DRAFTING

PHOTOCOPY
— PRESERVATION

DRAFTING

file drafting changes

Draft Changes

General

- CBO approved language on nurses
- Independent contractors
- Pediatricians - periodicity schedule - Board must address immediately; also address adolescent schedule
- Medicare - $124 billion market basket
- Premium payments for AFDC and SSI- state expenditures slower, premium payments slower.
- MOE payments for non-cash - not required to do so.
- Quality - add deleted section.
- VA
- DOD
- Mental Health
- Add Practitioner Data Bank
- Remedies - 24 hour rule -- not emergencies.
- Retraining - $200 million for each year.
- Financing changes - several small changes - e.g. single parent and two parent pools need to be combined.
- Baucus changes

AFL

- Taxation of benefits - start in year 2004
- Include cost-sharing as tax deductible
- Supplemental plans for cost sharing - if offered by employer, want exception to supplemental restrictions. Fix for corporate alliance - both for self-insured and plan payed. Regional alliance - self-insure ok.
- Health care workforce changes.
- Early retirees - 20% share picked up by company if they provided coverage previously.
- Definition of part-time - problem of part-time employees under our definition paying part of the 80% share even

though they are full time in their industry, e.g. pilots; problem of those less than 10 hours per week for one employer who work full-time, e.g. building trades. Partial solution -- treat as self-employed so capped at 7.9% (still no tax deductibility), and all National Board to add categories of full-time employees based on industry practice.

- Federal employees - treat like current retirees, guarantee current benefits.

- Multiemployer plans - add several categories of Taft-Hartley plans that are under 5000 employees.fix

- Corp. alliances - 1% doesn't apply to Taft-Hartley plans

- Collective bargaining rights not affected.

- 200,000 public employees.

HHS

- Medicare Contracting

- Home Based Care Cost Sharing

- Medicaid Personal Needs Allowance

- Accountability for Quality

- Health Plan Discrimination

- Medicare Options

- Optional State Integration of Certain Medicare Populations

- Indian Health Service

- Family Share Discounts

- IME/DME Pool

- Waiver of Coinsurance

- Reporting Relationships

- Benefits Issues

Treasury

- Limit borrowing under Transition fund

- Limit borrowing under corporate guarantee fund

- 1.5% assessment for AHC etc. -- offsetting receipt language.

- Cash flow borrowing - advance on subsidies.

- Medicare Part B - Means testing - increase phase in amount.

- Fix charitable tax exemption

OMB

- Cash population cost sharing subsidy - paid for by Medicaid

- "Active duty members of uniformed services" - should include Coast Guard, PHS, and NOAH

- POS enrollment - penalty of 2x's premium - for how long

- Medicare drug - "average wholesale price"

- 120 day restriction on Medicare rules - need emergency out.

- §4033(b) "shall" to "may"

- §4105 - move updates to 10/1/95, and then every 2 years.

- High cost hospital staff

- §4115 Incentives for primary care - budget neutrality - take away from others what is given for primary care.

- §4213 State long term care integration - drop

- §4222(b)(1)(A) fiscal year

- Kids wrap around

- DSH - fiscal year [§§4231,4241, 9101, 9102}

- §6104 premium discount -- ??

- §9101 - Subsidy payment should be reduce by amount Sate "should" pay.

§9003, 9004 - remove cash kids.

DOL

- Want authority to order states to collect and provide workers comp data to assist DOL in formulating programs and policies to reduce workplace injuries.

Technicals

- Drugs - immuno-supp; fix participating pharmacies in light of no balance billing; other technicals.

- WIC $

July 28, 1993

MEMORANDUM

To: Hillary Rodham Clinton
Fr: Sara Rosenbaum
Re: Drafting status report

We are prepared to have a draft bill ready for you by the end of the Labor Day week. This memorandum provides you with a section-by-section update of our drafting progress.

In keeping with your initial request we are attempting to avoid a lengthy and detailed bill as much as possible through the use of broad Executive Branch delegation powers. However, the operational and legal complexity of the plan, as well as the hundreds of existing laws which must be amended, modified or repealed in order for the President to be able to put the plan into effect, mean that the document will be substantial.

We believe that an important strategic issue for you as you review the bill is in fact how brief you want to be in the end. We assume that your interest in brevity arises from your desire to retain within the Executive Branch as much discretion as possible regarding how best to shape and carry out the plan. However, to the extent that the President's bill is a broad legislative blueprint (at least relatively speaking) two consequences may arise:

First, the the lack of detailed direction may increase the likelihood that the numerous Congressional Committees that will consider the legislation will report multiple versions of the same provision of law. The more legislative cacophony around a matter this complex, the greater the likelihood of difficult conflicts to resolve.

Second, and perhaps more importantly, rather than letting the Executive Branch fill in the details, Congress may well be inclined to do so for you. In many cases the results may be consistent with the President's plan. In many more, the results may be profoundly different from what you proposed.

As you read the draft bill you may decide to have us add more detail to the plan than our initial draft will contain, at least in the case of those sections of the proposal which constitute fundamental, bottom-line matters.

Section-by-Section Update

1. Congressional Findings and Statement of Purpose: specifications under development and review

2. Coverage: legislation drafted; update for changes in current plan

3. Benefits: legislation drafted; update for changes in current plan

4. National Health Board; initial legislation drafted; revised drafting specifications developed

5. State responsibilities: drafting specifications developed

6. Regional Health Alliances: drafting specifications developed

7. Corporate alliances: drafting specifications developed

8. Health plans: drafting specifications developed

9. Risk adjustment: drafting specifications developed

10. ERISA modifications (limitation on preemption and amended fiduciary duties): drafting specifications developed

11. Rural communities: no separate drafting materials

12. Workers compensation and auto insurance: drafting specifications developed

13. Inter-Alliance Fund; Initial draft developed; **awaiting policy for revised specifications**

14. Budget development and enforcement: Initial legislative draft developed; **awaiting policy for revised specifications**

15. Quality assurance: Drafting specifications developed

16. Information and administrative simplification: drafting specifications developed

17. Patient and provider confidentiality and privacy: system rights: specifications to be developed

18. Workforce: specifications to be developed; **awaiting final policy decisions around IME and DME.** Amend existing law

19. Academic health centers: Specifications to be developed

20. Medical research: Specifications developed; amend existing

law

21. Public health reforms: specifications developed; amend existing law

22. Long term care: specifications developed

23. Malpractice reforms: initial legislation drafted; **awaiting policy decisions**

24. Anti-trust: specifications developed; amend current law

25. Underserved populations: specifications to be developed; amend current law

26. Mental health: specifications to be developed; amend current law

27. Fraud and abuse: specifications developed; amend current law

28. Medicare: specifications developed for DSH, IME, DME, drugs, provider payments for primary care, and state waivers; provider certification and qualification standards; amend current law. **Awaiting policy decisions**

29. Medicaid: specifications to be developed; **awaiting policy decisions**

30. Transition: **awaiting policy decisions**

31. Financing: **awaiting policy decisions**

32. Individual rights in the new system: legislative specifications developed; amend current law and add new law.

COVERAGE
INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
American Medical Assoc.	Corporate alliance must pay for all individual's medical services if they are obtained outside the individual's geographic area.			Under coordination of coverage, change last portion of sentence to: the plan must pay for such care.	YES
Children's Coalition	Children in foster care – how they will enroll etc.			They will give language.	DONE
Amer. College of Emerg. Physicians				Mandate that hospitals and emergency physicians be provided federal support for the provision of emergency care to undocumented persons.	Clarify funding stream.
State of CT Commission on Hospitals & Health Care	Mandatory enrollment of unenrolled individuals who present for services in the lowest cost plan may penalize the low cost plan b/c the plan will get people at the time they need services.			Alternative: random assignment as used for long distance telephone companies.	FIX

BENEFITS PACKAGE

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Carol Rasco		19–20		Add Nutrition Counseling	YES – service not provided
OMB	Research guidelines will be centralized & promulgated by DHHS.			Delete.	Checking
	Coverage for investigational procedures is described as automatic for government–conducted research only.			Delete.	Checking
	The low cost–sharing option would not require coinsurance on home health, extended care, preventive care, durable medical equipment, or most mental health services.			Require cost–sharing.	Not necessary

YESADOB

BENEFITS PACKAGE

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Children's Coalition	They don't like grouping ages 6–19 together.			The proposed age category of 6–19 should be replaced by 2 new age categories: 6–12 and 13–21	Checking
Women's Health Groups (ie, PPFA, ANA, WLDF) etc. 11 groups				Adding to the prevention chart: Pap smears & mammograms, annual pap smears to other ages besides 20–49, annual mammograms starting age 40. Pregnant & post–partum women currently receiving care through Medicaid. 3 issues in financing, privacy & Medicaid.	Checking
American Academy of Pediatrics	The plan's periodicity schedule inappropriately limits the number of visits to only 5 between the ages of 6 & 19.			Recommendations developed by the Bright Future's project include annual visits in adolescence from age 11–21.	Checking
				For newborn babies discharged early (less than 24 hrs) there should be provided a visit within one week.	YES
Invacare – Innovation in Health Care				Suggest that the plan include provisions for patient–directed upgrades on DME. The price of a lighter chair is $1,200. Under the upgrade provision the patient co–pay would be $560 and the dealer would still be reimbursed $640 by the accountable health plan.	YES
Children's Defense Fund	For preventive clinical services, (well–baby & prenatal) a weakening of the periodicity sched. compared to current standards & those recommended by experts will restrict access to such svcs to levels below what is approp. for children's and women's health.				Checking
Nat'l Council\Sr. Citizens				Add colo–rectal screening.	Checking

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Children's Defense Fund				Occupational, speech & physical therapies should not be restricted to restoring functional capacity only.	Must be restricted because of cost-benefit
Children's Defense Fund	Current services mandated for children under EPSDT are not included in the new plan.				Working on
Amer. College of Emer. Physicians				Specific standards should be included in the plan to ensure that plans recognize the provision of care in the emergency department.	Mention
March of Dimes	Birth defects (congenital conditions) do not fall into illness or injury category.			They urge inclusion of language that would include birth defects.	Checking
Iowa State Dept. of Public Health	Environmentally related – it should be noted that approx. 7% of children tested in Iowa have an unacceptable lead level.			Add more lead testing to prevention schedule.	Checking

STATE RESPONSIBILITIES

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Dept. of Labor		51		insert, in lieu of last sentence in first para., "Only plans qualified by the state may offer health coverage through regional alliances or contract with corporate alliances. States also certify plans (except self-funded plans) that contract with corporate alliances for compliance with national stds."	YES
US Senate\Cmte. on Disabilities	Alliance boundaries	50	3	Add Disability to groups protected from redlining.	YES

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
UCLA Sch. Of Public Health - E. Richard Brown, Ph.D.				states that choose single-payer option must apply only for waiver to include Medicare beneficiaries; Sec. of HHS must act within 180 days of applic.; no other waivers required	**ICM agreed**
				state that chooses single-payer option is eligible for all subsidies for which the state would have been eligible had it not chosen single-payer option	**ICM agreed**
AFSCME				They want states to have the option of levying a payroll-based tax or the other taxes currently relied upon in the President's health care plan to provide a single payer plan.	DONE - ICM
Bob Brandon/DNC	Single payer advocates are very concerned that the language reflects a bar to states to adopt adequate funding streams to implement single-payer because of the language in the last paragraph.				DONE
National Council\Sr. Citizens	Too many waiver requirements to adopt single-payer plan.				ICM agreed.

REGIONAL HEALTH ALLIANCES

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
US Senate\Cmte. on Disabilities				Alliances co-ops should be considered "public entities" for purposes of ADA	YES

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Mayo Foundation – Dr. Robert Waller	The plan indicates that health alliances can't cross state lines. This needs to be expanded upon.			There should be a corollary statement indicating that alliances would not be able to keep patients from using providers in other states.	Point of service option.
Amer. Nurses Assoc.	Anti-discrimination provision for the plans.			They will provide language.	Mix of providers up to plans.
Consumers Union				Consumers enrolled in a low-cost sharing plan should be allowed to seek treatment outside of the plan.	Point of service.
H.R. Cmte. on Post Office & Civil Service	Concerned that federal employees and retirees will be subject to the wide variations in the 50 states.			Plan should contain important safeguards to ensure that the interests of both the federal government and its employees are represented in each state.	
AFSCME & Public Unions AFT/AFL-CIO				Unions may represent their members in any and all complaint procedures established by the regional alliances and/or health plans.	Fine.

CORPORATE ALLIANCES

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Dept. of Labor		66 – Taft–Hartley		add at end of 2nd sentence, first para.: "However, the trustees of the Taft–Hartley plan may vote to enroll the plan in the regional alliance as a single employer plan and continue to operate this way outside of the alliance for the provision of non–health benefits.	Check w/Gary Claxton
		73 – financial reserve req		amend 2nd para. to add: "pursuant to such standards as may be estab by DOL"	
				revised stmnt. "A new national guaranty fund for self–funded plans provides financial protection for health providers in case of financial failure of a plan. DOL oversees the natl guaranty fund"	
Sen. Metzenbaum				Corporate alliances should be required to provide employees w/same information required by regional alliance.	They are.

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
American Medical Assoc.	Don't want alliances creating plans.	86		delete bullet under guaranteed universal access: 1) creating alliance sponsored plans;	YES

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Dept. of Labor		67 – health plans		revise first para. as follows: "Corporate alliances provide health benefits to eligible employees and dependents either through a certified self–funded employee benefits plan or through contracts with state–certified health plans. the DOL is responsible for certifying self–funded plans in consultation with HHS."	
		76 – grievance proc		insert in lieu of 2nd para.: "DOL will ensure that both regional and corporate alliance health plans estab. grievance procedures and monitor the performance if such procedures in accordance with uniform guidelines prepared by DOL"	
US Senate\Cmte. on Disabilities	Disability not included.	77	16	HP may not discriminate against providers based on... (insert disability)	YES

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Mayo Foundation – Robert Waller, MD	want to ensure patients freedom of choosing a physician			require every accountable health plan to offer a "point of service" option for patients to receive care outside the plan's provider network, if they are willing to pay some additional coinsurance	YES
American Medical Assoc.	Do not believe that reimbursement provided to members outside its service area should be based on fee–for–service rate schedules.	77		Delete sentence that says reimbursement based on fee–for–service schedules in alliance where service provided.	YES
American Medical Assoc.	Do not believe that the national health board should set rules for access to health plan information by advisory board.	77		Delete "under rules established by the National Board" in last paragraph	YES

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
American Medical Assoc.	Clarify who the loan programs will assist. Not just community-based health plans	78		Add "integrated provider-established" health plans to first sentence	YES
Nat'l Council\Sr. Citizens	Age not included.			Add age to list to prevent discrimination.	YES
Nat'l Council\Sr. Citizens				There should be a provision for children w/special needs to access different plans than parents.	YES
Consumer Union				In the event of serious new illness or dissatisfaction with treatment provided, some flexibility to go outside of a low cost-sharing health plan should be allowed.	Point of service option.
Amer. College of Emer. Physicians				Language mandating that health plans provide adequate financing to maintain the 24 hour operation of ED services.	Already covered.

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
OMB	The financial incentives for providers seem generally skewed toward physicians.			All health professionals.	Reworking workforce section.
	Only community-based organizations would be eligible to receive guarantees.			Add health plans expanding into rural areas.	YES
	NHSC loan repayment recipients.			Setting up a special exclusion from gross income is not necessary.	Checking

WORKERS COMPENSATION

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Dept of Labor		88 – integ works comp		change first sentence in last para: "state laws regarding choice of provider for workers' compensation cases are overridden"	Check w/Gary Claxton

BUDGET DEVELOPMENT

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Amer Academy of Family Physicians	method for establishing a per capita baseline premium target for each alliance incorporates unjustified historic variation in health care expenditures	95		include explicit language calling for elimination of said variation	Being done over 8 yrs.

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Dept of Labor		101		insert, in lieu of current,: "Natl Qual Mgmt Prog under Natl Hlth Brd should develop policies and provide uniform stds incl core set of measures of performance that apply to all health plans, institutions, and practitioners. These stds will be applicable to corporate alliance and Taft-Hartley trusts as appropriate."	
Sen. Metzenbaum				should be "establishes minimum standards of access and quality", not "minimal"	FIX
US Senator\Cmte. on Disabilities				Ensure certification process & report cards include data on compliance w/ADA.	ADD
Congressional Hispanic Caucus				Mandate cultural & linguistic competency standards & guidelines for reporting & data collection	ADD

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
American College of Physicians		106		There should be language to ensure that national quality standards, when implemented, replace not only PROs but also replace or integrate carefully with state departments of health, JCAHO, and other requirements.	Checking
Mayo Foundation - Dr. Waller				data collection requirements should be established at the federal not the state or health alliance level. **Also, we should approach data collection from the viewpoint of what is the minimum amount of data needed.**	
Nat'l Council\Sr. Citizens	How does the Administration plan to protect recent nursing home reforms?			State explicitly.	

PROTECTION OF PRIVACY

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
11 Women's Hlth. Grps. (ie, ANA, PPFA, WLDF)	Privacy – unclear how the privacy of an individual will be kept if they are covered under a spouse, or parent, etc.			Elaborate & enhance privacy section.	DONE
80 Organ. Campaign				Confidential medical care must be made available to all individuals covered under the new plan.	DONE – Problem w/adolescents?

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Iowa State Dept. of Public Health	Lead testing not sufficient.			Regular testing for lead should be part of prevention schedule.	Checking
Iowa State Dept. of Public Health	Training and education			Change clause on continuing education to read ... preprofessional, continuing and, as appropriate, remedial or advanced, education...	Reworking

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Mayo Foundation – Robert Waller, MD				The distribution of residency positions should be on a national basis, rather than by state of region.	DOING
				Special fellowships and residency training provided to foreign physicians who will be returning to their home countries that an institution would fund from sources outside the government pool should be allowed above the allocation without the host organization being penalized.	No longer an issue.
Amer. Academy of Pediatrics				Recommend estab. of indep. Nat'l workforce Commission, insulated from political process, broad represent. from primary care community (inc. pediatr.)	Checking.
Amer. Academy of Pediatrics				National Workforce Commission should establish total number of residency positions, including IMGs (in some parts of USA,IMGs provide significant portion of pediatric care, especially in underserved areas, so don't reduce residencies until alternate care providers are put in place.	
Dept. of Labor & AFL–CIO	Need to provide for worker dislocation.			Add new program on retraining of workers displaced by health reform.	

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Mayo Foundation – Robert Waller, MD	would AHC all receive these supplemental funds in a uniform fashion rather than through individual cost reports?			there needs to be better definition on how these funds will be distributed.	

PUBLIC HEALTH INITIATIVES

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Dept of Labor		144		insert in first bullet: "occupational disease and injury"	
		145		insert occup. safety and health as enforcement function	
		146 – training and educ. bullet		include "industrial hygienists" in list of health care professionals, and insert at end of bullet: "Training also should be provided for employers and employees w/ resp. to occup. hazard prevention and control, incl. training for particip. on joint safety and health committees"	
		148 – chronic & env– related dis.		add subhead: "**occupational injury and disease** – ergonomic and repetitive strain diseases, such as carpel tunnel syndrome have become epidemic. Back injuries at work cost employers and the economy tens of billions of $ a yr. and affect the health of tens of thousands of people	

LONG-TERM CARE

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
AFSCME & Public Unions - AFT-AFL-CIO	By allowing states to provide vouchers or direct payment of cash to eligible individuals, it will be impossible to monitor the quality of care/labor standards of home care.			Add language stating: Wherever practical, states shall operate agencies to provide home health services. In cases where home services are provided by private agencies, states shall monitor the private agencies to ensure quality of car and enforce labor standards. States should also monitor private agency screening, training, and management of providers. States may elect vouchers,direct cash to eligible individuals, or consumer-directed services only when no public or private agency can provide services. States shall monitor these methods of providing services to ensure the quality of care meets the needs of eligible individuals.	ICM response: no vouchers.

MALPRACTICE REFORM

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
American Medical Assoc.	Do not want national health board to develop national models for alternative dispute resolution.	166		Each state (not health plan) establishes an alternative-dispute resolution system.	ICM - YES

ANTITRUST REFORMS

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
American Medical Assoc.	Physicians & providers need protection or safe harbors when negotiating w/plans during the transition	170		Add to policy - clarify	YES
AMA		170		Change "Provider Collaboration" section to "Provider Discussion"...(absent threat of boycott) - (check orig. document). Delete section except: Physicians who provide health services for the benefit package may collectively discuss price and other matters related to plan if no boycott is threatened.	
Amer. Nurses Assoc.				Expand antitrust section to give nurses the same protections doctors had.	ICM Agreed.

HEALTH CARE ACCESS INITIATIVES

CONGRESS AND DEPARTMENTS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
AIDS Action				Community-based alcoholism & drug abuse treatment programs should be identified as "essential providers"	Eligible

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Children's Coalition				Put a chart in explaining the new mix of funding for community health centers.	ICM agreed - clearer in new draft.
				School-based clinics - concentrate some of the early money on elementary schools.	
Amer. Academy of Pediatrics	Coverage for supplemental services is adequate to link low-income enrolled individuals w/needed services.			Expand coverage for transportation; child care at service sites; translation services; case/care coordination; screening follow-ups; and health promotions to be provided.	

MEDICAID

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Office for Church in Society – United Church of Christ	re: subsidies for low-income: sliding scale or abrupt change at 150% poverty?				
11 Women's Health Groups (ie, ANA, PPFA, WLDF)	Medicaid currently pays for supplemental svcs., such as transportation for medical visits for Medicaid recipients. Prob. that under plan it will continue as under current lay – only for AFDC/SSI cash recipients.			Expand benefit.	
80 Organization Campaign	Some low-income & post-partum women will now have to pay due to 150% poverty level ineligibility.			Expand coverage.	
	Supplemental services paid for only AFDC/SSI recipients, excluding Medicaid recipients.			Cover for non-cash Medicaid.	
National Association of Child Advocates				Limit amount that individuals & families pay for health care to 3.5% of annual income.	DONE 3.9%

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
H.R. Cmte. on Post Office & Civil Service	The federal government should offer its employees & retirees a supplemental benefit package to augment the standard package.				OPM may assist.
	The FEHBP should be integrated into the regional alliances; OPM should continue to assist federal employees in resolving service disputes & to assist agencies in adapting to the system.				
Laborers' Int'l Union of N.A.	Concerned that draft preliminary proposal may be read to prevent the mail handlers plan from competing as a qualified HP. FEHBP phase – out section in plan does not refer to such conversion of FEHBP plans into qualified HP.				

TRANSITION

INTEREST GROUPS AND OTHERS

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
AFSCME & Public Unions AFT/AFL–CIO				Employers and unions which are parties to collective bargaining agreements must negotiate the methods and timeframes by which changes to the National plan will be implemented, as well as the application of any resulting savings.	ICM response; – will consider.

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
Dept of Labor		228 – indiv & fam in corp–ally		add onto last sentence: "if the worker earns annualized wages of $15000 or less, the employer contributes the greater of 80% of the average premium or 95% of premium of lowest cost plan available to the employee in the corporate alliance comparable to the subsidy available in the regional alliance	
		231 – corp alli		revised stmt: delete present bullets on risk–adjusted phase–ins, replace: "employer contributions will phase in at 10% per year of community rated premium for a total of ten years	
		232 – contrib for PT		insert at end of first para.: "another exception is that the legislation will specify a date prior to the implementation of the American Health Security Act and stipulate that all employees meeting the definition of full–time for purposes of enrollment in a corporate alliance on that date will remain enrolled in the corporate alliance even if their hours of service are reduced to the level of part–time employees"	
		239 – tax subsidy		add: "benefits that exceed the fully phased in benefit pkg are taxable to the employee, however they continue to be fully tax preferred for 10 yrs after enactment if they were provided as of Jan 1, 1993. To qualify for the continued tax exclusion, employers must register their benefit plans with Treasury prior to Dec 31, 1994. This will not pre–empt existing filing requirements by plans with DOL"	New policy pre–empts.

SOURCE	PROBLEM	PAGE	LINE	PROPOSED SOLUTION	DECISION
UCLA Sch. of Public Health – E. Richard Brown, Ph.D.				premium contributions of all persons should be capped at 3% of family's gross income	3.9%
American Federation of State, County and Municipal Employees, AFL–CIO (AFSCME)				should give states the option of levying a payroll–based tax or other taxes (but not those that reduce businesses' liability)	DOING
Small Business Legislative Council	It is now SBLC's understanding that the proposal will rely on another approach to prevent abuses, perhaps based more along the lines of traditional IRS interpretations of independent contractor status.				YES

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cong. Hispanic Caucus	Ethical foundation to recognize importance of enhancing public health for everyone in the nation		Mandate cultural and linguistic competency standards and guidelines for reporting & data collection	DOING

COVERAGE

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ed. & Labor	Need for uniform claims procedures across all plans and all alliances rather than letting each plan/alliance establish it's own.			
	Need to create private causes of action for participants.			
	Need to establish clear procedures for arbitration or mediation.			
	Establish legal and equitable remedies.			
	Create a forum -- new health benefits court -- to hear these claims.			
	What is the legal standard?			
	How will the subsidized pool work?			
	Who pays -- on whom is the assessment made and on what bases?			
	Would this include the miners health funds?			
	What is the tax treatment of these contributions or assessments?			
	How do you determine whether an employer had a prior obligation to provide health benefits and how it is proven?			
	What benefits are being guaranteed?			
	Is this a trust; which agency has oversight; what are the solvency standards; what is the funding schedule?			
	How will supplemental benefits be treated?			
	Does the employer cap of 7.9% include the employer's payment of the 20% of premium for retirees?			
Cmte. on Ways & Means	Need federal enforcement mechanism for mandate on individuals & employers			
	The plan should include a clear federal enforcement mechanism for the mandate on individuals and employers.			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
House Energy & Commerce Cmte.	Undocumented persons continue to use emergency services as under current law.		Is this federal funding for undocumented persons discretionary or entitlement authority? How much is it?	Plan will target federal assistance to hospitals who serve illegal aliens. Exploring guarantee.
Sen. Metzenbaum			National board should have explicit authority to establish national standards for coverage of experimental procedure\treatment.	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ed. & Labor	How will supplementals be marketed?			
	What will be the tax treatment for supplementals and cost-sharing coverage?			
US Senate/D. Nexon			Comprehensive services for children should come immediately (mental health)	
Cmte. on Ways & Means	Cost sharing will result in low income individuals being prohibited from joining other plans in alliances.			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ed. & Labor	Questions about make-up and representation on the board.			
	Question about size and cost of national health board.			
	Extent of consumer protections.			
Cong. Hispanic Caucus	Made sure there is adequate Latino representation.		NHB and all other policy-making bodies should include Latino representation.	
Cmte. on Ways & Means	Plan requires NHB to develop sophisticated risk adjusters within only 2 years.		Set longer timeframe.	
	Functions given to NHB appear to duplicate & overlap those of HHS.		HHS should take that responsibility.	
Sen. Metzenbaum			National board needs explicit statutory directive to take any action necessary to assure that each state plan guarantees access and quality care.	
			Breakthrough Drug Committee should have authority to negotiate voluntary price restraints.	
			Add some explicit process through which individuals may file a complaint against their alliance to the national board (eg: alleging that the alliance is an industry).	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Disabilities	Alliance boundaries.	50	Add disability to groups protected from redlining.	
	Alliance risk adjustment should be across all segments of society.	51	Add disability to risk adjustment.	
Sen. Metzenbaum	States are not up to the job of "certification of health plans", "financial regulation of h.p.", or "quality management and improvement of prog."		National board should establish national minimum standards or direct states to do so in certain areas.	
	Reliance on guaranty funds will not work: (states pool health/life ins. claims into one fund, run by ins. industry w/o consumer representation, not funded in advance, don't pay out until other co. assets are dissipated).			
	Clarify federal responsibility w/regard to single payer.		Should say "federal government shall waive ... for single-payer..." instead of "may".	
	State may run health plan and bear risk, right?			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ed. & Labor	Clarify the structure and relationship between the health alliance and the national board.			
	Specific clarification as to the alliance board -- functions relating to state certification of the plans; are those who sit on the board fiduciaries; how do the accounts work re: incoming premiums and outgoing payments?			
	Questions about the alliances generally -- which agency oversees the alliances as to solvency requirements; who monitors to insure no conflicts of interest; are these alliances liable for provision of services or for the failure to do so; can they be sued, and who is ultimately liable for any numbers of failures to act?			
	How do they handle the capacity question regarding the plans - can we insure fair distribution of enrollees?			
	Anti-discrimination provisions - medical redlining.			
	Structure and factors for premium setting - needs review.			
	Need standards for determining the number of alliances within a state.			
	Need an explicit requirement to the states to develop the means for serving rural areas where networks are not available.			
	Explain the process by which states could set up a single payor option - ERISA considerations.			
	Need for information regarding the treatment of seasonals and part-time workers. Definition of an "employee" and a "leased employee".			
	Need more information on how retirees (post 65) who wish to remain in the alliance are treated a to premiums; future eligibility for Medicare specifically Part B; and their eligibility for the new drug and long-term care benefits.			
Cmte. on Disabilities	Alliances may not discriminate on the basis or race, gender, ethnicity, etc...	61	Add disability.	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
	Contracting requirements for health plans must include non-discrimination categories.	60	Add disability.	
			Alliances should be considered "public entities" for purposes of ADA	YES
Cmte. on Ways & Means			Eligibility for low-income subsidies should be uniform across alliances.	YES
Sen. Metzenbaum			Consumers should compose majority of alliances.	
			Alliances should exclude all individuals who derive "significant" not "substantial" income from the health care industry.	
			Need to beef up Ombudsman office (5-10% of all alliance funds).	
			Provide consumers w/information on plan, administrative expenses and profits/reserves.	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ed. & Labor	When and under what circumstances can a corporation choose between a corporate alliance and a regional alliance?			
	Will you develop an experience rated premium if they come into the regional alliance, and for how long; will it act as a disincentive or incentive?			
	Why aren't low income workers in a corporate alliance eligible for subsidies?		Low-income individuals should be eligible for subsidies even if they work in a large corporation.	
	Tax treatment of supplementals and cost sharing benefits -- could they be part of a basic premium within the corporate alliance?			
	Concern about prevention of cherry picking between the alliances.			
	Creation of the guaranty fund -- how will it work? How will it be funded? What benefits will be guaranteed?			
	Extent of DOL's oversight, regulation and administration of their alliances? Where is the additional funding for the resources that will be needed?			
	What are the solvency standards for the corporate alliance? Who does oversight as to premium structure? will there be a separate claims review process? Who will monitor and insure quality of services and by what standard?			
	Should others be allowed to self-insure and be treated as a corporate alliances (MEWAS)?			
	What is significance of the 5000 worker cut off.			
	How precisely is the ERISA preemption going to be framed?			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
US Senate\D. Nexon			Freedom of choice requirement should be waived if fee-for-service plan is not financially viable.	
Cmte. on Disabilities	Disability not included.	77	Alliances may not discriminate against providers based on...(insert disability)	YES
Sen. Metzenbaum			Health plan that terminates coverage should be required to notify 30-60 days in advance.	
			Cannot allow each plan to establish its own dispute procedure: (claims deadlines, legal remedies, legal rights must be authorized by statute).	
			Need consumer advocacy board in all health plans.	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Disabilities			Add disability under risk-adjustment and incentives to serve disadvantaged groups.	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ed. & Labor	Are others in the alliance subsidizing the greater care given workers comp patients?			
	How will these specific work related injury protocols be developed?			
	How will plans bid to insure ability to service this population?			
	If this is, as assumed, going to cut costs of providing services, describe the savings recapture mechanism so that the employer will benefit from a corresponding reduction in premiums otherwise we will crate a windfall for the insurers.			
	Who and through what channels are claims paid; are they handled by the alliance or are the transactions simply between the comp carrier and the provider – what are the safeguards as to the services provided and the rates paid for services in these cases?			
	Concerns over locking in some very low health standards if accept all state law as the basis of these services.			
	Must insure equalized treatment between all types of workers – migrants in particular.			
	Basis for capitalizing these separate services.			
	Will there be any change in claims procedures or dispute resolution mechanisms relating to these claims?			
	How do these costs relate to the overall national budget?			
Rep. David Obey (H. Paster)	He cannot support health care reform that wipes out Wisconsin's model system for worker's compensation.			
	He does not have a problem with us including worker's compensation as long as states could choose to drop out.			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ways & Means			Current incentive to create moving people into high cost-sharing plans w/lower premiums could be reduced by including cost-sharing for covered services within budgeted amounts.	
	Do not make the current differentials any worse.			
	Clarify the treatment of Medicare beneficiaries within the alliance budgets.			
	The current formulation also presumes that it will be possible to estimate the initial premium targets net of cost-sharing. This problem could be avoided by including cost-sharing within the initial budget targets.			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cong. Hispanic Caucus			All reporting and data collection should include the providers that remain outside the health plans.	
Cmte. on Disabilities			Ensure certification process and report cards include data on compliance w/ADA.	
Sen. Metzenbaum			Should read "establishes minimum standards of access and quality", not "minimal".	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cong. Hispanic Caucus			Include ethnic identifiers for data collection.	
Sen. Metzenbaum			National board should have explicit authority to collect and report on financial data.	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
US Senate\D. Nexon			Plans must not discriminate against categories of providers.	Cannot do.

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
US Senate\D.Nexon	Concerned about estimates showing $1 vs. $5–6 billion for initiatives.		Increase funding.	
Sen. Kennedy	Improve performance of the core function of public health.		Incorporate the preventive health and health services block grant and some of the currently authorized disease and injury prevention programs within the Centers for Disease Control for which the state is the grantee.	
	Include the sexually transmitted disease, tuberculosis & childhood immunization programs.		Include major metropolitan areas as grantees under the new competitive grant program. The Administration's program should include funds for new initiative in smoking, violence and chronic disease prevention.	
			In addition to above, I would like to spell out clear performance standards and outcome measures for the use of these funds in order to maintain and improve accountability as we move to consolidate and expand current programs.	
	I am very concerned about new resource allocations for the public health system.		If overall funding for the public health programs is in the low range, priority should be placed on programs that directly expand access to health care for the most vulnerable groups.	
	Pleased that the Administration is proposing mandatory funding for new initiatives.		I would propose that we establish a mandatory "capped entitlement" fund for public health initiatives which would be subject to appropriation.	
House Energy & Commerce Cmte.	The assumed public health savings are too fast and excessive.		These services should receive continued grant support and be expanded; assumed savings should be slowed or dropped.	Savings occur w/universal coverage. Exploring reinvestment.
	Formula grants are difficult to account for and oversee. States will supplant existing efforts.		A new public health infrastructure project grants program for state & local health departments should be proposed instead; no formula grant should be proposed. Services should be provided through existing grant mechanisms	Agree

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
House Energy & Commerce Cmte.	Priority health problems: Consolidation of categorical programs that have been in place will limit available funding and undermine efforts.		Increased funding for ongoing programs w/admin. simplification & expanded demonstration auth. should be pursued instead and the new proposal should be dropped.	Agree
	New public health initiatives.		Public health services (both basic public health and service delivery) require significant new investment, far beyond this level.	Believe funding levels adequate but will continue to explore.

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
House Energy & Commerce Cmte.	Medicaid LTC programs for the severely disabled who do not meet eligibility criteria are replaced w/a new community-based LTC program for low-income people.		Existing Medicaid LTC community services must remain individual entitlements as under current law.	Agree

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Sen. Metzenbaum			Alternative dispute resolution models should not include early offers of settlement.	
			Under collateral source rule change, should not penalize individuals who recover under other policies that they pay for.	
			Either party should be allowed to use practice guidelines under demonstration project.	
	Does the plan include medical licensing and disciplinary reforms as Mrs. Clinton has said?			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cong. Hispanic Caucus	Essential community provider.		Define.	
			ECP funds need to have more definite guidelines.	
	State waivers to avoid contracting w/ECPs.		Should be eliminated.	
Sen. Kennedy	Concerned about proposal to overlay new consolidate programs on top of existing categorical project grants to community-based health service providers. I believe at least half of any urgently needed additional resources should be added to existing programs that have a history of servicing hard-to-reach & at-risk individuals & their families. Remaining funds, not earmarked for current categorical programs, should be provided to grantees contingent on their agreement to include all categorical grantees within their service area in any new practice network.			
	I do not support a large, new formula grant program to states to "enable" low-income individuals to receive necessary health services.		I would like to see the bulk of new funds directed toward existing programs.	
House Energy & Commerce Cmte.	Formula grants for access: these services should be provided through existing grant mechanisms to serve such populations.		No new formula grant should be proposed. Services should be provided through existing grants.	
			The contracting protections for essential community providers should be extended beyond 5 years & extended to include protection against excessive risk. Family planning clinics, which service as primary care providers for many women, should be presumed to be essential as well.	Understand concerns w/5 year limit. Re-writing.
	Capital payment cuts for hospitals are too high given OBRA '93 and need for capital is financially vulnerable hospitals.		Need targeted capital assistance program for vulnerable hospitals.	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ways & Means	State governments totally inadequate to manage Medicaid program & regulate private health insurance.			
House Energy & Commerce Cmte.	Supplemental services for cash recipients will remain as in current law.		The current entitlement of Medicaid eligibles (cash or non-cash) to supplemental services, especially supplemental EPSDT services, must be maintained.	Provide to cash beneficiaries under current law - considering extending to non-cash.

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ways & Means	Concerned about impact on Medicare program if younger age cohorts opt out.		Amend plan to make transition at 65 less dramatic.	
	Have grave concerns about the adequacy of protections for Medicare beneficiaries implied by the plan specifications. Some of the plan's Medicare proposals could have a significant & negative impact on the future integrity of Medicare.			
	What proportion of retired individuals turning age 65 are expected to select coverage through private plans in the alliance, rather than coverage under Medicaid?			
	Won't higher income individuals, who will be required to pay the full, non-subsidized Part B premium, have strong incentives to stay w/their private health plan, rather than enroll under Medicare Part B?			
	What will be the effect of requiring working seniors to retain private coverage, rather than Medicare coverage?			
	How will premiums charged by health plans to Medicare beneficiaries be determined? Will they be capped as a percent of the blended premium otherwise applicable to plan enrollees?			
	How will the premiums charged by the private health plan within the alliance to Medicare beneficiaries compare w/premiums incurred by beneficiaries under Medicare/Medigap.			
	What criteria would be used by the Secretary of HHS to evaluate whether states should receive the waiver to absorb all Medicare beneficiaries?			
	How will the Secretary assure that Medicare beneficiaries are adequately protected under the state plan?			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ways & Means	Proposed system would permit a significant differential to exist between Medicare & private plan payments to hospitals & physicians. This will permit further reductions in Medicare payments to increase cost-shifting to the private plans, blunting the ability of alliance plans to stay within their premium targets. The plan should, at a minimum, not make the current differentials any worse.			
	Plan imposes a variety of changes on people when they turn 65: their premium contributions and benefits will change. This creates a "notch" that will be an enormous political headache for years to come.		Recommend that the plan be amended to make the transitions at age 65 much less dramatic. This could be done either through a long range policy to equalize benefits, or through policies that would encourage employers to continue their wrap-around coverage for their retirees.	

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ed. & Labor	Insurance reform must address how to avoid dumping.			
	Need more detailed information about transition.			
Cmte. on Ways & Means	Impossible to have tools in place for implementation by 1-1-96.			
	Need to reconsider interim cost containment.			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
US Senate\D. Nexon			Desire cap on total premium as a percent of income.	
Cmte. on Ways & Means	Optimistic about speed in constraining health care growth.			
	Concerns re: plan's reliance on two separate & unrelated cost containment approaches.			
	Should narrow current unreasonable differentials in per capita spending.		Recommend specific process.	DOING
	Subsidies are entitlements to individual & must be the same across all types of plans & alliances – regional and corporate.			
	Doubts the total capped contributions plus unspecified subsidies will be adequate for alliances to pay premiums.			
	No methodology to equalize risk faced by corporate & regional alliances.			
			Clarify. Lines of authority & oversight for distribution of subsidies.	
	The subsidy structure for premiums and cost-sharing creates a powerful financial incentive that would force low income individuals into the least cost plan.			
	The method for determining eligibility for low-income subsidies should be uniform across alliances as these subsidies are funded using federal funds.			
	Method used to adjust payments to individuals retroactively should also be applied consistently across alliances.			
	Current plan may create an incentive to move individuals into the high cost-sharing plans since these plans would have lower premiums & thus be more likely to be below the premium target. This incentive could be substantially reduced by including the cost-sharing for covered services within the budgeted amounts.			

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
Cmte. on Ways & Means	Concerned about whether the proposed financing will be adequate to fund the federal contributions towards premium and benefit subsidies implied in the plan, or to fund premium payments by the alliances.			
	Have grave doubts as to whether the total of these capped contributions plus unspecified subsidies from the federal government will be adequate for many alliances to pay the health insurance premiums for all residents in the region.			
	Adequate funding for alliances will be a particularly difficult problem in geographic areas with high levels of unemployment and high numbers of uninsured.			
	By allowing large corporations to establish their own alliance, you are creating selection problems that will place further pressures on the financing of the regional alliances.			
	Plan is very vague on who would be responsible for handing out the federal subsidies.		Clarify the lines of authority and oversight.	
Sen. Metzenbaum	Why do all part-time workers have to go into a regional alliance?			
	Regarding retirees: do you mean employers that are under an existing obligation must pay at least the 20% employee share.			
House Energy & Commerce Cmte.	Overall, Medicare cuts are excessive in light of OBRA '93 cuts and other proposals in the package.			If Congress believes specific measures are inappropriate, we will work w/them to design appropriate measures.
	Premium subsidy levels.		To assure the poor a realistic choice of a fee-for-service plan, the premium subsidy must reach premiums higher than the average in cases where there is no fee-for-service plan available in the alliance w/a premium at or below the average.	See attached sheet.

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
House Energy & Commerce Cmte.	Cost-sharing subsidy levels.		Cost-sharing subsidies must be available even in plans with a low-cost sharing and even where the premium is at or below the average premium in the alliance.	See attached sheet.
	Sliding scale for premium & cost-sharing subsidies.		Individuals w/incomes below 100% of poverty must receive subsidy coverage for all premium & cost-sharing obligations. A sliding scale should apply between 100 & 150% of poverty.	See attached sheet.
	Entitlement nature of subsidies.		For federal budget purposes, the federal subsidy payments must constitute an individual entitlement in the same substantive and procedural senses as current federal Medicaid matching payments do; they must not be subject to annual appropriations caps.	See attached sheet.
	Bona fide DSH hospitals & other essential community providers.		The Medicare & Medicaid DSH subsidies must not be phased out w/respect to bona fide DSH hospitals identified by the secretary until the alliances certify that universal coverage within that institution's service area has in fact been achieved.	See attached sheet.
	Hospital cuts - phasing out of DSH & IME payments.		Phasing-out should be delayed.	See attached sheet.
	Physician cuts: the 3% reduction in the fee schedule conversion factor is not strongly supported.		Seems to be arbitrary cut.	
	Tighter expenditure targets assume physician services grow at same rate as overall economy.		Should provide a phase-in for this change in growth rate that follows overall phase of growth limits.	See attached sheet.
	Income testing Part B premium has potential to drive out health/wealthy.		If premium is raised for higher income people, it should not exceed 20% of Medicare program costs, putting higher income beneficiaries in comparable position to others.	See attached sheet.
	Setting Part B premium in law beginning in '96 is based on using CBO Part B estimates. These are higher than OMB estimates.		Congress should continue 25% policy as included in OBRA '93.	See attached sheet.
	Deficit reduction should not be built into this plan. There are no assurances about what will be required of Medicare for deficit reduction in each of the future years covered by these Medicare cuts.			See attached sheet.

SOURCE	PROBLEM	PAGE	PROPOSED SOLUTION	DECISION
House Energy & Commerce Cmte.	The implementation of some of the largest cuts are not coordinated with the transition to universal coverage.			See attached sheet.

Energy and Commerce Committee
Responses to Written Comments

The Energy and Commerce Committee written comments were prepared by Henry Waxman's staff. These issues raised in these comments have all been discussed at meetings with Waxman and/or his staff. The discussion below indicates how we have responded to these issues in the course of these meetings.

Medicare

Rather than respond to inquiries regarding individual Medicare cuts, we would recommend using the more general talking points on 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.

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.

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.

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.

Medicaid and Low-income Issues

1. Premium and cost sharing subsidies

We understand the Committee's concern that low income participants should have as much choice as possible, and that they should be assured of access to a plan that will meet their needs.

The plan is designed to *improve* the quality of care available to low income participants. Medicaid patients today have limited choices -- their choices are limited to providers who agree to accept Medicaid reimbursement. I think we would agree that in many cases, the choices today are not what we would like them to be.

Under the health plan, all Medicaid participants will be guaranteed comprehensive coverage through plans in their regional alliance. However, low income participants will no longer bear the stigma of being in a separate health care system. Simply integrating low income people into the broader health care system will provide many with better choices than they have today.

We are exploring the suggestion that broader premium subsidies and cost sharing subsidies be provided. We are concerned about the cost of expanding these subsidies, but will continue to work with the Committee to explore options.

If the concern is that low income participants should not face "redlining" which would force them into plans that cover only low income people, we are prepared to explore either strengthening provisions which assure that boundaries not be drawn in a discriminatory manner and that plans be open to a broad range of participants.

2. **Entitlement nature of subsidies**

We agree that discounts which are provided must be a matter of right. The plan calls for reserve funds to be established to help finance extra costs at times when more individuals and families are eligible for discounts than expected. In general, the funding of these reserves would be through the alliances. In the event that the alliances are unable to finance these discounts at a given time, there must a fallback of federal funding to ensure that individuals eligible for discounts can receive their discounts. We will work with the Committee to design an appropriate mechanism.

3. **Bona Fide DSH**

During the transition period when the new plan is being phased in, it will be necessary to continue to provide assistance to hospitals that are disproportionately serving the poor.

A portion of the Medicare DSH payments will continue, but they will be targeted to institutions that truly merit these extra payments. In the past, DSH has been taken advantage of and that practice must not be permitted to occur again.

We will work with the Committee on a transitional provision that addresses this concern.

4. **Medicaid Long Term Care**

We agree that existing long term care community service benefits which are individual entitlements under current law should remain so.

5. **Supplemental Services**

The plan proposes to continue to provide supplemental services to cash beneficiaries as under current law. Supplemental services for non-AFDC and SSI medicaid recipients could be converted into a block grant through the states. We are considering extending the current law treatment to the non-cash population (which includes many pregnant women who are not yet eligible for AFDC). [The states reacted very negatively when they heard that we were discussing this change with Waxman.]

6. **Illegal Aliens**

The plan would target federal assistance to providers who serve illegal aliens. We are exploring mechanisms to guarantee funding to providers in areas where service is provided to illegal aliens.

Public Health Initiatives and Savings

1. Public Health Offsets/Savings

Savings in this area will develop as presently uninsured patients become covered. We are exploring ways to reinvest these savings, as well as additional new dollars to support this system.

2. Formula Grants for Access

We have agreed that these funds will continue to flow through existing programs rather than a block grant.

3. Core Public Health Functions

We have agreed that a new infrastructure grant program should be proposed instead of a formula grant program.

4. Priority Health Problems Initiative

We have agreed that increased funding should flow through existing programs, rather than through a consolidated program, with administrative simplification and expanded demonstration authority.

5. Essential community providers

We understand the Committee's concern with the five year limit on the essential provider provisions and we are reviewing the recommendation that the period be extended beyond five years. The essential provider provisions are intended to ease the transition for these providers to be integrated into plans or to form new community based plans. We will work with the Committee to make certain that essential services are available in traditionally underserved areas.

6. Amount of Public Health Investment

The plan was designed to provide a significant increase in funding for traditional public health programs -- such as TB control. We believe that the proposed funding levels are adequate, but will continue to discuss concerned raised by the Committee and review the policy in this area.

IRA'S CHANGES

- pg.14 - Define Taft-Hartley plans
- pg. 15 - Corporate alliance employers required to pay premium for terminated employees for six months.

  reg for Taft. Hartley's.

  Yes.
- pg. 17 - employee defined under Internal Revenue rules.
- pg. 17 - Define full-time as 30 hours a week.
- pg. 2 - Change preventive dental service for children to dental services. Add in year 2001 preventive dental service for adults and restorative services.
- pg. 33 - Move mental health expansion from mental health section into expansion of benefit section.
- pg. 42 - National Health Board

  Serves as board of directors (and other framing changes).

  The board convenes an advisory committee of experts to establish the price of the national benefit in alliances. The board certifies the baseline in each alliance according to the competitive bidding process in section on health plans.

  The board oversees quality system developed and managed by consortium of medical schools and academic health centers. The board approves quality measures recommended by consortium.

  Add individuals with expertise in practice of medicine to list of qualifications for possible appointment to the National Health Board.

  Insert phrase "as a last resort" to introduce possibility of imposing premium surcharge on state that fails to implement reform.

- pg. 49 - Elements included in state plan:

  Add "quality and solvency" to list under as basis for certification of state plans.

  Delete "financial regulation of plans"

  Delete "administration of data collection and quality management"

- pg. 50 - Alliance size - change phrasing from "to ensure that it controls adequate market share" to "to ensure adequate market share to form a large community pool and to allow it to negotiate effectively with health plans."

- pg. 54 -- Single payer option -- feds automatically waives requirements under ERISA, rules related to regional and corporate alliances and Medicare continuation as separate program.

- pg. 55 --Single payer -- Add: A single-payer state may utilize a payroll tax instead of a premium based assessment. National subsidies for low wage and small firms, low wage families and early retirees will flow to single payer states according to the same criteria as states adopting a competitive approach.

- pg. 56-57 Alliance -- Delete phrase that describes alliance board of directors as only for alliances incorporated as non-profit agency. Delete option for alliance to be state agency.

- pg. 58 -- Change assignment to plan for individuals who do not enroll from assignment to lowest-cost plan to assignment to an "available" plan.

- pg. 60-61 -- Powers of Alliance

  Contracting requirements and exclusion of health plans:

Delete -- The plan is a fee-for-service plan that is not a successful bidder. Through a competitive bidding process, an alliance may limit to three the number of plans that pay any willing providers operating under a contract with the plan.

Delete -- Alliance may decline to contract if proposed premium would cause alliance to exceed budget target.

- pg. 62 -- Fee for service: Delete state ability to waive requirement to offer fee-for-service plan if not viable in area.

- pg. 62 -- Balance billing -- clarify prohibition against balance billing applies only to services in guaranteed benefit.

- pg. 64 -- Delete Department of Labor oversight of alliances. HHS. solvency issue ?

- pg. 65 -- Corporate Alliance -- Delete phrase assigning to Department of Labor responsibility to "regulate employers." Leaves phrasing that DoL "determines whether a corporate alliance may continue to operate in the case of merger, acquisitions and bankruptcies."

- pg. 78 -- Health plans -- under "Additional Requirements for Plans" delete reference to National Health Board as establishing authority and change to read:

  State certification requirements for health plans must meet national uniform conditions of participation including: (Fiscal soundness, etc.)

- pg. 81 -- Delete National Health Board establishing rules for supplemental insurance and cost sharing in corporate alliances.

- pg. 82 -- Under supplemental insurance -- shift responsibility for setting marketing standards for supplemental insurance from National Health Board to states.

- pg. 85 -- Rural Communities in the new system -- Add "urban" throughout section. underserved

- pg. 90 -- Add insert describing savings to employers from workers compensation.

- pg.93 -- Change outer budget targets to 1999 and 2000 (instead of leaving it open-ended as "thereafter")

- pg. 4 -- New draft of budget section -- change allowed premium increase from percentage increase to dollar increase.

  Shift responsibility for calculating premium cap from National Health Board to alliances.

  Insert process for closing disparities between high cost and low cost geographic areas in spending over 8 years starting in 1996.

  Delete section on "Tools to meet premium targets."

- pg. 100 -- Change responsibility for oversight of Quality Management from National Health Board to private, non-profit consortium established by medical schools and academic health centers.

  Add "Supervises" the national network of regional centers to obtain quality management data.

  pg. 103 -- Shift establishment of regional or statewide technical assistance through a non-profit foundation or other organizations from state role to National Quality Management Program under consortium.

  pg. 103 -- Under state role in quality management: Delete "develop and implement plans to meet enrollment, access and quality standards established by federal government." Delete "Prepare comparative reports on the performance of alliances, plans, providers and practitioners."

  pg. 104 -- Set per capita levy on insurance premiums to support quality program at 1% rather than set by National Health Board.

  pg. 105 -- Under role of health plans in

quality program delete "Meet national conditions of participation established for health boards by National Health Board.

- Workforce development
- pg. 201 - Medicaid - Shift responsibility for assessing ability to handle Medicaid disabled from national board to HHS.
- pg. 203 - Medicaid -- Establish baseline for state maintenance of effort equals spending for services covered in national benefit package in 1992. To statement "that figure is projected forward by 'actual medical expenditures in 1993 and' the budgeted growth in the state's weighted-average premium for the state population not covered by Medicaid."
- pg. 203 -- Insert federal Medicaid caps.
- pg. 210-211 -- Inserts on FEHBP -- supplemental benefits.

October 3, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: CAROLYN GATZ

SUBJECT: SUBSTANTIVE CHANGES TO POLICY

Following is a list of substantive changes to the draft plan book of which I am aware. Ira is editing the draft plan and will be making substantive changes through that process, although I have not yet received material from him.

From discussions with him, with the drafting team and with various members of the policy team, these are the larger issues that require change or clarification of policy:

- Expand and strengthen privacy protection and confidentiality section.
- Expand schedule of preventive services in benefit package to include annual clinical breast examinations, more frequent mammograms.
- Change periodicity schedule for well-child checkups.
- Impose 3.9% of income cap on liability of individuals/families for health coverage.
- Institute a required "point-of-service" rider to be offered by health plans that do not already include point of service option.
- Insert 1% of payroll assessment on firms that operate corporate alliances.
- Rewrite budget section to reflect automatic imposition of premium adjustment if alliance premiums exceed budget targets. Budget is now described as an enforceable cap.
- Clarify that people get their Health Security Cards through their alliance.

- Add ob-gyn to list of primary care providers for allocation of residency slots. Increase percentage mix of primary care-specialists accordingly (requires about 7% increase in primary care

- In response to HHS and other interested parties, change mechanism that allocates residency slots from regional councils to national council.

- Possibly eliminate 110% limit on number of residency slots.

- Change proposed policy on coverage of Medicaid population not in cash-assistance category to ensure that children with disabilities currently enrolled in Medicaid do not lose coverage for supplemental benefits.

- Make revisions to Medicare policy, particularly as relates to working Medicare recipients.

- Use ~~Social Security~~ Treas. rules for determining classification of independent contractors.

- Expand role of nurses in practice of medicine through multiple changes in plan.

- Clarify that ~~providers~~ allowed to negotiate fee schedule with alliance (anti-trust).

- Set mental health benefit.

- Clarify single-payer option as per memo from Greg Lawler.

- Clarify intention that health care reforms undertaken by Hawaii and Wisconsin are not disrupted by national reform.

- For purposes of discriminating among full-time and part-time workers, create three categories: Unless an employee works a minimum of 40 hours a month, they are treated as self-employed or not employed for purposes of health coverage. Employees who work between 40 and 120-hours-a-month are part-time. Above that amount is full time.

- Clarify power of alliances to decline to enter into a contract with a health plan.

- Specify policy to narrow variation in premium targets between high-cost and low-cost areas over 10 years.

- Clarify if states eventually take over responsibility for enforcement of premium caps (national budget).

- Make allowable increases in premiums under national caps dollar amount rather than percentage amount so as not to disadvantage low-cost plans.

- Clarify coverage obligations for early retirees for employers who currently provide health care benefits.

- Change tax deductibility to eliminate grandfathering by not imposing limit at level of guaranteed benefit until 2003.

- In response to HHS, make funding for capacity expansion in underserved areas through currently successful programs (community and migrant health centers) as well as through new authority

- In response to HHS, fund outreach and enabling services through targeted project grants rather than formula grants to states

- In response to HHS, fund school-related clinics through separate authority rather than through capacity expansion program.

- In response to HHS, funding for core public health functions through competitive grants rather than formula grants