups will be under substantial pressure to lower their costs.

Proponents of a tax cap are faced with difficult issues of administration. The politically most attractive (least unattractive) approach is to set the tax cap at the level of the lowest cost plan available in a geographic area. But this is an administrative nightmare, even for regional alliances, and next to impossible for corporate alliances. An alternative -- setting a national cap -- will have the consequence of requiring some people who do choose the lowest cost plan available to them to be paying for some of their premium with after tax dollars.

Alliance Flexibility and Regulatory Authority: In the 'classic' managed competition theory, it is assumed that health plans will continually search for ways to prosper through segmentation of the market, favorable selection of risks, and other anti-competitive maneuvers. The theory of 'managed' competition rather than 'naked' competition suggests that an active and intelligent sponsor is required to structure a market in which health plan strategies can be countered.

In response to the concern that the regional alliances will be overly regulatory, the Health Security Plan circumscribes the flexibility that is proposed for alliances in the 'classic'

managed model. The proposed limitations on alliance flexibility in the Health Security Plan have not been much appreciated or noticed by managed competition purists, who criticize the Plan as overly regulatory. However, alliances are required to contract with almost all plans that the state certifies as qualified, and are required (subject to budget enforcement) to accept any price the plans offer.

Fee Schedules for Providers: The Health Security Plan includes a prohibition on balance billing, while the 'classic' managed competition model does not address balance billing in fee-for-service, PPO, or point-of-service plans. A prohibition on balance billing is a vital element of promising health security to Americans.

An alliance wide negotiated fee schedule is required in order to prohibit balance billing and guarantee the availability of a fee-for-service plan that includes all the providers in a community. Without an alliance wide fee schedule, consumers could not simultaneously be assured of a ban on balance billing and that all providers would accept their copayment as payment in full for fee-for-service or out-of-network-PPO services.

Provision for a Single-Payer Option: Some states, particularly those that are primarily rural, may prefer a single-payer option in which providers are paid directly by the state rather than through intermediaries of health plans. 'Classic' managed competition does not provide for such an option. The Health Security Plan recognizes that there are wide variations across the country in demography and political preferences, and allows for variations in the methods of provider payment.

ADDRESSING BIASED SELECTION THROUGH REINSURANCE AND RISK-ADJUSTMENT

BACKGROUND

Competitive insurance markets must address the problem of "biased selection." Biased selection occurs when a health plan enrolls a population with a better or worse than average health status.

The problems of biased selection can result from the actions of individual consumers or health plans.

Individual consumers can contribute to biased selection through their decisions about when to purchase insurance and the level of coverage to purchase. Consumers who know they are in poor health or at higher risk for needing health care services are more likely to choose to insure and to choose more extensive benefits when they do insure. This tendency is often referred to as "adverse selection." In a reformed market, adverse selection may occur if higher-risk people systematically select certain types of health plans (e.g., plans that offer greater choice of health care providers).

Health plans can contribute to biased selection through the use of various techniques which discourage enrollment by higher-risk people and attract healthier enrollees. In the current marketplace, insurers use medical underwriting, preexisting condition exclusions, minimum group participation requirements, and industry exclusions to prevent enrollment by poorer risks. Even in a reformed market, health plans may attempt to influence the composition of their enrollment. Decisions relating to which providers to contract with, where to locate service areas and facilities, and the amount of service and support to provide higher-cost patients all can affect the mix of enrollees attracted to a health plan.

Biased selection affects the premiums charged by health plans and therefore how the competitive market operates. If biased selection occurs, health plans with relatively sicker or higher-risk enrolled populations generally will have higher claims expenses than plans with average enrollment mixes, and will be forced to charge higher premiums to cover their higher costs. On the other hand, health plans with relatively healthier enrolled populations will have relatively lower claims expenses and can charge lower premiums.

To the extent that health plan premiums reflect biased selection rather than the efficiency and quality of the competing plans, the benefits of competition are diminished. To achieve all of the benefits of competition among health plans, strategies to address the problem of biased selection must be pursued.

ADDRESSING BIASED SELECTION

The health reform plan addresses biased selection in several ways:

- Universal coverage and insurance reform address the problem of health plans cherry-picking only healthy risks.

- In the short-run, limited premium adjustments and mandatory reinsurance is used to protect health plans from adverse selection.

- Within a couple years after reform, a prospective risk-adjustment system will be developed. Premiums paid to health plans will be adjusted to reflect the health status of the plan's enrollees.

Universal Coverage and Insurance Reform

Many of the risk selection problems that exist in the current system are addressed through assuring universal coverage to comprehensive benefits and through insurance reforms.

- Universal coverage. In the current system, insurers worry that people with or at high-risk for health problems are more likely to seek coverage. In the reformed system, everyone will have health insurance coverage. People will be unable to wait until they have health problems to choose coverage, so this component of the adverse selection problem will disappear.

- Uniform comprehensive benefit package. In the current system, insurers worry that less healthy people tend to choose richer benefits. In the reformed system, everyone will have the same comprehensive benefits package. There will be less reason for high-risk or low-risk people to systematically choose a particular health plan because of the level of benefits offered.

- Guaranteed issue and renewability of coverage. Insurers use medical underwriting and a host of other strategies to discourage enrollment by higher-risk people. Under a reformed system, all health plans will be required to accept any enrollee who applies for coverage. Plans will not be able to discourage enrollment based on health status.

- Enrollment through alliances. Under the current system, health plans can influence the composition of their enrollment through their marketing activities. Under a reformed system, enrollment will occur through alliances. Regulations can be used to assure that marketing is not directed only toward more desirable areas. Standard service areas for integrated health plans could be used

to limit the ability of health plans to avoid higher-cost areas.

- Satisfaction and disenrollment surveys. Health plans can discourage higher-risk enrollees by giving them poor service or failing to contract with providers that can address special needs. Under a reformed system, enrollees can be periodically surveyed to detect problems with health plan service. People who switch plans can be surveyed to determine if they left their former plan because of poor service or inadequate access to specialists. Problems uncovered can be addressed through alliance contract negotiations or state certification.

Mandatory Reinsurance

Mandatory reinsurance will be used to protect health plans that attract a disproportionate share of enrollees with high-cost or chronic illnesses.

Under a reinsurance approach, health plans share the costs of treating higher-cost or chronically ill enrollees. If a health plan has a high-cost claim or enrollee, the reinsurance system reimburses a portion of a health plan's payments for these cases. Health plans are required to pay premium to the reinsurance fund for this protection.

Reinsurance systems are being used today in a number of states as part of their insurance reform efforts. For example, as part of its community-rating law, the State of New York created a reinsurance pool for high-cost cases. Insurers are required to pay a premium to the reinsurance pool; in exchange they receive lump-sum or periodic payments from the pool when they have a claim for one of the conditions covered by reinsurance.

Risk Adjustment to Health Plan Premiums

Short Term Strategy

A short-term strategy to address biased selection will be pursued that contains both prospective and retrospective components. This approach was recommended by a panel of experts on risk adjustment

In the short-term, the following measures will be relied upon:

- Demographic adjustments to premiums. Cost weights for demographic cells (age, sex, etc.) will be developed from National Medical Expenditure Survey (NMES) and private insurance data sources.

- Limited health status adjustments. Adjustments may be made for perceived health status or the presence of

chronic conditions, based on data collected through the use of health status surveys. NMES and private insurance data will be used to develop cost weights in the short term.

- Retrospective adjustments for high cost cases. Reinsurance will be used to reimburse health plans for some of the costs associated with high-cost cases or diagnoses. Reinsurance may reimburse a percent of costs above a reinsurance threshold or may provide specific payments for identified high cost conditions, like AIDS or organ transplantation. Cost weights will be developed from a private insurance data base (New York State uses weights developed from Kaiser data).

- Geographic adjustment. Adjusters will be developed to adjust for price (and perhaps utilization) variations within health alliance areas. Such adjustors already exist to some extent for Medicare. Cost weights will be developed from private insurance and Medicare data.

Medium Term Strategy

Within a few (3-5 years) years, health status risk adjustors will be developed which rely on diagnosis-based measures. The risk adjustment system will rely on diagnosis and treatment information collected through the data and quality information system implemented as part of health care reform. Reinsurance may continue to be used for particularly high-cost cases.

Mental Illness

Given the present state of knowledge, mental illness will need to be treated differently than other conditions in a risk adjuster system. There is more disagreement about an appropriate patient classification system than with physical illness, and the severity and resource demands of patients within a diagnostic category probably vary more than with physical illnesses. In addition, underservice is a problem for the severely mentally ill, and a purely prospective payment could exacerbate the problem. A heavy reliance on reinsurance will be necessary in the short and medium terms.

Research and Model Systems

Federal research efforts will be necessary to support the development of model risk adjustment and reinsurance systems that can be used by states and alliances. The federal government will increase its support for new research related to the development and testing of risk adjustment systems for the short and medium terms. An on-going program aimed at improving existing risk adjustment measures and developing new approaches will be maintained at the federal level.

Risk-Adjustment Questions and Answers

Q: Researchers and others have been trying to develop a risk-adjustment system for Medicare for ten years and have not succeeded. How are you going to develop a system in two years?

Our plan deals with the risk-adjustment problem in two stages. During the first couple years after reform, we rely on a combination of demographic premium adjustments and mandatory reinsurance to address biased selection. Demographic adjusters for age, gender and area are possible with current technology. Reinsurance is currently being used in a number of states as part of small group reform. We also will develop limited health status adjusters, based in survey information collected from health plan enrollees.

Beginning several years into reform, risk-adjusters will be developed which rely on diagnosis-based measures. Health plans will be paid based on the relative health status of the population they enroll.

The new quality management system is key to our ability to develop a sophisticated risk-adjustment system. Current efforts to implement good risk-adjusters have been frustrated by the lack of information about the relative health status of enrollees of health plans, especially HMOs. Our quality management system captures diagnosis and treatment information about each patient encounter, which will for the first time give us the ability to evaluate the relative health status of the enrollees of each health plan.

Q: How did you arrive at this strategy?

During the task force process, we met with the leading experts in risk-adjustment field. We also met with health plans that are currently experimenting with or actually using risk-adjustment, for example to adjust payments to group practices. There was broad agreement that our approach was appropriate.

Q: Current risk-adjusters explain only a small amount of the variation of costs for any specific enrollee. Critics question whether this is enough to protect health plans?

No adjustment system can explain all expected cost variation at the individual level-- much of the variation in costs is random. The goal is to develop adjusters that predict enough variation in health care costs so that health plans can compete successfully on the basis of efficiency.

The issue of how much variation in costs can be "explained" by risk adjusters is very complicated. For example, critics claim that current adjusters based on demographic factors, such as age and gender, explain only about one percent of variation in expected costs for an individual. This is true. However, these factors explain quite a bit of the variation in expected costs across

groups, such as the groups of enrollees in two health plans. Thus, adjustments for age and gender are very important to assure proper payment to health plans that get a disproportionate share of older people or woman of child-bearing age.

Several promising risk-adjustment approaches are currently being developed and implemented. They use prior health care use by individuals to predict their future costs and have the potential to explain a meaningful percent of the cost variation that can be explained. The federal government will be conducting and sponsoring research efforts and demonstrations to develop and improve these adjusters over the next couple of years.

Q: Until risk adjusters are perfected, won't health plans have incentives to avoid higher risk enrollees? How will these people be protected?

While the incentive may still be there, the insurance reforms under the proposal -- such as community rating, enrollment through alliances, guaranteed renewability -- effectively eliminate the tools health plans use to cherry-pick.

Q: Critics are concerned that fee-for-service plans suffer from adverse selection if the risk-adjusters are not good enough. For example, the fee-for-service plan in the Minnesota public employees program became financially inviable when managed competition was put in place there. How will these plans be protected?

We recognize the need to protect fee-for-service plans from adverse selection. That is why we mandate reinsurance for high-cost cases. Reinsurance will be required until better risk-adjusters are developed.

Taxing Health Benefits and the Middle Class

Health care reform must control costs without creating new or hidden taxes on the middle class. Taxing health benefits is just that -- a new tax on the middle class.

During the last two decades most Americans have seen little or no growth in wages. Many working Americans have traded higher wages for health insurance.

Under the Clinton health reform plan, comprehensive health insurance will not be taxed -- now or in the future. Only insurance coverage *over and above comprehensive insurance* will be subject to any tax, and this will not apply to anyone now covered by a collective bargaining agreement for many years.

Other health reform plans would tax all or some of the employer contributions for basic health insurance, without requiring universal coverage through employer contributions. This is wrong for several reasons:

-- if the cost for employers to provide health insurance goes up, fewer employers will provide health insurance

-- employers who continue to provide insurance would be likely to cut back on their payrolls in other ways, resulting in a loss of jobs or lower wages

-- if basic health benefits are taxed at the individual level, it will increase middle class taxes by taxing the only portion of their income that has seen any growth over the past two decades

Taxing health insurance will not bring us health security. It would only result in a bigger tax burden on the middle class.

We looked at the possibility of taxing health insurance, but concluded that it was the wrong way to pay for health care reform. According to the Treasury Department, if our plan taxed all premiums over the average, it would raise taxes for over 35 million working Americans a year. This tax would raise $86 billion between 1996 and the year 2000. We rejected this idea because we think it would be wrong to raise taxes on middle class working Americans.

Other plans propose taxing even a greater portion of health insurance benefits. As Congress reviews these proposals, we think that most will agree that after two decades with little or no increases in wages, working Americans should not be taxed in this way to pay for health care reform.

Taxing health insurance could create incentives for people to pay more and get less. That is not what health care reform is all about.

Distribution Table

"Under Health Security Plan"

* current estimates *

Change in Health Insurance Premium Payments Under Health Reform

**63% of currently insured families will spend the same or less for similar benefits under reform. 54% of singles will spend the same or less for similar benefits, while 68% of couples and families will spend the same or less for similar benefits.

**22% of those currently insured will spend more, but will receive better health insurance benefits.

**15% of those currently insured will spend more for similar benefits they have today. These are primarily younger, single individuals.

INDIVIDUAL SCENARIOS: HEALTH CARE PREMIUMS
TODAY AND UNDER REFORM[1]

I. If you are...

Policy Type	Today: Range of Cost	Today: Avg Monthly Cost[2]	Reform: Avg Monthly Cost
Single	$0 – $70	$26	$32
Family, Two Adults No Children	$0 – $250	$85	$64
Family, Parent Children	$0 – $250	$85	$65
Family, Two Adults Children	$0 – $250	$85	$73

II. Or if you are...

Self-employed: The self-employed and independent contractors can deduct 100% of their health care costs from their taxes. As with any business, they pay the employer share and are eligible for any discounts which apply. They also pay the individual share, and, if they are low-income are eligible for discounts on that portion as well.

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[1] Monthly costs for people insured all year; above 150% of poverty

[2] Today, most employers offer either an individual policy or a family policy without distinction as to whether or not the family has one or two parents or whether or not they have children. Therefore, costs in today's system don't vary by family policy type. Some people pay nothing under the current system because their employer pays 100% of their policy premium.

Retiree, 55–65: If the retiree had a contractual agreement with their former employers, the employer will pay the retiree's 20% contribution and the government would pay the remaining 80%. If no contractual obligation exists, the retiree would pay their 20% and would be eligible for discounts if they are eligible.

65 or older: As today, would receive health benefits through the Medicare program or if they choose, through their local health alliance.

Low-Income Families: Individuals and families with incomes below 150% of poverty are eligible for discounted premiums, on a sliding scale, on their 20% share or the average plan premium. This applies to individuals with income below $10,445; couples with incomes below $14,145; single parent families with incomes below $17,835; and families of four with income below $21,525.

Unemployed or Nonworking: Unemployed individuals and heads of households who make less than 150% of the poverty level are eligible for individual discounts on a sliding scale. Those with unearned income pay all or part of what would normally be the employers share of the premium. Those whose incomes are 250% of the poverty level or less -- pensioners for example -- are eligible for discounts on what would be the employer's share.

BUSINESS SCENARIOS TODAY AND REFORM[3]

Page Three

A. Monthly Premium

If your business employs...	**Today: Average Monthly Premium per Worker**	**Reform: Average Monthly Premium per worker**	**Reform: Percent of Payroll**
Less than 25	$190	$136	5.4%
25–99	$176	$150	5.8%
100–499	$200	$163	6.2%
500–999	$214	$170	6.3%
1000+ within alliance	$215	$174	6.1%
5000+ and out of alliance	$218	$209	6.9%

[3] Monthly business costs for individuals who are currently insured

Total Premium

	New York		Illinois		Texas	
	Current System Comparable Benefit	Reform	Current System Comparable Benefits	Reform	Current System Comparable Benefits	Reform
Family Type:						
Single	2249	2223	1933	1991	1900	1759
Couple	-----	4445	-----	3981	-----	3517
Single Parent	-----	4477	-----	4010	-----	3543
Dual Parent	5023	5014	4714	4491	4510	3968

Adjustment of estimated national average premium under reform to state specific reform premiums are done using a PRELIMINA
Current system premiums are estimates based on regional and state specific variations.

Total Premium

	California		Virginia		Oregon	
	Current System Comparable Benefits	Reform	Current System Comparable Benefits	Reform	Current System Comparable Benefits	Reform
<u>Family Type:</u>						
Single	2231	1972	2016	1836	2316	1604
Couple	-----	3942	-----	3672	-----	3208
Single Parent	-----	3971	-----	3698	-----	3231
Dual Parent	5056	4447	4590	4142	5056	3619

~~[illegible] developed by the Urban Institute~~

Family Premium Share

	New York		Illinois		Texas	
	Current System Comparable Benefit	Reform	Current System Comparable Benefits	Reform	Current System Comparable Benefits	Reform
Family Type:						
Single	471	445	384	398	470	352
Couple	-----	889	-----	796	-----	703
Single Parent	-----	895	-----	802	-----	709
Dual Parent	1157	1003	1178	898	1651	794

Adjustment of estimated national average premium under reform to state specific reform premiums are done using a PRELIMINA
Current system premiums are estimates based on regional and state specific variations.

Monthly Family

	California		Virginia		Oregon	
	Current System Comparable Benefits	Reform	Current System Comparable Benefits	Reform	Current System Comparable Benefits	Reform
Family Type:						
Single	38	33	42	31	34	27
Couple	-----	66	-----	61	-----	53
Single Parent	-----	66	-----	62	-----	54
Dual Parent	105	74	132	69	103	60

R in e e elope by t e rban nstitute

Families and Individuals *

Who Spends and Who Saves Under Reform

- About two-thirds will pay less.
- A third will pay slightly more.
- Only 5% will pay more than $42/mth more.

* Currently insured

Who Spends and Who Saves Under the New System

Family and Individual Payments By Income *

Income	Pay Same or Less	Pay More
less than $20,000	61%	39%
$20,000 - $40,000	64%	36%
$40,000 - $60,000	64%	36%
$60,000 - $80,000	62%	38%
$80,000 - $100,000	60%	40%
$100,000 or more	63%	37%
Average	63%	37%

* For currently insured

Who Spends and Who Saves Under the New System

Family and Individual Payments by Policy Type *

Policy Type	Pay Same or Less	Pay More
Single/no kids/work	54%	46%
Single/kids/work	90%	10%
Couple/no kids/1 wrk	81%	19%
Couple/no kids/2 wrk	55%	45%
Parents/kids/1 wrk	86%	14%
Parents/kids/2 wrk	61%	39%
Average	63%	37%

* For currently insured

AEI/Martin Feldstein Briefing

Martin Feldstein held an AEI briefing last week on the health reform plan. The briefing was well attended by Republican staff. As reported in the Washington Post, the thrust of Feldstein's criticism was that the cost of the plan in 1997 would be $120 billion higher that we say it would be. Michael Boskin joined Feldstein at this briefing.

The Energy and Commerce staff suspect that a Republican question is likely to be based on this charge.

Response:

It is interesting that they make these charges without looking at the assumptions and models used by the Administration.

The numbers have been checked and rechecked by economists and experts both inside and outside of the government.

We stand by our numbers and will continue to work with Congress to provide the best possible numbers throughout consideration of the health reform plan.

[Attached is a copy of the Washington Post story on the AEI briefing.]

Washington

9/24/93

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Tampa Questions Clinton on Health Care

Citizens Air Personal Concerns About Proposals' Costs and Effects

By Ann Devroy
Washington Post Staff Writer

TAMPA, Sept. 23—President Clinton took his health care proposals on the road last night and was peppered with questions on everything from mental health benefits to long-term care to cost controls as Americans began wrestling with the basic question of how a radically altered health care system will affect them.

If Washington was awash in news conferences over the public policy issues involved in health care, the audience here for a televised town hall meeting with Clinton was far more personal, asking about their own health problems and discussing their own concerns.

Clinton, in his element late into the night and early morning for two hours discussing community ratings and health care alliances and Medicaid reimbursement rates, left behind the soaring rhetoric of his speech to a joint session of Congress in an attempt to reassure questioners that in virtually all cases, they would be at least as well off, and sometimes better off. He insisted his proposal could be paid for by savings in Medicare, Medicaid and other areas and by adding a new tax of what he called "a little under a dollar" on cigarettes.

Experts invited to quiz the president during the town hall session were more dubious about that claim. John White, a Kennedy School of Government economist and former adviser to Texas billionaire Ross Perot, said he doubted that the savings would materialize but had no doubt Congress would agree to all the new benefits. He asked Clinton why he could not lock in the savings first, before expanding benefits and so quickly covering all Americans.

Clinton stuck with his timetable but said, "All of you have to be prepared to face the consequences if the cost savings don't materialize." If that happens, he said, the administration will have to "slow down the benefits, or raise more money."

Only Tuesday, senior officials pledged that if cost savings did not occur, taxes would not be raised. Aides said tonight that if additional money is needed, it would come from people paying more for benefits, not from tax increases. One major fear about new government programs is that they end up costing more than originally envisioned and that Washington never trims the benefits, only raises more in taxes to pay for them.

Some of the questions to Clinton were so detailed and his answers so involved, the exchanges were almost incomprehensible. Some were wrong. The president late in the show had to correct two of his answers after misstating small details of the program and getting offstage advice from health care adviser Ira Magaziner.

Tonight's discussion here was his first face-to-face session with average health care consumers after his Wednesday address to Congress. In it, the Tampa-area residents selected by ABC's "Nightline" staff displayed the concerns that average people, even those with insurance, have about the current system and Clinton's proposal to reform it.

In one poignant exchange, Clinton told a self-employed father who cannot pay his child's $186,000 medical bill but makes too much to qualify for Medicaid that the family is the perfect example of why the current system needs to be changed.

Clinton also faced his first sharp challenge on abortion, a procedure that would be covered under his program. He acknowledged it was a "political minefield" after a questioner objected to the "use of my tax money" for a procedure she described as immoral. Clinton offered a technical explanation of why her money was not going for abortion, but the woman was unconvinced. "A whole nother show could be devoted to this issue alone," Clinton said, suggesting that the problem of unwanted children could be solved without abortion if "every pro-life family" adopted a child.

Clinton, his voice growing hoarse by the end of the televised session, left behind a health care debate in Washington that was marked by assertions and counterassertions and offered a glimpse of the coming months.

At an American Enterprise Institute conference, Martin Feldstein, chairman of the Council of Economic Advisers in the Reagan administration, said the plan would cost the government $120 billion more in 1997 than the White House has estimated. He was joined in his attack on the administration's numbers by Michael J. Boskin, former chairman of the council during the Bush administration, who said that he had "heard nobody outside the administration" who accepts the White House's estimates of the cost of the health plan.

At the same time they were speaking, lobbyists were blitzing Washington with faxes about their positions and held more than a dozen news conferences to express their views on the Clinton health plan.

The Pharmaceutical Manufacturers Association suggested that parts of the president's plan would have a "devastating impact" on patients, mentioning his efforts to "blacklist" new drugs if they are excessively or inappropriately priced."

The Council for Responsible Nutrition contended that the U.S. health care system could save $8.7 billion annually if Americans consumed "optimal levels of the antioxidant vitamins C and E and beta-carotene."

The Coalition to Preserve Health Benefits, which described itself as a group of employers and insurers, said that Clinton's plan would reduce Americans' flexibility to choose their benefits, "returning to the one-size-fits-all health care policies of the 1950s and '60s, when male-dominated, single-earner households were the norm."

As part of the White House's public relations effort, more than a dozen Cabinet and senior staff members were racing from one end of the country to the other to promote the plan.

Feldstein's estimate is the first public challenge—that includes specific numbers—made by a nationally recognized senior economist to the tentative budget figures attached to the president's health plan by the administration.

It calls into question the ability of the plan to cover large groups of uninsured people with a "Fortune 500"-type health without huge new outlays or taxes.

Feldstein indicated he thought the administration's figures erred because of mistaken assumptions about the impact on the use of health services of bringing millions of more people under health insurance coverage; the impact on employment and earnings that employers pay for health insurance for their workers; and the practical and political possibility of getting huge amounts in saving from cutting Medicaid, Medicare and certain other items.

Staff writers Clay Chandler and Spencer Rich in Washington contributed to this report.

THE WHITE HOUSE

WASHINGTON

September 27, 1993

FROM: Lynn Margherio
Jessica Yellin

SUBJECT: State Cost Containment Efforts

I. SUMMARY

A number of existing health care organizations have successfully kept down costs without compromising quality through a combination of competition, standardization, innovative organization, and budgetary targets. Programs with proven results include: Minnesota's Mayo Clinic, a private health care provider; and California's CALPERS, a public alliance program. As well, newer reforms such as Minnesota's MinnesotaCare; Florida's regional alliances; and Washington State's Basic Health Plan promise great savings in upcoming years.

II. MINNESOTA

Mayo Clinic: Savings through Innovation

The Mayo Clinic is a private group practice organization that provides care to 300,000 patients annually through an integrated network of doctors and hospitals working on a salaried basis.

* **In FY 1991-2, the rate of growth in revenue per patient registration at the Mayo Clinic was 3.6% as compared to a 9.5% growth in national health care spending per capita. (See attached graph.)**

Mayo's cost-containment success demonstrates that good quality reduces costs. The Mayo Clinic attributes its success in cost containment to the following four factors:

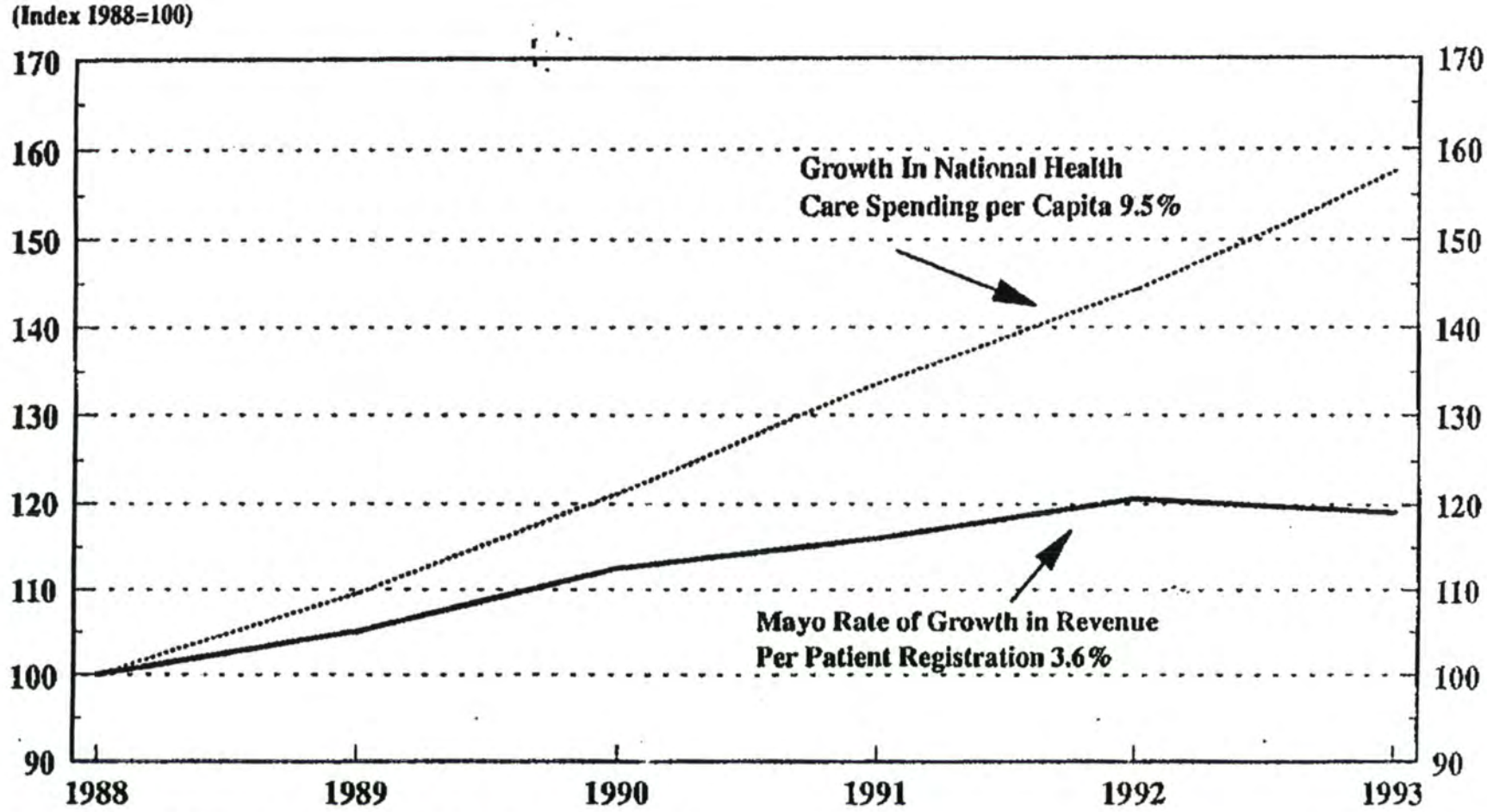
1. Efficiencies of the Integrated Group Practice Model:
   Integration of the clinic and hospital allows Mayo to streamline its operation. By creating a single administration, laboratory, medical record, and appointment system, Mayo eliminates the duplication of staff, facilities, and equipment, and enhances its efficiency.

2. Salaried Physician Staff:
   By placing physicians on a salary, Mayo eliminates any financial incentive to provide more or fewer services than a patient requires. In addition to limiting costs, this reform improves the quality of care.

3. Reliance on Out-Patient Treatment:
   Centered around a clinic rather than a hospital, Mayo avoids emphasizes outpatient care and thus avoids unnecessary hospitalization.

4. Emphasis on Quality:
   The Mayo philosophy is driven by three principles: (1) do it right the first time; (2) don't do it if it isn't necessary; (3) continuous peer review makes better medicine.

Mayo Health Care Cost Performance Index
1988-1993



Sources: Health Care Finanical Administration, Bureau of Labor Statistics &
Mayo Foundation Accounting

II. MINNESOTA

MinnesotaCare: Savings Through Budget Targets

MinnesotaCare includes subsidized coverage for the low-income uninsured; insurance reforms; new programs to improve rural health; health care data initiatives; a tax exemption for insurance to the self-employed; and a purchasing pool for employers. These reforms are financed by a cigarette tax increase and a 2% provider tax. Beginning July 1, 1994, Minnesota also plans to introduce a comprehensive cost containment program which is expected to cut state health care spending annually.

* **MinnesotaCare's spending limits are expected to achieve a 10% reduction in the rate of growth each year, for the first 5 years of the cost containment program. This will produce a cumulative savings of approximately $7 million for Minnesotans by 1997.**

Minnesota's cost containment program limits the rate of growth of public and private health care spending through the enforcement of predetermined budget targets (i.e.--premium caps). The limits are designed to allow regular inflation to fluctuate, while progressively constricting the amount by which health care inflation can exceed regular inflation. These limits are established and enforced by the Commissioner of Health, who has the authority to adjust the historical spending base to offset any artificial inflation.

Minnesota's spending limits are enforced through two mechanisms: (1) the ISN system; (2) the all-payer system.

1. Integrated Service Networks (ISN): These health plans are subject to an aggregate limit on growth of the ISNs total spending, and will be penalized for overspending (they will be faced with future growth limits).

2. The all-payer system: a payment and review system for use by all payers outside of ISNs, will also be managed to keep costs under the statutory growth limits; any excess spending will be recovered in future years by reducing provider fees, or by other methods.

The growth limits for the first five years as enacted in statute are:
1994 -- CPI + 6.5
1995 -- CPI + 5.3
1996 -- CPI + 4.3
1997 -- CPI + 3.4
1998 -- CPI + 2.6
* CPI = Consumer Price Index

Budget Target Implementation Timetable:

1/94	Introduction of Cost Containment Program
2/94	US Department of Health and Human Services will make bugetary recommendations for MinnesotaCare.
7/94	INS operational; all-payor rate setting system operational
Summer 94	Report card on quality and cost available
7/96	Minnesota Health Care Commission disbands

III. CALIFORNIA

CALPERS: Savings through Competition & Standardization

California Public Employees Retirement System (CALPERS) is a multi-employer purchaser that uses its $1.5 billion strength to negotiate premiums and purchase health care for 150 employers. CALPERS' numbers demonstrate the savings that can be realized by limiting health care increases through aggressive negotiation and standardization.

* **In FY 1992-3, CALPERS held health care increases down to 6.1%, when the nation experienced a 16% increase in costs during the same period.**

* **In FY 1993-4, CALPERS held down premium increases to 1.4%. In the same year, they achieved an overall reduction of 0.4% in premiums for HMOs, as compared to an overall increase of 10-12% for HMO premiums throughout the state of California.**

* **CALPERS estimates that in two years, they saved $180 million in health care costs. As this is a public organization, these savings are passed on to taxpayers.**

CALPERS maintains that a crucial element in containing costs is the standardized HMO benefit design. Standardization has made it easier for consumers to compare and contrast plans, and has enhanced the board's effectiveness at the negotiating table. CALPERS assistant executive officer attributes the organization's impressive 1.4% increase in FY93-4 to standardization.

The consumer-orientation of the CALPERS board has enabled this alliance to cut costs without compromising quality. The 13 member board includes 5 individuals elected by CALPERS system members -- state employees, retirees, public agency employees, and all patients in the system (of the remaining 8 members -- there are 13 members in total -- 6 are employers, 1 is appointed by governor, and 1 is appointed by the legislature). The board's demand-side focus helps to assure that high quality health care is available to its membership.

IV. FLORIDA

Regional Alliances: Savings through Competition
Florida's 11 regional Community Health Purchasing Alliances act as clearinghouses and data analysis centers for small businesses. Without negotiating premiums or establishing a standard package, the CHPAs assist consumers by offering individualized advice to each buyer, by publishing comprehensive evaluations of each participating insurer, and by increasing the leverage of the small business buyer.

Although legislation was only recently passed, Florida has already begun to see lower bids and increased efficiencies.

* **In the latest negotiations for the Lee County employee health care contract, 15 plans came forward with bids. According to a preliminary analysis, the lowest bidder, the Columbia Hospital Group, a recently formed network, bid $7.5 million -- 40% below the county's expected $12 million cost.**

* **In Orlando, the 78-member Central Florida Health Care Coalition succeeded in negotiating better prices with regional hospitals that enabled the Orange County School Board to keep 20 teaching jobs it had planned to cut.**
  -- The coalition persuaded hospitals to analyze why costs and quality of care differed for patients with the same illnesses. With this information, costs per patient admission for the two major hospitals fell 2% in each of the past 2 years; death and complication rates improved across a variety of procedures.

Florida attributes its success in cost reduction to providers' desire to position themselves for the opportunities that will exist under the state's new managed competition system. As the new system is entirely voluntary, Florida points to the above successes as evidence that providers will voluntarily increase efficiency and reduce costs in a competitive environment.

V. WASHINGTON STATE

Basic Health Plan: Savings through Standardization, and Budget Targets

Washington's Basic Health Plan is a program of subsidized health care coverage initially created to provide premium reduced coverage for the low-income uninsured, with adjustments based on age, family size, and income. In 1993 the plan was enlarged to include small businesses and subscribers with higher incomes who must pay the full cost (they receive no state subsidy), but benefit from the state's negotiating power.

Projected savings from the Washington plan, implemented in its current form July 1, 1993, include the following:

* **Without health care reform, the cost of insurance premiums is expected to rise 13% per year, costing businesses and households $22 billion annually by the year 2005.**

* **Under health system reform, the growth rate of health insurance premiums is expected to fall to 5% per year, saving businesses and households $7 billion annually by the year 2005.**

The cost control features of the Washington State health system reform include managed competition, managed care, malpractice reform, consolidated purchasing groups, administrative efficiencies, premium caps, practice guidelines, reduced cost-shifting, and preventive services. In addition to these features, Washington underscores the effectiveness of establishing a standardized benefits package as a means of simplifying the negotiation process and thus enhancing the state's effectiveness in bringing down costs at the negotiating table.

Washington's premium caps are also expected to help to limit the growth in health care costs. Washington policymakers believe that the presence of premium caps complement the competitive structure. Premium caps force health care providers to be more efficient by limiting the flow of funds into the health care system.

Timetable for Implementation of Premium Caps:

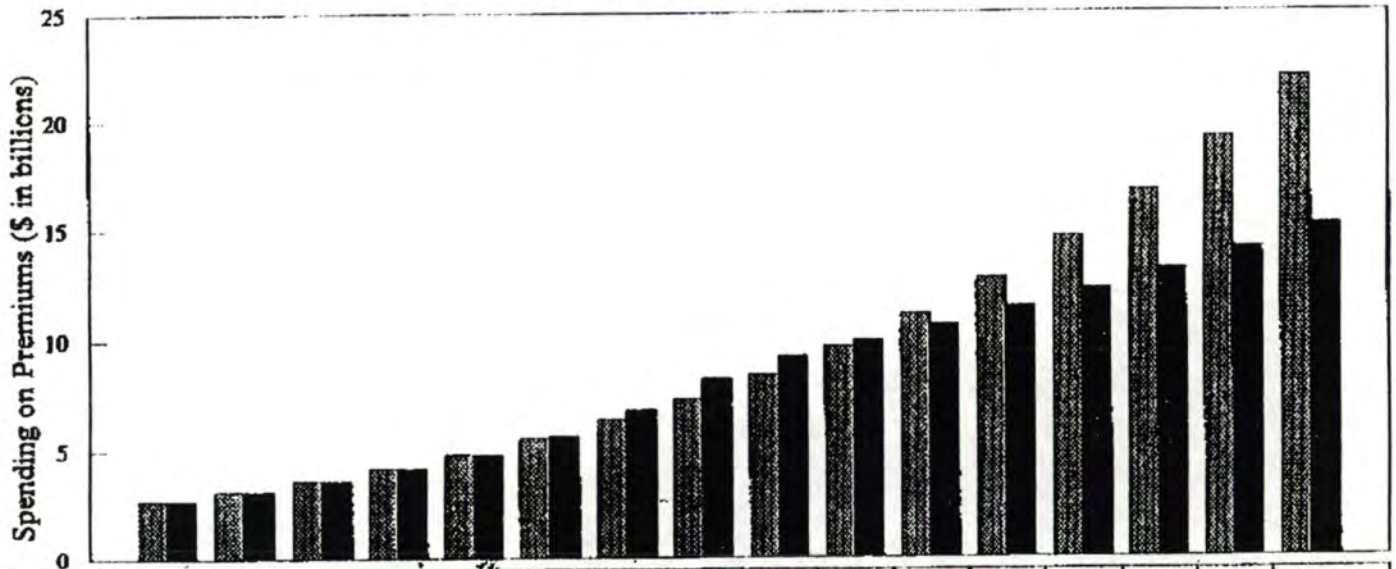
1993-1995-- 14% (or 13% per capita) is the estimated aggregate growth in premiums for the uniform benefit package under the reformed system.

1996-c.2000 -- 2% annual reduction in growth rate of premiums for uniform benefit package until they reach the level of the projected 5-year moving average of Washington State per capita personal income growth (approximately 5% per year.)

2005 -- Growth rate of health insurance premiums expected to fall to 5% per year.

BUSINESS AND HOUSEHOLD SPENDING ON HEALTH INSURANCE PREMIUMS

In Billions of Dollars, Nominal



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Without Reform	$2.7	$3.2	$3.6	$4.2	$4.8	$5.6	$6.4	$7.4	$8.5	$9.7	$11.1	$12.7	$14.6	$16.7	$19.2	$22.0
With Reform	$2.7	$3.2	$3.6	$4.2	$4.8	$5.7	$6.9	$8.3	$9.3	$10.0	$10.7	$11.4	$12.3	$13.1	$14.1	$15.2

Without health care reform, the cost of insurance premiums is expected to rise 13% per year, costing businesses and households $22 billion annually by the year 2005.

Under health system reform the growth rate of health insurance premiums is expected to fall to 5% per year, saving businesses and households $7 billion annually by the year 2005.

Cost Control Features of Health System Reform

Managed Competition	*Consolidated Purchasing Groups*	*Practice Guidelines*
Managed Care	*Administrative Efficiencies*	*Reduced Cost-Shifting*
Malpractice Reform	*Premium Caps*	*Preventive Services*

Washington State

From: Gregory E. Lawler

September 27, 1993

Re: Antitrust

The AMA feels that the DOJ guidelines and our description in the plan book do not go far enough. The Antitrust Division and the antitrust supporters on the Hill, such as Senator Metzenbaum, feel we have gone too far.

There are three provisions at issue --

• **State Action** - we have said DOJ will put out guidelines on state action, interpreting current law to assist hospitals and others in knowing whether state laws provide them immunity. DOJ believes guidelines in this area are unnecessary since the case law is clear, and their guidance would do little good. The American Hospital Association would like these guidelines; the AMA cares little, if at all.

This issue should not be a big deal, although Metzenbaum may ask about it. DOJ doesn't want to do guidelines, but I don't think they object strongly; the FTC is obviously a different story since they are an independent agency.

• **Provider Collaboration and Fee Schedule Negotiation** - Since alliances will be establishing fee schedules, under the plan physicians and others are allowed to negotiate with alliances on the fee schedule. The plan says DOJ and the FTC will put out guidelines describing what the term negotiations allows.

DOJ objects to the use of the word negotiations, preferring "discussions and information". They believe the term negotiation has a context under antitrust law which is too broad.

The AMA believes the language is not broad enough. They want language that makes it clear they can collectively negotiate, and if there is no agreement, there is some mandatory, binding process of resolution. They want an exception written into the antitrust laws to allow this activity.

Metzenbaum and others object to the language the way it is, for the same reasons as DOJ. He will violently object to this provision if we do what the AMA suggests.

(Metzenbaum's staff has said they will provide copies of his questions prior to Thursday's hearing.)

• **Physician Network Joint Ventures** - The DOJ guidelines allow physicians who share financial risk and have less than 20% of the market to operate in the "safety zone", without fear of antitrust prosecution.

The AMA wants to eliminate from the guidelines the requirement of sharing risk and to raise the 20% to 35%.

There is no easy resolution of these issues between the AMA and DOJ. We need to continue to explore solutions.

The answers to questions from those opposed to antitrust changes, such as Metzenbaum, are --

- we have a new system with new requirements on health care providers. We need to make sure they can accomplish what we are counting on so that consumers will be better off - for example, hospitals sharing equipment without reducing competition.

- we want a competitive system, but we also want a fair system. When we establish fee schedules set by alliances, we need to be fair to providers.

- we are reviewing exactly what guidance people need in light of the new system. Where competition is called for, we want to encourage it. Where we put duties on people to cooperate, we need to protect them. These are tough legal issues, and we are continuing to discuss them.

CRITIQUE OF MEDICAL IRAs OR "MEDISAVE" ACCOUNTS

This approach would also shift responsibility for health care from employers to individuals. It revolves around the creation of "Medisave" accounts, medical accounts along the lines of Individual Retirement Accounts, to encourage individuals to put money away to cover small medical bills. Employers might be asked to contribute a certain amount for each employee to the accounts but employer-provided insurance would no longer be tax deductible.

State requirements for minimum insurance benefits would be eliminated to create a market for catastrophic health plans that would cover only major medical expenses. Tax incentives would encourage consumers to purchase such plans. Individuals would pay for routine care and deductibles out of their Medisave accounts, using insurance only for more serious medical problems. They would retain whatever funds they did not use from their accounts, creating an incentive for them to keep health care use down.

The biggest drawback to this approach is that it creates a disincentive for people to seek out and receive the less costly primary and preventive services that keep people healthy and lower long-term medical costs, while having a catastrophic plan in place to fully cover major hospitalizations. This perpetuates a system in which insurance rewards consumers by covering the costs of care when they seek it too late and in the most expensive settings, and punishes them (by drawing down these savings accounts) when they seek early, primary, inexpensive treatments.

We agree with the premise embodied in this approach: consumers should make informed choices regarding health plans, and share the financial responsibility for purchasing insurance coverage and paying for care. However, the Medisave model would leave too many Americans with inadequate protection against health care costs. Further, it seeks to control costs by pitting individual consumers against doctors and hospitals without giving them the clout to bargain effectively. As a result, health care costs would continue to rise, leaving the American consumer paying the bill. And again, Medisave accounts create incentives for consumers to delay needed care, resulting in more complex medical problems and ultimately require more costly treatments.

Clinton Presidential Records
Digital Records Marker

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HOUSE WAYS AND MEANS COMMITTEE

MEMBER PROFILES AND BACKGROUND

for

SEPTEMBER 28th HEARING

WAYS AND MEANS COMMITTEE
September 24, 1993

DEMOCRATS:

CHAIRMAN DAN ROSTENKOWSKI (D-IL): The delicacy of the situation of the Chairman of the Ways and Means Committee is clear. In a September 22 column, David Broder pictures Rostenkowski as anxious to pass this historic health care legislation, both because of his own personal problems and because of his treatment during the repeal of catastrophic.

RECENT DEVELOPMENTS: Following the President's address, Rostenkowski told the AP that he thought the plan might not solve all problems but it's a start. "I'll do whatever I can to pass it." He also told the Chicago Tribune that the tobacco tax is likely to be 75 cents a pack.

POLITICAL PROFILE

After over three decades in the House, Ways and Means Committee Chairman Dan Rostenkowski still wields a heavy gavel. He backs his subcommittee chairmen, allowing them free reign to move key legislation. However, during the last session, as the debate over health care reform heated up in the Health Subcommittee, Rosty refused to let Subcommittee Chairman Stark's bill move without assurances it could garner the votes necessary to pass the full Committee. The bill died in Subcommittee. Since 1989, the Chairman's ability to build coalitions on health care issues within Committee has diminished.

In 1989, he opposed the Medicare catastrophic coverage repeal, but outside interests stymied his efforts to save this legislation. He was particularly upset with the tactics of the pharmaceutical industry in opposing the legislation. On health care reform the Chairman has not taken a position, preferring to keep his options open. In the last Congress, he leaned toward small group market reform and other incremental reforms. While this was the case, he also introduce an employer-based, comprehensive reform initiative that controlled costs by regulating provider payments. Interestingly, his bill also addressed the expensive retiree health issue by lowering the Medicare eligibility age to 60.

HEALTH REFORM ISSUES/PRIORITIES

Chairman Rostenkowski's primary concern in the upcoming health reform debate will be how the new program is financed and, relatedly, the jurisdiction his committee receives, rather than the details of the plan itself. Lately, the Chairman has been one of the members asking that the Administration is careful to take the time to ensure the plan is done right. He and his staff have indicated that they do not believe a mark-up is possible in

1993.

LEGISLATIVE INTERESTS

103rd: Cong. Rostenkowski has sponsored legislation (H.R. 19) to provide coverage of certain preventive services under part B of Medicare. He cosponsored a bill to improve the administration of the Medicare program (Pickle, H.R. 22).

CONGRESSMAN SAM GIBBONS (D-FL): While he is not a major player on health care issues, Congressman Gibbons wants to be helpful. He has long advocated extending Medicare coverage to all Americans.

On July 21, Gibbons told the Congressional Monitor: "I have told the Clintons that I would be ready to support whatever system the President comes up with."

POLITICAL PROFILE

Although Cong. Sam Gibbons has been in the House for over three decades and involved in many major debates, he has always been a step or two away from real power. For a decade he has held the No. 2 spot on Ways and Means. Gibbons was the floor manager for many of the social programs of the Great Society during the Johnson Administration. However, he voted against school busing and the Civil Rights Amendments of 1964 and 1968. He has since changed his stand on civil rights. Gibbons' primary legislative issue is free trade. As chairman of the Trade Subcommittee, he has blocked numerous Democratic attempts to raise trade barriers.

HEALTH REFORM ISSUES/PRIORITIES

Gibbons has not been a major player on health care legislation. However, he obviously will be the focus of much attention should there be any change in the Committee Chairman's status. One expects that his primary interest will be the preservation and protection of Medicare. In addition, his trade interests may make competitive advantages arguments (on health reform) very appealing.

LEGISLATIVE INTERESTS

103rd: Cong. Gibbons cosponsored the Family and Medical Leave Act of 1993 (P.L. 103-3).
Gibbons is also a cosponsor of H.R. 1200, the single payer bill sponsored by Cong. McDermott.

CONGRESSMAN J.J. (JAKE) PICKLE (D-TX): Congressman Pickle has been a key player on major issues, including Social Security. Pickle opposes global budgets or caps because he believes they undermine competitiveness. He is close to the AMA and the hospital lobby. Pickle worked with Congressman Stark in an unsuccessful attempt to rescue Medicare Catastrophic Act. Pickle rarely bucks his Chairman, however he is on Gephardt's list as a "no".

POLITICAL PROFILE

Like Lyndon Johnson, whose House seat he occupies, Cong. J.J. Pickle is a man of rural populist roots. As an LBJ protege, in his first two years in the House Pickle backed the Civil Rights Act of 1964 and the Voting Rights Act of 1965, which caused him political difficulty in his district. Now third in seniority on Ways and Means, he has been involved in a variety of major issues, including Social Security, trade and revision of the tax code. Significantly, Pickle rarely bucks the Chairman's priorities and is rewarded as a result. Partly because of this philosophy, he strongly supported the Chairman's defense of the catastrophic health care legislation.

Whatever he does on the Oversight Subcommittee in the future, he will have trouble matching his earlier achievements as chairman of the Social Security Subcommittee in the 98th Congress. Convinced that the way to save the Social Security system was to raise the retirement age, he successfully prevailed on the House floor against Claude Pepper of Florida, who proposed solving the system's financing problems by increasing the payroll tax. Pickle's approach became law in 1983 and he relinquished the Social Security subcommittee chairmanship, saying that he had accomplished his major goal.

HEALTH REFORM ISSUES/PRIORITIES

Pickle is closely allied with the Texas Medical Association and the Texas Hospital Association. This helps explain why he is so adamantly opposeds global budgets or caps. He believes they undermine competitiveness. Rural health issues are also extremely important to him. In a recent meeting, Pickle expressed his concern about health reform's impact on third party administrators (TPAs). Lastly, unlike most of his Texas counterparts, Pickle is a pro-Choice old time Democrat.

LEGISLATIVE INTERESTS

103rd: Cong. Pickle introduced legislation (H.R. 22) to improve the administration of the Medicare program (as well as a number of other Federal agencies). The bill emanates from Pickle's Oversight Subcommittee and institutes management reforms designed to prevent fraud, abuse and mistaken payments. In the 102nd Congress, Pickle introduced similar legislation, which was incorporated into H.R. 11, the Revenue Act of 1992.

CONGRESSMAN CHARLES RANGEL (D-NY): Many observers believe Congressman Rangel will be the next chairman of the Ways and Means Committee.

POLITICAL PROFILE

Cong. Charles Rangel has held the secure Harlem, New York City district seat for over two decades. He is 4th in seniority on Ways and Means and is a past chairman of the Health Subcommittee. Rangel is known as a skillful backroom negotiator, and he sees himself as a protector of the true liberal traditions of the Democratic Party. Rangel ran unsuccessfully against Tony Coelho for Democratic Whip in 1986. On the heels of this defeat, Rangel scrambled to recapture the chairmanship of the Health Subcommittee, but the Democrats voted 17-4 to give the job to Pete Stark. He is often vocal about his problems and is known to complain about being shut out of debates. When the 103rd Congress decided to reduce the number of Select Committees, the Select Committee on Narcotics Abuse, chaired by Rangel, was the first to be voted out of existence.

Rangel is critical of liberalizing trade with Mexico, because of his belief that lowering the trade barriers will allow illegal drugs to enter the United States. This helps explain his stong opposition to NAFTA.

HEALTH REFORM ISSUES/PRIORITIES

The Congressman is interested in health care policy, but is not viewed as a key player. He is very concerned about urban health and access for the poor. He is very influential with the Congressional Black Caucus. He has co-sponsored a number of single payer bills, including the McDermott bill. In addition, he has also supported the Matsui and Slattery bills which are designed to expand coverage to women and children. Rangel believes that drug abuse is one of the causes for spiraling health care. He is expected to be with the Administration, as long as the CBC is happy, and there is no overly regressive tax hike. His focus on health care will be on adequate subsidies for the poor and to assure that inner-city urban populations are well served. In addition, he will continue to be a strong advocate for adequate benefit coverage of chemical and substance abuse.

LEGISLATIVE INTERESTS

103rd: Cong. Rangel has sponsored H.R. 15, the Enterprise Zone Community Development Act of 1993, which would provide tax incentives to encourage private development in the inner cities. He cosponsored the Family and Medical Leave Act (P.L. 103-3) and a Pickle bill to improve the administration of Medicare (H.R. 22). Rangel is a cosponsor of H.R. 1200, the single payer bill sponsored by Cong. McDermott.

CONGRESSMAN PETE STARK (D-CA): Despite frequent consultation with him, the Chairman of the Health Subcommittee has been critical of the Administration's health care reform efforts from the start - and that posture seems unlikely to change in the foreseeable future. Stark is also Chairman of the District of Columbia Committee and he has already told District officials that they may need special provisions under the plan. The District now believes they will need special insurance subsidies because of the city's high cost of living.

Recent Developments: Congressman Stark has continued to be highly critical of the plan, particularly proposed cuts in Medicare and Medicaid. Among his more noteworthy comments:
September 9 in USA Today: I am unwilling to risk the destruction of Medicare just so the President can claim a pyrrhic victory;"
September 10 (Washington Times): "If you think limiting premiums will control costs, show me what you're smoking;"
September 13 (USA Today): "We're not going to make huge changes. People are quite comfortable and the seniors love Medicare."

At a staff briefing on September 13, Stark asked whether our plan would mean the elimination of Medicare. When told that we envisioned a single-tier system, he wondered what happened to the Medicare payroll taxes. He was not satisfied with Ken Thorpe's response and expressed concern over the whole scenario in a subsequent conversation with John Rother of AARP.

Following the President's speech, Stark was quoted as follows in USA Today: "The Clinton Administration is obsessed with being against the federal government."

POLITICAL PROFILE

Liberal Cong. Pete Stark has developed a reputation for being unorthodox. However, as Chairman of the Ways and Means Subcommittee on Health, he has been effective in moving legislation consistent with the liberal agenda. Stark was dealt a major blow in his efforts to improve health services for the elderly when the Medicare catastrophic coverage legislation was repealed. The demise of this legislation left many members of Congress wary of future efforts to expand health care coverage for any group.

Stark moved quickly during the 102nd Congress to introduce legislation which provided universal health care coverage based on a play-or-pay model. As the 102nd Congress drew to a close, and the House leadership searched for a reform vehicle to move, Stark offered up his "Health Care Cost Containment and Reform Act", which would have expanded health care coverage while reforming the health insurance market. The bill was held by Chairman Rostenkowski and did not move out of subcommittee.

HEALTH REFORM ISSUES/PRIORITIES

Medicare-for-all is Pete Stark's preferred approach to health care reform. He believes the Administration's health care reform plan would dismantle the Medicare program. Pete Stark is deeply distrustful of market-based approaches to contain costs or deliver appropriate, quality health care. As such he has significant reservations about anything in our proposal that relies too heavily on what is labeled as managed competition. He therefore believes our reliance on risk adjustments borders on fantasy. He is sharply critical of the HMO industry.

The HMO industry is not the only health player that Pete Stark has had run-ins with. He has had major feuds with the AMA, the AHA, the HIAA and Blue Cross, and the Pharmaceutical Manufacturers Association.

Although not market oriented, he also is greatly skeptical about the ability to guarantee cost containment through the use of premium caps. He cites his recently released CBO requested study as evidence. (He believes down to the core of his existence that the only way to control costs is through direct rate regulation.) Despite all of his bluster and strong policy feelings, his number one priority is to be the player in the House that delivers on health care reform. As such, we anticipate that in the end he will be an Administration ally.

LEGISLATIVE INTERESTS

<u>103rd</u>: Cong. Stark has re-introduced the Health Care Cost Containment Act (H.R. 200); also H.R. 2610, a Medicare-for-all plan. He has sponsored legislation to extend and improve the ban on physician referrals to health care providers with which the physician has a financial relationship (H.R. 345); impose an excise tax on certain sales of assets of medical service organizations to managers, etc. of such organization (H.R. 483); establish in the Food and Drug Administration the Patented Medicine Prices Review Board to regulate the prices of certain prescription drugs; and amend the Internal Revenue Code to recapture certain tax benefits (H.R. 916). He has cosponsored the Family and Medical Leave Act (P.L. 103-3) and Cong. Rostenkowski's bill to cover certain preventive services under Medicare (H.R. 19). He has also cosponsored a measure to improve the administration of the Medicare program (H.R. 22). Stark is a cosponsor of H.R. 1200, the single payer bill sponsored by Cong. McDermott.

CONGRESSMAN ANDREW JACOBS (D-IN): Congressman Jacobs is one of the most individualistic Members of Congress. He is the former Chairman of the Health Subcommittee and the present Chairman of the Social Security Subcommittee. Jacobs is strongly anti-smoking, and has advocated the doubling of the cigarette tax and earmarking the funds to pay for health care. Being the maverick that he is, it is and will be difficult to impossible to predict how he will vote on health care reform.

RECENT DEVELOPMENTS: After the President's speech Jacobs said, "I have my apprehensions about the employer mandate. I am encouraged there is a bipartisan atmosphere emerging. I am for the medical savings account plan. I don't like single payer. You've heard the saying, 'If it ain't broke, don't fix it?' Well, if it can be fixed, don't replace it. I will take it item by item as we go through the plan in the coming months."

POLITICAL PROFILE

Indianans seem attracted by the same traits in Cong. Andrew Jacobs that have kept him an outsider in House politics. Outspoken in his fiscal conservatism and attention to federal waste, he has long opposed congressional salary increases.

Before becoming Chairman of the Social Security Subcommittee, Jacobs chaired the Health Subcommittee. When the Social Security Reform Act reached Ways and Means in 1983, he added a Medicare payment plan which set fixed costs for inpatient treatment of various diseases. He also pushed to freeze Medicare payments to physicians and to prohibit the charging of extra fees beyond those covered by Medicare.

HEALTH REFORM ISSUES/PRIORITIES

Strongly anti-smoking, Jacobs has been a consistent advocate of doubling the cigarette tax and earmarking the extra revenues for the Hospital Insurance trust fund. He is also closely associated with the Pharmaceutical Manufacturers Association. He was a strong advocate of their position in Committee during the catastrophic health care debate.

LEGISLATIVE INTERESTS

103rd: Cong. Jacobs has sponsored legislation to streamline the Social Security disability application and appeal process (H.R. 646); to make the Social Security Administration independent of the Department of Health and Human Services (H.R. 647); to require the Secretary of the Treasury to issue to the Social Security trust funds certificates of U.S. obligations (H.R. 931); and to strengthen provisions prohibiting the use of Social Security symbols for deceptive purposes (H.R. 978).

CONGRESSMAN HAROLD E. FORD (D-TN): Representative Ford is the Chairman of the Human Resources Subcommittee which will have jurisdiction over the Administration's welfare reform. As such he will be interested in the link between reform of health care and of welfare.

Ford is supportive of health reform but not wedded to any particular approach. He has voiced concern for the elderly in the past.

POLITICAL PROFILE

After spending two Congresses waiting vindication from allegations of bank, mail and tax fraud charges, Cong. Harold Ford was cleared of charges at the beginning to the 103rd Congress, and chairs the Ways and Means Subcommittee on Human Resources. With the reclamation of the Chair, Cong. Ford reasserted his position as a leader on national welfare policy. During the 1987 debate on welfare reform, Ford sponsored his own welfare reform legislation, the centerpiece of which was job training for welfare recipients. Major portions of Cong. Ford's legislation were incorporated into the welfare reform package which became law in 1988. Importantly, he has strong reservations about everything the Clinton Administration is contemplating doing about welfare reform.

HEALTH REFORM ISSUES/PRIORITIES

Ford will be interested in health care reform as a facilitator of welfare reform. However, his discomfort with the Administration's more conservative approaches to welfare reform may lead him to voice related concerns over the health reform proposals. Specifically, he will be protective of low income populations and foster children. He will resist efforts that he views that will isolate the poor in low cost plans. Similarly, he will be critical of asking the poor to be "responsible" for paying a portion of their health care costs if he perceives that payment to be burdensome.

LEGISLATIVE INTERESTS

103rd: Cong. Ford cosponsored the Family and Medical Leave Act of 1993 (P.L. 103-3) and the Federal Program Improvement Act of 1993 (Pickle, H.R. 22). Ford is also a cosponsor of H.R. 1200, the single payer bill sponsored by Cong. McDermott.

CONGRESSMAN ROBERT MATSUI (D-CA): Congressman Matsui is a well respected Committee member who tends to follow the Chairman on major issues. He is very close to big business and, in particular, for profit hospitals and nursing homes. He views himself as a moderate who the Administration should lean on mjore frequently as a dealmaker. This was evidenced by the meeting he requested with the First Lady, Congresswoman Kennelly, and other moderate members of the Ways and Means Committee on August 6.

RECENT DEVLOPMENTS: After the President's speech he called the plan a step in the right direction, but that Congress may want to explore alternatives for limiting increases in insurance premiums. Congress has "to make sure it is not so onerous that it affects the quality of care and the ability of providers to do the kind of work . . . that we have been used to." He backs the employer mandates in the plan because companies that provide health insurance end up indirectly subsidizing those that do not. He was also optimistic of passage. He said, "Before the end of this Congress we will have major health care reform that is comparable to the Medicare and Medicaid legislation of 1964."

POLITICAL PROFILE

First elected to the House in 1978, Cong. Robert Matsui, is considered a loyal Democrat, but one who often sets his own agenda. He is a skilled fundraiser who has considered seeking higher offices including Alan Cranston's U.S. Senate seat and the California governorship.

With seven terms on the House Ways and Means Committee, Cong. Matsui combines a liberal approach to tax policy with a strong interest in protecting California businesses. Matsui's greatest accomplishment in the House was on Japanese-American redress. He was one of the lead sponsors of the 1988 law which provided monetary compensation for every survivor of the internment camps and for so-called "voluntary evacuees."

HEALTH REFORM ISSUES/PRIORITIES

On health issues, Congressman Matsui supports phasing in coverage for pregnant women and children first and introduced legislation to achieve this goal in the last Congress. He supports sin taxes and can push them on the committee. He also supports a tax cap, like the one recommended by the Jackson Hole group, because he believes it is necessary to force employees to make real choices. In addition, Congressman Matsui supports global caps to control costs.

LEGISLATIVE INTERESTS

103rd: Cong. Matsui introduced H.R. 727, the Children and Pregnant Women Health Insurance Act of 1993, to provide health insurance coverage for pregnant women and children through employment and State based insurance plans.

CONGRESSWOMAN BARBARA KENNELLY (D-CT): Congresswoman Kennelly can be a valuable ally both with the Congressional Women's Caucus and the House's Old Guard.

POLITICAL PROFILE

Cong. Barbara Kennelly has a knack for getting along with the male-dominated House leadership. She had been in the chamber less than a year when she won a seat on Ways and Means and in 1984 she was appointed to the Democratic Steering and Policy Committee. In the 102th Congress, she became a Chief Deputy in the majority whip organization. Kennelly is also the first woman to serve on Intelligence as Chairwoman of the Subcommittee on Legislation. As one of her first accomplishments on Ways and Means, she won passage of a law to encourage payment of child support. She is also considered an expert on the taxation of the insurance industry, and she has actively promoted legislation affecting the industry.

HEALTH REFORM ISSUE/PRIORITIES

Despite concerns about her Connecticut insurance constituency, Rep. Kennelly wants health care reform as shown by her request to meet in August to discuss strategy. She is a strong advocate of woman's health issues, particularly the coverage of mammography. If treated with sensitivity on the insurance side of the equation, she should be able to be counted on as a strong and influential ally during the reform debate.

LEGISLATIVE INTERESTS

103rd: Cong. Kennelly introduced legislation to improve Medicaid nursing home coverage and to clarify the tax treatment of long-term care insurance (H.R. 2407). She cosponsored the Family and Medical Leave Act of 1993, (P.L. 103-3), and the National Institutes of Health Revitalization Act (Waxman, H.R. 4).

CONGRESSMAN WILLIAM (BILL) COYNE (D-PA): Congressman Coyne is a former member of the Ways and Means Health Subcommittee. Coyne is a team player who prefers to work behind the scenes and is ALWAYS loyal to the Chairman.

POLITICAL PROFILE

Although he was elected to Congress in 1980, Cong. William Coyne has been so quiet that he has been almost invisible. Previously an accountant and a 10 year veteran of local politics, Coyne works almost entirely behind the scenes in Congress. A Party loyalist and member of Ways and Means since 1985, Coyne just switched from the Health to the Trade Subcommittee. Coyne is actively involved in issues related to his Pittsburgh district's steel industry. For example, Coyne has supported an extension of Clean Air Act compliance dates for the steel industry; promoted additional funds for unemployed workers; proposed enterprise zone legislation; and sponsored legislation to require the Bureau of Labor Statistics to collect and report data on "discouraged" workers. Coyne has never faced serious opposition, and has easily won each reelection, usually with over 70 percent of the vote.

HEALTH REFORM ISSUES/PRIORITIES

Congressman Coyne supports the single payer model and is particularly concerned about the effect of Medicare cuts on beneficiaries. Coyne likes and respects Congressman Stark and supported him when serving on the Health Subcommittee.

While on the Health Subcommittee, Coyne co-sponsored the Russo Single Payer and the Stark-Gephardt Health Care Reform bills. His primary health priorities are coverage for mental health and reimbursement for psychologists and other non-M.D. mental health providers.

LEGISLATIVE INTERESTS

103rd: Cong. Coyne cosponsored the Family and Medical Leave Act (P.L. 103-3). Coyne is a cosponsor of H.R. 1200, the single payer bill sponsored by Cong. McDermott, and
H.R. 2610, the Medicare for all bill sponsored by Cong. Stark.

CONGRESSMAN MICHAEL ANDREWS (D-TX): Congressman Andrews is one of the conservative Democrats on the Committee. He is close to Chairman Rostenkowski, as well as Secretary Bentsen and Rep. Stenholm. Andrews is considered a bellwether for his delegation.

Recent Developments: In public statements, Andrews has been very supportive of tobacco excise taxes. On September 9, he told Knight-Ridder: "I honestly believe we cannot have health care reform without a cigarette tax."

On September 24, Andrews was quoted as follows in the New York Times: "By giving so much regulatory power to the alliances, Clinton's plan will undermine the competition we are trying to promote."

After the President's speech, he told the Houston Post, "I used to think, it's going to be so hard to get beyond these special interest groups. I don't think that anymore." But he still worries about too much "government intrusion."

HEALTH REFORM ISSUES/PRIORITIES

One of the new members of the Health Subcommittee, Cong. Andrews is enjoying his new status. A member of the Conservative Democratic Forum, Andrews was a key force behind the introduction of the "Managed Competition Act." Although the bill has yet to be reintroduced, CDF members (Andrews, Cooper, and Stenholm) are expected to soon reintroduce this legislation to lay it down as a marker and to assure their roles on the debate.

His primary concerns include children, immunization, low-income women, rural areas, and academic health centers. He is pro-choice and anti-tobacco. Andrews supports a tax cap on benefits and the use of excise taxes, particularly cigarette taxes, to fund health care reform. He is nervous about cost controls and the impact they might have on managed competition. Likewise, he is concerned about the impact of employer mandates.

Congressman Andrews' district is known as the health capitol of the world because the Texas Medical Center -- the largest facility in the nation -- resides there. He is close to the Texas AMA. He is not known to be an idealogue and, as such, should be open to horse trading during the legislative development process.

LEGISLATIVE INTERESTS

103rd: Cong. Andrews introduced legislation to increase excise taxes on cigarettes and use the money to expand Medicaid (H.R. 1246). Cong. Andrews has cosponsored legislation to protect children from exposure to environmental tobacco smoke (Durbin, H.R. 710).

CONGRESSMAN SANDER LEVIN (D-MI): Congressman Levin was one of the Subcommittee members who asked to meet in August to discuss strategy.

Levin will be influenced mainly by unions and retirees. In addition, Levin has a large teaching hospital in his district and he actively defends GME payments. Levin is a quiet member, but helpful behind the scenes. He helped draft the Stark-Gephardt compromise in the 102nd and was one of the last defenders of the Medicare Catastrophic Act.

POLITICAL PROFILE

A former labor leader who represents a district dominated by auto industry workers, Cong. Sander Levin's main interest is international trade. A strong loyalist, Cong. Levin was appointed to the Ways and Means Committee in 1988. He has used the seat largely to pursue his interests on trade. First elected in 1982, he has easily won each reelection with over 70 percent of the vote.

Known for his gentlemanly demeanor and cerebral (if verbose) approach, Levin tends to discuss complex issues in detail. When he first arrived on Ways and Means, Levin proposed welfare reform legislation, which he cosponsored with Senator Moynihan of New York. His bill would have required states to establish work training and education for AFDC recipients and provide services to help those trying to become self-sufficient.

HEALTH REFORM ISSUES/PRIORITIES

On health care, Levin has not endorsed any reform proposal; however, he was an important participant in drafting H.R. 5502, the Stark-Gephardt compromise proposal of the 102nd Congress. Congressman Levin believes that consumers want fraud, waste and abuse cut before they will be willing to pay more. He believes that the Administration can cut costs by using home care and living wills. He thinks that Congress will need plenty of Presidential leadership and warns about over-promising on health care.

In support of the large teaching hospitals in his district, Levin defends Medicare payments to hospitals (particularly indirect medical education (IME) payments to teaching hospitals). Of note, he has been the primary author of every major mental health Medicare expansion that has been passed during the six years. Although he does not want to be taken for granted (and should not be), he can be counted on to be a loyal and helpful ally during the debate.

LEGISLATIVE INTERESTS

103rd: Cong. Levin cosponsored the Family and Medical Leave Act (P.L. 103-3).

CONGRESSMAN BEN CARDIN (D-MD): Congressman Cardin is one of the Subcommittee members who most wants to see health care moved in this Congress. Cardin is close to Rostenkowski and has continuously urged the Administration to undertake widespread consultation before introduction of the final bill.

Recent Developments: On September 9, Cardin told the New York Times: "If Medicare and Medicaid are subjected to the same type of cost controls as the private sector, then its fair." That same day, he said in the Congressional Record: "President Clinton's commitment to national health reform gives this Congress an opportunity to address the real needs of American families."

POLITICAL PROFILE

After serving in the Maryland State Legislature for 20 years, the last 8 as Speaker, Congressman Cardin was elected to Congress in 1986. Cardin was only 23 when elected to the State Legislature, and at 35, became the youngest Speaker in the State's history. In his third year in Congress, Cardin was appointed to Ways and Means. At home, Cardin has easily won each reelection with over 70 percent of the vote. In his capacity on the Ways and Means Subcommittee on Health, Cardin has supported the party positions on Medicare and Social Security.

HEALTH REFORM ISSUES/PRIORITIES

Cardin strongly advocates an all-payer rate setting system like the one he helped to create in Maryland. In addition, he believes the federal government should adopt national standards and use the states for implementation. He will always be a strong advocate for state flexibility.

Although Cardin introduced his own state-oriented health care reform bill last year, he was an active participant in drafting H.R. 5502, the Stark-Gephardt compromise bill. In addition, Cardin sponsored Medicare bills that would impose standards relating to the prevention of fraud and abuse on suppliers of durable medical equipment under Part B of Medicare.

LEGISLATIVE INTERESTS

103rd: Cong. Cardin sponsored a bill modeled after Maryland's program that would allow states to develop their own rate-setting/payment programs to meet a budget target. It includes an emphasis on preventive care and portability in insurance plans (H.R. 1398). He cosponsored the Family and Medical Leave Act (P.L. 103-3). He also co-sponsored Cong. Fazio's access to abortions bill and legislation to require/expand

Medicaid/Medicare coverage of mammography screening. In addition, he sponsored a provision that was included in OBRA 1993 to provide coverage of anticancer drugs in Medicare.

CONGRESSMAN JIM MCDERMOTT (D-WA): Since gaining the throne of single payer lead sponsor from Marty Russon, Jim McDermott has received more national attention in one year than he has in all his time as a public figure. He enjoys his position and will likely use the role to extract as much out of it as possible.

Recent Developments: On August 30 McDermott told USA Today that health care would be the "toughest battle of the last 75 years." After the White House briefing on September 3, he was critical of the White House for insufficient dollar figures on Medicare and Medicaid and told the AP that without those there would be "wholesale Democratic defections." McDermott continues to push his single payer approach; however, on September 7th, he told the Boston Globe, "It's not my bill versus the President's. I will keep working for a compromise I can live with." On September 10, he told the L.A. Times, regarding the consultation process, "There has been very little in the way of tangible evidence that they have really paid attention." On September 13, he told USA Today, "It'll come to the Congress, and then we'll shape it to what we think the American people can accept." In a September 14 AP story, McDermott said: In reality, a lot of people won't be able to afford the money it will cost to have their own choice of physician so they will be forced into a (plan) that restricts their choice."

On September 20 McDermott said at a news conference: " There are some legitimate questions that need to be raised about their choice of a financing mechanism. We'll have a big debate about that."

Following the President's speech, McDermott told USA Today: "This is not going to be pretty...It's going to be a long, long debate. But this is how a democracy makes a tough decision." He told The Morning News Tribune, "I made my first speech on this (topic) in 1973 to the Young Democrats. This is not an issue that I discovered yesterday."

POLITICAL PROFILE

One of just three physicians in the House, Cong. Jim McDermott is generally well liked and respected by his colleagues. McDermott's legislative experience, political connections, personality and pragmatic attitude have made him a serious player in health policy debates.

McDermott began his political career in the Washington State House in 1971, served in the State Senate from 1975-80, and made three unsuccessful attempts for the governor's office. In 1988, he gave up a three year Foreign Service commitment as a psychiatrist in Zaire to run for the U.S. House seat.

HEALTH REFORM ISSUES/PRIORITIES

The single most important priority for Congressman McDermott is to be treated with the respect that he feels the sponsor of a bill with 80 plus cosponsors should be accorded. He wants to be a dealmaker -- and recognized as such -- and in the room when the final deal is cut.

Like his single payer supporters, McDermott is extremely sensitive to any Administration criticism of their plan and fearful of being taken for granted. Congressman McDermott told the LA Times on September 23: "I think it's always a mistake to take for granted the vote of any member of Congress." Likewise, he and others are very sensitive to any reference by the Administration calling the President's plan the "American Health Security Act." (We are sticking to only the Health Security Plan because we know we cannot introduce the same name titled bill).

In the end, McDermott will compare the list of single payer principles with the proposal that comes before the full House for a vote before he makes a final decision. If we are close to him at that time in terms of substance, and we have paid him adequate attention and respect, he is likely to be with us in the end.

LEGISLATIVE INTERESTS

<u>103rd</u>: Cong. McDermott sponsored H.R.1200, the American Health Security Act, a single payer National health insurance program (85 co-sponsors). He has cosponsored the Family and Medical Leave Act of 1993, (PL# 103-3); the National Domestic Violence Hotline Act of 1993, which would provide grants to establish and operate a national domestic violence hotline (Morella, H.R. 522); and the Preventing Our Kids from Inhaling Deadly Smoke (PRO-KIDS) Act of 1993, which would require the EPA to develop guidelines for nonsmoking policies in buildings owned or leased by Federal agencies (Durbin, H.R. 710).

CONGRESSMAN GERALD KLECZKA (D-WI): Congressman Kleczka votes dependably with the Democratic Leadership and his committee chairman.

POLITICAL PROFILE

First elected to the Wisconsin State Assembly at the age of 24, Cong. Gerald Kleczka has had a long career in politics. He served 11 years in the State House and was elected to the U.S. House of Representatives in 1984. Cong. Kleczka comes from a safe, largely Polish, Democratic district from the southside of Milwaukee. Although viewed as a dependable Democratic vote for the leadership, he is known also as a street-smart combative politician.

Much of his past legislative agenda has been on banking and savings and loan issues. In the social issues arena, Cong. Kleczka had been a consistent vote against abortion rights until the 1989 Supreme Court Webster ruling, when he was a swing vote allowing federal funding of abortions in cases of rape and incest.

HEALTH REFORM ISSUES/PRIORITIES

Kleczka is a smoker and takes money from the tobacco lobby. He was a cosponsor of Congressman Russo's single payer bill in the 102nd Congress, but Congressman Gephardt considers him a reliable vote for the Administration's health reform initiative. He seems to be relatively comfortable with our plan to date, but we cannot afford to take him -- or anyone else -- for granted.

LEGISLATIVE INTERESTS
103rd: Cong. Kleczka cosponsored the Family and Medical Leave Act (P.L. 103-3); and the Gift of Life Congressional Medal Act of 1993, a measure that would establish a congressional commemorative medal for organ donors and their families (Stark, H.R. 1012).

CONGRESSMAN JOHN LEWIS (D-GA): Congressman Lewis is a freshman member of the Ways and Means Committee and serves on its Subcommittee on Health. He is also a Chief Deputy Whip.

Recent Developments: After the President's speech he told The Atlanta Constitution, "He hit it out of the ballpark. He can pass it with modifications. Before the next congressional election, we will have passed a bipartisan piece of legislation and signed it into law."

POLITICAL PROFILE

The son of a black sharecropper and the first in his family to finish high school, Representative John Lewis is a celebrated leader of the Civil Rights movement. Having met and been influenced by Dr. Martin Luther King at the age of 18, Lewis organized the first lunch counter sit-in in Nashville, Tennessee. In May 1961, he was on the first of the Freedom Rides, riding buses as they were attacked and burned; he was viciously beaten in Rock Hill, South Carolina, and Montgomery, Alabama. In the 1970's he served as the Associate Director of ACTION under President Carter.

After serving four years on the Atlanta city council, Cong. Lewis fought a bitter campaign with his former ally, state Senator Julian Bond, for the U.S. House seat vacated by Wyche Fowler in 1986. He won that seat and subsequent House elections with over 75 percent of the vote. In the 102nd Congress, Lewis was appointed one of three Chief Deputies in the Majority Whip organization.

Representative Lewis is a confirmed liberal and votes with the Democratic Party on key issues, including cutting funds for the Strategic Defense Initiative, opposing death penalties for drug-related murders, and supporting the requirement for plant-closing notifications, which none of his more conservative colleagues in the Georgia delegation supported.

HEALTH REOFRM ISSUES/PRIORITIES

On health issues, Congressman Lewis is concerned about access to substance abuse and mental health programs, and about long-term care. He strongly opposes smoking and favors raising excise taxes. Although he has lots of hospitals in his district, he will be a trooper. Lewis believes the American people are out on front on this issue. He will be influential with the Congressional Black Caucus and shares the caucus' positions.

LEGISLATIVE INTERESTS

103rd: Cong. Lewis has cosponsored the Family and Medical Leave Act (P.L. 103-3). He is also a cosponsor of H.R. 1200, the single payer bill sponsored by Cong. McDermott.

CONGRESSMAN LEWIS F. PAYNE (D-VA): Congressman Payne represents Southern Virginia where his constituents include several thousand tobacco farmers. He is very conservative and is a member of the Conservative Democratic Forum, the Rural Health Care Coalition, and the Mainstream Forum.

He is a consistent supporter of abortion rights and civil rights, but voted against a minimum wage increase and the Family and Medical Leave Act. If he supports the President on health care, he will do so on his own and not due to pressure from the Chairman or the Leadership.

POLITICAL PROFILE

Cong. Lewis Payne, a successful developer, was tapped to fill the vacant seat created by the death of Cong. Dan Daniel. Payne is considered a "progressive conservative," who balances being a conservative with traditional Democratic actions. For instance, he voted for using force against Iraq and a constitutional ban on flag burning. However, he is a consistent supporter of both abortion and civil rights. Also, Cong. Payne endeared himself to the business community by voting against a minimum wage increase and the family and medical leave act.

Cong. Payne is a member of the Conservative Democratic Forum (CDF), the Rural Health Care Coalition and the Mainstream Forum.

HEALTH REFORM ISSUES/PRIORITIES

Congressman Payne's primary work on the Committee during health reform will be to either reduce the amount of the tobacco tax or, at the very least, make sure it is not raised anymore. Although he is very concerned about the impact of a tobacco tax on his constituency, he is also not interested in voting against health reform. He wants to be with the President. The only other known health issue in which he has been actively engaged has been that of graduate medical education reform. He believes we need to increase the numbers of primary care physicians trained by Federally-supported medical schools around the nation.

LEGISLATIVE INTERESTS

103rd: Cong. Payne is a cosponsor of H.R. 5936, the CDF Managed Competition bill sponsored by Congressman Cooper.

CONGRESSMAN RICHARD NEAL (D-MA): Congressman Neal attended the August strategy session regarding the Subcommittee. He is said to be close to the leadership and to Congressman Moakley. While generally liberal, he is strongly anti-choice, and has voted against federal funding for abortions in the case of rape or incest.

POLITICAL PROFILE

A former city councilman and mayor of Springfield, Cong. Richard Neal was first elected to Congress in 1988. Neal spent a quiet first term "learning the ropes" on the Banking Committee. After surviving a strong challenge in 1990, Neal is now entering his third term. He was appointed to the Ways and Means Committee this year, replacing former Congressman Brian Donnelly (D-MA). Although Neal has usually voted the party line, he voted in opposition to Federal funding for abortions, (even in cases of rape and incest); in opposition to the 1989 congressional pay raise, and in opposition to the 1990 budget summit agreement. Neal's legislative activities have focused on banking issues, such as insolvent savings and loan institutions, and proposals to restructure the industry's deposit insurance system.

HEALTH REFORM ISSUES/PRIORITIES

Not well known at this time.

LEGISLATIVE INTERESTS

103rd: Cong. Neal cosponsored the Family and Medical Leave Act (P.L. 103-3). He has also cosponsored the Enterprise Zone Community Development Act of 1993 to provide tax incentives to encourage community development in enterprise zones (Rangel, H.R.15). He has not cosponsored health care reform legislation.

CONGRESSMAN PETER HOAGLAND (D-NE): As a recent appointee to Ways and Means, Congressman Hoagland is considered a moderate Democrat. He is also a member of the Mainstream Forum and the Rural Health Care Coalition.

RECENT DEVELOPMENTS: Following the President's speech, Congressman Hoagland told the AP that he supported the tobacco tax, noting that his mother had died of lung cancer.

POLITICAL PROFILE

Although elected to Congress in 1988, Congressman Hoagland served for eight years in the Nebraska State legislature. A moderate Democrat, Hoagland served on the Banking Committee where he joined other moderate Democrats in writing legislation to provide incentives for landlords to continue renting to low-income families.

Hoagland has supported abortion rights, increased minimum wage and has opposed a constitutional amendment to ban flag burning. In his second term, Hoagland was appointed to the Judiciary Committee, where he pursued his interests in drug interdiction and "boot camps" for drug offenders. In the 103rd Congress, Hoagland was appointed to the Ways and Means Committee.

HEALTH REFORM ISSUES/PRIORITIES

Congressman Hoagland's desire to meet with the First Lady in August to discuss Subcommittee strategy may indicate that he will be more upfront in supporting health care reform than is his usual "wait and see" approach. He has a good number of hospitals in his district who will be important to his decision making. Although not on the Health Subcommittee, he has taken a relatively active interest in legislation including bills to expand home health care, provide more preventive services, simplify claims forms, and to require hospitals to advise parents on the importance of ensuring high immunization rates.

LEGISLATIVE INTERESTS

103rd: Cong. Hoagland has introduced legislation to expand Medicare coverage of home health services from 5 to 7 days per week for up to 40 days(H.R. 72); a bill to require the President to send to Congress a balanced budget each year, and to require the Congress to consider the balanced budget (H.R. 75); and a bill to require as a condition of participation in Medicare, hospitals to provide parents of newborn children with information and recommendations on childhood immunizations (H.R. 77). Hoagland has not sponsored any major health care reform legislation.

CONGRESSMAN MICHAEL MCNULTY (D-NY): Congressman McNulty is new to the Ways and Means Committee and he has no record on Ways and Means issues.

POLITICAL PROFILE

Cong. Michael McNulty entered politics at age 22, and served in local and State government for 18 years. He was elected to Congress in 1988. Appointed to the Armed Services Committee, McNulty is more supportive of defense spending than many of his Democratic colleagues, particularly spending in support of defense installations in his district. He was one of only three House Democrats who voted for both the leadership resolution calling for continued sanctions rather than war in Kuwait, and the resolution authorizing military force. In 1990, despite his 100 percent labor voting rating, McNulty was supported by the Conservative Party and easily won reelection.

HEALTH REFORM ISSUES/PRIORITIES.

The Democratic Leadership considers McNulty a reliable vote for the Administration's health reform plan. In the last Congress, McNulty cosponsored comprehensive universal access reform bills including Congressman Russo's single payer bill. McNulty will want a strong substance abuse and mental illnesses benefit package.

LEGISLATIVE INTERESTS

103rd: Cong. McNulty sponsored H.R. 911, a bill to grant immunity from personal civil liability to volunteers working on behalf of nonprofit organizations and governmental entities.

CONGRESSMAN MIKE KOPETSKI (D-OR): Congressman Kopetski is another first term Ways and Means Committee Members this year.

POLITICAL PROFILE

After holding Republican incumbent Denny Smith to the smallest margin of victory of any incumbent in 1988, Cong. Mike Kopetski returned to win in 1990. Kopetski is considered a moderate Democrat representing a conservative district.
He chairs the House mental health working group. He believes tort reform should be part of health care reform, but he has not cosponsored any health care reform legislation.

HEALTH REFORM ISSUES/PRIORITIES

Congressman Kopetski has expressed concerns that the Administration's benefit package is not be as generous as those included in current union contracts. The current provisions to grandfather in current collective bargained agreements for years is something that should appease the Congressman. It is important to note that Kopetski chairs the House mental health working group and will press for parity for mental health benefits with coverage for physical ailments. He wants the President's plan to be comprehensive and include tort reform. Despite his specific concerns, Congressman Kopetski is expected to vote for the Administration's health reform proposal.

LEGISLATIVE INTERESTS

103rd: Kopetski cosponsored the Family and Medical Leave Act (P.L. 103-3).

CONGRESSMAN WILLIAM JEFFERSON (D-LA): As a former malpractice attorney, Congressman Jefferson will be very sensitive to the changes in malpractice laws. He urged the President to be cautious regarding capping malpractice awards and wanted a negligence standard instead. Unless the Congressional Black Caucus is in rebellion, Jefferson should be okay.

Recent Developments: Regarding the health care proposals, Jefferson was quoted in the **New Orleans Times-Picayune** as follows: "This is one issue where there's a lot more involved than just the high-priced lobbyists...The people back home feel the issue very directly and so do your local physicians, local nurses associations, chiropractors, pharmaceutical and business groups. All are wanting to be heard."

POLITICAL PROFILE

Cong. William Jefferson is Louisiana's first black congressman since Reconstruction. In 1990, in a close race with the son of New Orlean's first black mayor, Jefferson won the House seat of former Cong. Lindy Boggs, wife of the former House majority leader. Jefferson defeated the son of New Orleans' first black mayor to win election. Jefferson launched his political career in the State legislature, where he developed an interest and expertise in finance and budget issues when he chaired the Government Affairs Committee of the Louisiana Senate. He is known as a liberal Democrat, with the skill to steer federal program funds to New Orleans, and was an early supporter of President Clinton. He is a former malpractice attorney.

LEGISLATIVE INTERESTS

103rd: Jefferson cosponsored a bill to create an entitlement program for immunizing infants (Byrne, H.R. 940). He has not cosponsored any health care reform legislation.

CONGRESSMAN BILL BREWSTER (D-OK): Congressman Brewster is a conservative and a member of both the Mainstream Forum and the Conservative Democratic Forum. He is close to Reps. Montgomery, Peterson, and Stenholm.

Recent Developments: After the President's speech he said, "If this bill is done incorrectly, this county will suffer. It has to be a balanced approach. As the old saying goes, the devil is in the details." Although he supports universal coverage and reducing the costs to many small businesses, problem areas for him could be how the health alliances are not always available and residents may not have as many options that could reduce costs.

POLITICAL PROFILE

Oklahoma's 3rd District is one of the state's most economically depressed and its most reliable Democratic stronghold; in the 84 years since statehood, it has never elected a Republican. This seat was held by former Speaker Carl Albert for 31 years. Cong. Bill Brewster began his political career in the Oklahoma House where he specialized in business and energy issues.

HEALTH REFORM ISSUES/PRIORITIES

A licensed pharmacist, he is one of five health professionals in the Congress. As such, he is sensitive to the concerns of pharmacists in a reformed health care system. In particular, he believes that many rural pharmacists, who cannot compete with large purchasers, may go out of business. The result may not only be one less store, but much less access to needed medications. (He should be pleased with our current provision that assures that pharmacists can compete on an equal plane with other purchasers of medications.)

Congressman Brewster is concerned about the ongoing funding for health reform. He believes the revenue base must be strong and permanent, and he wonders whether sin taxes will be sufficient. He will be a strong supporter of rural health reform and primary care. Brewster supports the use of global budgets. Lastly, of note, he has not cosponsored any health care reform legislation.

LEGISLATIVE INTERESTS

103rd: Cong. Brewster has cosponsored legislation to establish a congressional commemorative medal for organ donors (Stark, H.R. 1012).

CONGRESSMAN MEL REYNOLDS (D-IL): Congressman Reynolds is expected to use his Ways and Means post to pursue tax policies to promote private investment in housing and other inner-city concerns. While the Congressman was adamant in his support of sin taxes in prior meetings with the First Lady, it is worth noting that he has been given some pause thanks to a well-orchestrated effort by the tobacco industry.

Recent Developments: Reynolds told the New York Times on September 23: "The telephone lines are burning up. He said that Mom-and-Pop grocers and tobacco industry lobbyists were deluging his district office with warning about higher cigarette taxes. While Reynolds said he would still support "sin taxes" he said: "When constituents come in like that, it gives you a moment of pause to think." He went on to note that many of his inner-city constituents "die disproportionately from cigarette smoking."

POLITICAL PROFILE

Cong. Mel Reynolds was the only member of the 1992 class tapped for the Ways and Means Committee. This plum assignment was out of recognition for his stunning upset of the incumbent, Gus Savage. After two previous unsuccessful attempts, Reynolds defeated Savage by 63 percent to 37 percent. Although both men grew up poor in the streets of South Chicago, Reynolds excelled in school and was a Rhodes scholar, while Savage was a street organizer. The campaign was a bitter, head-to-head clash that centered on Reynolds' success in painting Savage as an ineffective politician who could not deliver to his constituents. Even some core Savage wards believed this message and voted for Reynolds. Reynolds won the majority of votes of middle class blacks and whites; he even won some Republican cross-over votes.

HEALTH REFORM ISSUES/PRIORITIES

He was a gunshot victim during his campaign and supports doubling the excise tax on firearms and earmarking money for hospitals with high numbers of trauma cases.

LEGISLATIVE INTERESTS

103rd: Cong. Reynolds cosponsored the Family and Medical Leave Act of 1993
(P.L. 103-3). Reynolds is a cosponsor of H.R. 1200, the single payer bill sponsored by Cong. McDermott.

REPUBLICANS

CONGRESSMAN BILL ARCHER (R-TX): The ranking Republican on the Ways and Means Committee has a congenial relationship with Chairman Rostenkowski.

Recent Developments: After the President's speech Archer told the Houston Post, "We all, on a bipartisan basis, know that we have problem and we have to do something about it."

POLITICAL PROFILE

Cong. Bill Archer has two areas of acknowledged expertise: the oil industry and Social Security. It was his idea to separate Social Security trust funds from budget calculations, and he has long supported making the Social Security Administration independent from the Department of Health and Human Services.

As a member of President Reagan's National Commission on Social Security Reform, Archer argued that Social Security should be made solvent by reducing the growth of benefits, not by increasing the payroll tax rate for younger workers. Although the Commission's recommendations lead to legislation which gradually raised the retirement age to 67, Archer did not feel it went far enough in restraining benefit growth.

In 1989, Archer led a crusade to repeal of the Medicare Catastrophic law.

A Houston native, Archer occupies the House seat of George Bush. A well-known opponent of taxes, Archer entered politics as a Democrat and did not switch parties until he was in the State Legislature. Over the years he has shown a commitment to leading while at the same time getting along.

HEALTH REFORM ISSUES/PRIORITIES

Archer serves on the Republican Task Force on Health. He led the crusade to repeal the Medicare Catastrophic law and is firmly anti-choice. One of his sons is a Ob/Gyn MD. In the 102nd Congress he introduced legislation to reform the health care liability system and cosponsored bills to reform the health insurance market, contain health care costs and to establish medical savings accounts. He has not sponsored any health care reform legislation in this Congress.

CONGRESSMAN PHIL CRANE (R-IL): The second ranking Republican on the Ways and Means Committee, Congressman Crane is one of the most conservative Members of Congress. No longer a powerful conservative voice, however, there is some question as to whether or not Crane will run again.

Recent Developments: Following the President's address, Crane told the AP that he thought the proposal would cost jobs and that he opposed the tax increases. "I really find it difficult to imagine the Democrats are going to want to vote again for a humongous tax increase."

POLITICAL PROFILE

A one time presidential hopeful, Cong. Phil Crane had hoped to be the conservative standard bearer in the House, but lost out to a younger and more combative Newt Gingrich. Known for his intellect and oratorical skills, Crane is also an unyielding conservative. His actions define the ideologically pure frontier which were evidenced in his calling for the outright abolition of the National Endowment for the Arts. On the Ways and Means Committee, Cong. Crane has kept a low-profile except for issues relating to trade (he is the ranking member on the Subcommittee). He is quick to endorse cuts for domestic programs noting that neither education, housing, mail service nor a variety of other programs are mandatory Federal functions.

HEALTH REFORM ISSUES/PRIORITIES

Beyond being strongly anti-abortion, Congressman Crane's views on health reform have not been well fleshed out. It is clear that he is likely to be a difficult to impossible members to attract, however.

LEGISLATIVE INTERESTS

103rd: Cong. Crane is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

CONGRESSMAN BILL THOMAS (R-CA) - The Ranking Republican on the Subcommittee, Congressman Thomas is an assertive partisan who wants Republicans to offer clear alternatives to Democratic policies. A close friend of Rep. Gingrich, Thomas is also an ally of the National Federation of Independent Business.

Recent Developments: After the President's speech, Thomas asked in USA Today: "Is Clinton interested in passing a plan, or is Clinton interested in passing his plan?"

POLITICAL PROFILE

The departure from Congress of Congressman Bill Gradison led the way for Bill Thomas to assume the ranking position on the Health Subcommittee. Thomas' combative style may invite confrontation with Chairman Stark, who enjoyed a collegial relationship with Gradison. A former roommate of Rep. Gingrich, Thomas has worked with fellow conservatives to unite GOP members in opposition to the Democratic Party line. In his first term on the Ways and Means Committee, Thomas lobbied successfully to raise the Social Security retirement age as a way to stem future payroll tax increases. Also a member of the House Administration Committee, he has led the GOP effort on campaign finance reform. He serves on the Republican Task Force on Health. He has voted for reproductive rights.

HEALTH REOFRM ISSUES/PRIORITIES

Thomas serves on the Republican Task Force on Health. In February he wrote to the President outlining his concerns about health care, particularly his doubts about the benefits of cost controls. He supported expanded coverage, particularly for low-income families. He hoped that quality health care in rural and large urban areas and long-term health care addressed. Thomas outlined his steps for reallocating federal resources to improve health care, reducing health care delivery costs while increasing availability, and enhancing the role of the consumer in health care.

Of some interest, he is a strong home health care provider advocate. (There apparently is a well organized home health provider entitity within his District). Most recently, he also pushed for legislation to assure for continuity of care for patients to assure that those patients who left close panel HMOs could have access to non-panel members and still get reimbursement for it. (Some skeptics have questioned as to who he was advocating for: the patient or the providers.)

Thomas attended the February Republican meeting with the First Lady and has also attended the breakfast meetings with Ira. Thomas has voted for reproductive rights.