Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	Susan Smith to Hillary Clinton (2 pages)	05/16/1996	b(6)
001b. letter	Douglas Traeger to Daniel Foley (4 pages)	03/08/1994	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10255

FOLDER TITLE:
Healthcare 1

2013-0534-S
rc1604

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

MEMORIAL SLOAN-KETTERING CANCER CENTER
ESTABLISHED 1884

Office of the President

When she's in NYC for another date

August 2, 1993

— NY City

PERSONAL & ~~CONFIDENTIAL~~

VIA FACSIMILE 202/456-6244
AND FEDERAL EXPRESS

① File copy in NY HC file

② Return copy to me.

Melanne Verveer
Deputy Chief of Staff to The First Lady
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Melanne:

I am writing in follow-up to our telephone conversation on July 30th. Memorial Sloan-Kettering Cancer Center would be honored to invite the First Lady to be the recipient of the Mme. Marie Curie Award for Outstanding Contributions to Health Care and to speak at our Center on this occasion.

Some 75 years ago, Mme. Curie, working at Memorial with her clinical colleagues, introduced the first radiotherapy for treating cancer. This represented a breakthrough in the control and cure of this disease.

Mrs. Clinton's efforts to develop plans for health care reform have already had an important impact, with health care reform moving forward in many states even as we anticipate health care reform at the federal level.

Special institutions, such as Memorial Sloan-Kettering, which are at the leading edge in prevention and curative care must play a vital role in health care reform. The audience for Mrs. Clinton would include the staff of the several major health Centers in New York City and the surrounding metropolitan area, as well as Trustees and friends of these Institutions.

Memorial Sloan-Kettering Cancer Center
1275 York Avenue, New York, New York 10021
212 639-6561 Fax: 212 717-3299

We are flexible with respect to the date and time. You mentioned a possible date in the latter part of September or in October. We could work with such dates. We could have a luncheon or dinner in honor of Mrs. Clinton, either of which could precede or follow the presentation of the Madame Curie Award and her address.

I will look forward to hearing from you and hope that Mrs. Clinton's schedule will permit her to accept our invitation.

With kind regards,

Sincerely,

Paul

Paul A. Marks, M.D.
President

cc: Ann Dibble Jordan

Enclosures: 1992 Annual Report - Memorial Sloan-Kettering Cancer Center
MSKCC Center News - June, 1993

PAM/mkp

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Health Cares

Harry and Louise Were Right, Sort Of

By ROBIN TONER

REMEMBER the frightening things that were going to happen if the Clinton health care plan passed? Like losing the right to choose a doctor or a health plan? How about the slow death of old-fashioned medical insurance and the like-it-or-not march into health maintenance organizations? Not to mention restricted benefits and even rationing.

Harry and Louise, the fortysomething couple created by the Health Insurance Association of America, vented their anxieties about these possibilities — and, by extension, millions of other Americans' fears, too — in a series of television commercials in 1993-94, fretting around the kitchen table as health care legislation was furiously debated, and ultimately killed, on Capitol Hill. Now, with the benefit of three years' hindsight, it can be said: Harry and Louise were at least half right. There were indeed big changes in their future.

Imagine the surprise around that kitchen table today: The proportion of American workers in managed care plans has grown to 74 percent, up from 55 percent in 1992, when Bill Clinton was beginning his first campaign for health care reform, according to a recent survey of employers by KPMG Peat Marwick.

As for choice, the study found that employers of all sizes have reduced the number of alternative health plans available to their workers over the last year; among mid-size employers, 52 percent now offer their workers only one plan.

"People believed that if the Clinton plan died the managed care revolution would die with it, that you'd be able to keep your choice of doctors," said Bob Blendon, an expert on public opinion and health at Harvard. "People were calling the Clinton plan socialized medicine because they were going to force you into an H.M.O., and yet we've had this huge growth of managed care since the plan died."

The supposedly halcyon days of fee-for-service medicine, covered by traditional indemnity insurance, have clearly passed for most Americans: Just 26 percent of the people who get their insurance through work are enrolled in the traditional plans, down from 71 percent in 1988. And hospital stays are now so strictly limited by some insurers that Congress recently stepped in and required that new mothers and their babies get a minimum stay of 48 hours.

Still, Louise did not have to deal after all with the new "billion-dollar bureaucracy" that she so often worried about, because the Government was left out of this revolution.

And a lot of analysts argue that, in retrospect, this turned out to be a good thing — and not just because of the abiding American mistrust of bigger government. Insurance companies and employers had the expertise and the stomach, these analysts say, to do things that elected officials could not do — like closing underused hospitals, restricting the freedom to choose a physician and taking other measures to squeeze down the costs of health care.

Uwe Reinhardt, a health economist at Princeton, argues that President Clinton ought to be thankful the dirty work was done by somebody else.

"Maybe it's not a bad thing to have it come out that way — because otherwise government would have gotten a terribly bad name for things that are not really government per se, but things that needed to be done," Mr. Reinhardt said. "Someone had to say to doctors and patients, you cannot have all these resources all the time." He concluded that "the managed care industry has become the flak-catcher for all the things that Clinton would have been the flak-catcher for."

Continued on Page 3

Continued From Page 1

Moreover, there is little dispute that in the realm of cost control, which was always the primary concern of many of the policy elites anyway, the private sector has been quite successful. And it restrained health care spending without the unwieldy, confusing new Government entities that Harry and Louise — and, judging from the polls, millions of other Americans — had found so unappealing.

No big new alliances, the much-maligned purchasing cooperatives that Mr. Clinton and the chief architect of his doomed plan, Hillary Rodham Clinton, envisioned as the middlemen between consumers and the insurance companies. No complicated cost controls or global budgets.

Private Choices

"While it's certainly true that there's been a powerful movement in the direction of managed care, these are private choices rather than government choices," said Bill Gradison, president of the Health Insurance Association of America, which led the industry's fight on Capitol Hill.

"Moreover, in an employment situation, if you're really unhappy with the choice your employer made, you often have a union to go to bat for you, or an employee benefit department. You may not always prevail, but it's easier than going to some distant government agency."

But would Harry and Louise be happy with the way things turned out? Do they even realize how much has changed? A survey published last summer for the Robert Wood Johnson Foundation, a health research organization, suggested that most Americans do not perceive the great slowdown in health care costs, not to mention the profound changes in the marketplace.

Still, there are signs that at least Louise, who was usually the one reading up on health care in the commercials while Harry stood by supportively, would have recognized that there was a price to be paid for letting employers and insurance companies work their will.

Paul Starr, another health care expert at Princeton who worked on the Clinton plan, said, "What we're getting is managed care but without the consumer protection and patients' rights that people have a right to expect."

He noted that the alliances, unlike employers, would have been required to offer consumers a variety of health plans, and would have provided many more safeguards for consumers' rights.

Drew Altman, president of the Kaiser Family Foundation, a health-care research group, said, "There are a lot of people out there who feel, or should feel, that they fought off the Government monster only to find themselves faced with changes in the marketplace that they care about a lot more."

There's a price for letting employers and insurers, rather than the Government, reinvent health care.

Defenders of managed care systems, like Karen Ignagni, president of the main industry group, the American Association of Health Plans, argue that consumer satisfaction within these networks is actually quite high.

"Consumers now have access to a product that is more affordable, that has very low out-of-pocket costs, that has more comprehensive benefits and that stresses prevention," Ms. Ignagni said. Where people have a choice, as is the case with Medicare recipients, they are increasingly choosing managed care plans, she said.

But there is clearly some backlash brewing among the Harrys and Louises of America. Accordingly, Congress has shown a new willingness to regulate the industry in the wake of a flurry of complaints, ranging from shortened hospital stays to restrictions on what doctors in some managed-care networks can tell their patients about treatment options. The law requiring 48-hour maternity stays is only the beginning, many analysts say.

"The big, somewhat underreported health care story of 1996 is that the Congress, in a bipartisan manner, has moved into regulating health insurance, which they have not done before — and there wasn't a dime's worth of difference between the Democrats and the Republicans on this," said Mr. Gradison.

President Clinton, for his part, has announced that he will appoint a panel of experts to recommend ways of protecting consumers in this fierce new health care marketplace. This kind of bipartisan consensus reflects the broad popularity of these regulatory moves, analysts say.

In other words, Government may not look so frightening to Louise these days, as she sits at her kitchen table fuming over her latest dispute with her new health care plan. Perhaps she has a few regrets. She may even be muttering, once again, her mantra from three years ago:

"There's got to be a better way."

The New York Times

Sunday, November 24, 1996

file health care

Hucksters

Who Needs This Ad Most?

By NATALIE ANGIER

YOU know a commercial has plucked a nerve when the most startling thing about it is not the sight of wild chimpanzees aping famous lines from movies like "The Godfather," "Star Wars" and "Animal House."

The really shocking part of the new advertisement for Home Box Office on network television is the shot of Jane Goodall, doyenne of primatology, sitting in her cabin in the Gombe Preserve, Africa, writing up field notes about the "inexplicable" behavior of the chimps. Seems they have been imitating Marlon Brando and John Belushi after peeking through her cabin windows at her television set. "Dr. Jane Goodall, HBO viewer since 1978," the final tag line tells us.

Why in the name of Godzilla is Dr. Goodall, who has always projected a sense of quiet, even self-effacing dignity, hawking a television movie channel?

For the stubbornly snobbish, the reaction is indignation: Is nothing sacred? Have even scientists sold out? For others, the commercial burnishes Dr. Goodall with the glow of wit: Even scientists have a sense of humor!

Whatever the reaction, the commercial has provoked much chest-pounding over who is willing to advertise what, and how the audience responds to a familiar figure from film, music, art, politics — or science — in the unfamiliar position of huckster.

Bob Dole, the former Presidential candidate, appeared in a print ad for Air France last week (he donated his $3,000 fee to a community center for the elderly). Ed Koch, the former New York City mayor, plugs Dunkin' Donuts' bagels. Michael Jordan becomes a thesaurus entry for Nike. Richie Havens sings plaintively in a travel ad. We love celebrity endorsements, in part because we love doing the quick mental calculus of where the personage must be in the arc of his or her career to agree to the spot.

Top Bananas

Our reactions may be colored by our feelings about television, commercials and capitalism generally, but a few rules apply. When sports stars pitch athletic goods, it is a sign of their Olympian stature. When an icon of 60's rebellion warbles for tourism, you know he needs the work. And when a scientist like Dr. Goodall shows up, well, uh ....

"My first response was disbelief," said Frans de Waal, a renowned primatologist at the Yerkes Primate Research Center in Atlanta. "I thought, Is this real? Does Jane know about it?"

Yes, it is real, and Jane knows about it. She even got paid $100,000 to do it. "When they first approached me, I said, 'You must be joking!' I was totally horrified," Dr. Goodall said in an interview. "But when they ran through what they wanted to do, I realized it was actually fantastic." She liked the idea that the creators of the commercial, Michael Patti and Don Schneider of BBDO in New York, would use real chimpanzees in Gombe, not trained chimps dressed in cute clothes. "Entertainment chimps are often cruelly treated," Dr. Goodall said. "It dawned on me that here is a way to show how animals can be used in advertising in a non-exploitative manner." Besides, she said, "The HBO thing is hilarious. If you can can make someone laugh, you make the world a better place."

The fee, she said, is "enough money to keep our biggest chimp sanctuary in the Congo running for a year. There are people who said we should have gotten more, but we didn't know."

Joshua Gamson, a sociologist at Yale and the author of "Claims to Fame: Celebrity in Contemporary America," sees the ad as a brilliant example of advertising's fundamental desire — to put a fresh twist on the tried-and-true. "Advertising works by ferreting out new things, ways of selling that are familiar but on the edge," he said. "It's the spread of the celebrity system into fields where it hasn't been before. We're seeing it now in academia, certainly in the arts, and in nonprofit organizations, with things like the high-profile AIDS Awareness campaign."

These pitch people are, in the phrase of Joshua Meyrowitz, a professor of communication at the University of New Hampshire, "our new media friends." Or, as Madison Avenue puts it, they are commercial "virgins."

Dr. Goodall's reputation is not likely to suffer. For one thing, she has contributed too much to biology for too long. For another, any colleagues who resent her newfound market appeal already resented her fame as a primatologist. And the chimps looked awfully glamorous banging their sticks on the ground and chanting, "Toga! Toga!"

Sometimes appearing in an ad can lend a public figure some panache, particularly if the spot plays off the person's fame. O. J. Simpson succeeded in the Hertz commercials because they showed him doing what he does best: running for his life. Tina Turner is in a $20 million ad campaign for Hanes hoisery, a natural move for the possessor of the greatest set of legs this side of a centipede. Dan Quayle made delicious use of his most infamous gaffe, the misspelling of the word "potato," by appearing, wordlessly, in a commercial for Wavy Lay's potato chips.

I Want a Mustache

Some commercials are so hip that celebrities are insulted when they are not asked to appear in one. The pasha of cool, Spike Lee, directs blue jeans commercials and appears in milk mustache commercials. Indeed, everyone wants to be shown wearing one of those white mustaches: Kate Moss, Lauren Bacall, Danny De Vito, Pete Sampras all do it; why not me? The campaign has been so successful that for the first time in 20 years, milk sales are going up, according to the sponsor, the Milk Industry Foundation.

Not every act of mercantilism helps. When the director Orson Welles became a pitchman for Paul Masson wine, many of his fans saw it as an act of desperation, a sign of how far the giant (in every sense) had fallen. Cher admitted that she probably harmed her career by doing infomercials for a skin-care product line. When Geraldine Ferraro, a former vice-presidential candidate, was in an ad for Diet Pepsi — which she did because, she confessed, she needed the money — she received a drubbing for being mercenary.

There are stars who cherish their reputations so much that they refuse to do any sort of product flacking — at least not in America. Woody Allen has written and directed ads for a grocery store chain, but only in Italy, and Sharon Stone has pushed Pirelli tires and Freixenet champagne, but only in Europe.

Lest anyone conclude that these entertainment demigods are driven by simple plebeian greed, note that Ms. Stone's Pirelli fee will go to the conservation of rubber trees everywhere.

The New York Times
Sunday, November 24, 1996

improve conditions. But it would do nothing to fix the system's decision-making problems, which have a deeper root: A pervasive unwillingness to acknowledge that some mothers are unable to raise their children and that only adoption or long-term foster care can give their children a chance.

I saw this most dramatically in a case I handled in the early 1980s as a volunteer attorney in the Family Court Division of D.C. Superior Court. I was representing five children, ages 4 through 15, who had been in foster care for three years. Their drug-addicted mother had repeatedly beaten them so badly that they had been hospitalized a number of times for their injuries. She had recently incited her then 15-year-old daughter to run away from her foster home, and then prostituted her until she got pregnant.

Because the official case record said almost nothing about the mother, I made a home visit to see how she was doing. The hallways in the mother's apartment building had feces smeared on the walls and smelled of stale urine. Her apartment had broken windows, inoperative plumbing and an unlocked kitchen door that opened to a missing fire escape—three floors off the ground. Without tremendous improvement, this mother was never going to regain custody of her children.

When I returned to my office, I called the family's caseworker, recounted what I had seen and suggested that he consider initiating adoption proceedings for the younger children—who were still young enough and emotionally healthy enough to be adopted. He said he appreciated my report since he had not seen the mother for many months but that, no, adoption was premature. I shall always remember his reason: "I don't like to give up on a mother."

Don't fault the caseworker. His actions only reflected the prevailing attitude, embodied in state and federal law, that the prime objective of child protective agencies should be family preservation.

Attitudes have changed little since I was involved in this case, as national statistics show. Each year, about 250,000 children are placed into protective foster care, according to the American Public Welfare Association. Although many children are returned in a matter of days, many others languish in foster care with little hope of adoption. The most up-to-date data are from 1990, when about 40 percent of the 400,000 children in foster care had been away from home for at least two years. About half of these children had been in at least two foster homes.

Fewer than 5 percent of these hundreds of thousands of children are freed for adoption each year. Too many children are returned home, where they frequently are abused again and once more placed in foster care. This revolving door is particularly common in cases of parental crack addiction, where despite the best treatment programs parents tend to relapse into addiction.

Some blame this failure to take more decisive action on a misplaced commitment to parental rights. That surely contributes. But, as the statistics suggest, the system is unwilling to accept the uncomfortable truth that some parents are beyond the reach of even the best treatment programs.

We need to take the necessary steps to help their children grow up safely and reach their full potential. Caseworkers have to be able to say to a severely abusive mother: "You have had two chances (or three or four). Now, we want to give your kids a chance. We need to take them from you and place them in a safe, nurturing home."

My service on the Fatality Review Panel convinces me that making this change won't be easy. Our panel is no toothless tiger. Over the years, many of our recommendations have been adopted, particularly those urging improvements in training programs, supervision of workers and caseload standards. The authorities have even paid attention to suggestions about which individuals to discipline or prosecute for endangering children.

But we have gotten nowhere in our efforts to get New York City and state officials to respond more forcefully to cases of severe abuse, including parental drug abuse. In writing this article, I went back and looked at our past reports. We have regularly called for changes in law and policy to make it easier to terminate parental rights, and for an expansion of long-term residential options for children who can't go home and don't have much hope of being adopted.

One obstacle, no doubt, is the fear of the cost of taking responsibility for severely abused and neglected children until they grow up. But doing the right thing need not cost more than current practices. Take Washington, for example. Its child welfare system was considered to be in such bad shape that the federal courts placed it under the supervision of a "receiver," Jerome Miller. After examining the agency's budget, Miller calculated that it was spending roughly $40,000 per year per child. Many of these children could be placed for adoption, which would save money; others could be placed in stable residential settings, which should cost the same or less.

Program advocates are another obstacle. For years, they have made unsupported claims—repeated unquestioningly by some politicians and some in the media—that programs like family preservation can repair even the most dysfunctional families. Moreover, many of the children most in need are too old or too troubled to be adopted and would have to be placed in long-term foster care or residential institutions (which opponents would quickly call orphanages).

Race only aggravates the difficulty. Since the crack epidemic of the late 1980s, which hit disadvantaged African-American communities like a sledgehammer, child welfare caseloads have become progressively more black. Between 1982 and 1990, the last year for which there are data, the proportion of foster children who were African American rose from 34 percent to 41 percent, two and one-half times their number in the general population.

The reality that a "get-tough" policy would fall disproportionately on poor, black mothers rightly should make everyone think twice before adopting it. But the present course—ignoring the long-term harm being done to black children—may be an even more insidious form of racial discrimination.

So the next time you read about a child's death, don't blame just the caseworker who perhaps did not do everything possible to protect the child. Some blame belongs to the rest of us. Until we collectively accept that many severely abused and neglected children need a permanent place to live away from their parents, and until we make such placements a real option, we should expect to read about many more Nadines.

Jacob W. Dembosky helped prepare this article.

The Washington Post

SUNDAY, DECEMBER 1, 1996

2/2

When Home Is Hell

We Are Too Reluctant to Take Children From Bad Parents

By Douglas J. Besharov

LAST MONTH, as I have regularly for the past nine years, I traveled to New York City to try to make sense of a child's death.

I serve on New York City's Child Fatality Review Panel, a remarkable body that conducts no-holds-barred investigations in-

Douglas Besharov is a resident scholar at the American Enterprise Institute and a visiting professor at the University of Maryland School of Public Affairs.

to child abuse deaths. It is an experience that is both rewarding and dispiriting. In effect, we conduct social autopsies: Why did the child die? Could the authorities have prevented it? If so, should we recommend any disciplinary actions or systemic changes that might save children now in danger?

This time when we gathered inside the plain conference room where we hold our discussions, we already knew a fair amount about the case before us. Unlike many of the 100 cases I have reviewed, the gruesome death of 4-year-old Nadine Lockwood had received saturation coverage in the New York media.

Nadine weighed 15 pounds when the police found her shriveled, lifeless body in a Manhattan apartment last August. For many months, her drug-addicted mother had kept her in a blanket-covered crib, slowly starving her to death. What made it front-page news was that Nadine's mother and her six children had been reported to the city's child protective agency numerous times over the previous seven years.

A hospital first reported Nadine's moth-

See CHILD, C5, Col. 1

CHILD, From C 1

er to authorities in 1989, when her newborn tested positive for cocaine. The case was closed within six months after the mother started attending a drug treatment program. Nadine was born less than two years later, also with cocaine in her system. The agency confirmed this report as well but again closed the case after six months.

A year later came yet another baby—this one abandoned in the hospital and later placed for adoption. Over the next three years, the agency received more reports, including several that the older children rarely attended school. Still, it did not take protective action. (As a member of the panel, I have access to confidential agency files, but all the details discussed in this article have already become public.)

Sadly, Nadine's story is not unusual. Nationally, about 1,500 children die each year under circumstances suggestive of abuse and neglect, according to the National Committee to Prevent Child Abuse. No matter what we do, some of these deaths cannot be prevented, because they happen without any warning. But about half the time, the children died after the family was reported to a child protective agency. In such cases, one can fairly ask: What went wrong?

I have spent much of my professional life trying to answer this question—first as a young prosecutor in New York City, then as the founding director of the federal government's National Center on Child Abuse and Neglect and more recently as a consultant to public and private agencies across the country. But it's easy to lose touch with the real world. That fear, as well as the chance to make a small contribution, has kept me on the Child Fatality Review Panel. Case after case has taught me about the immense challenges child welfare agencies face each day—and has forced me to reexamine (and often modify) my most deeply held beliefs about how best to protect children.

The conventional wisdom blames most of these deaths on inadequate funding and on poorly trained and overworked caseworkers. On the basis of my experience, however, I do not think that more money will help matters much. Decision-making problems plagued New York City, for example, even when it had one of the lowest per worker caseloads in the nation. Although most agencies can certainly use more (and better) resources, the real culprit is wishful thinking about parents and the efficacy of treatment.

Think about how the system handled Nadine's mother, a confirmed drug addict with years of well-documented problems in caring for her children: As soon as she *began* a drug treatment program, the system concluded she could make it on her own. Worse, it continued in that belief in the face of repeated reports from concerned professionals and neighbors.

Since I started out in the field almost 30 years ago, child protective programs have expanded enormously. Thanks to stronger child abuse reporting laws, the number of children reported to the authorities in the United States has increased from only about 150,000 children a year to the over 3 million today (although many reports turn out to be unfounded). Most communities now have specialized investigative agencies, so that those reports that once languished in piles on workers' desks are usually investigated within a day or so. Moreover, for better or worse, millions of children have been placed in foster care. Between 1982 and 1995, for example, the number of children in care almost doubled, from about 262,000 children to about 494,000 children. And, back in the 1960s, child welfare expenditures were a fraction of the approximately $5.7 billion spent last year just for investigations, foster care and adoption services.

These expansions have made a dramatic difference. By most estimates, child abuse deaths are half or less of what they were three decades ago, even as social problems such as drug addiction have worsened. And thousands of other children have been saved from injuries short of death. More money for additional caseworkers and other services would surely

The Washington Post

SUNDAY, DECEMBER 1, 1996

1/2

file health care - achievements

THE WHITE HOUSE

WASHINGTON

August 16, 1996

MEMORANDUM TO THE PRESIDENT

FROM: Carol Rasco and Laura Tyson

SUBJECT: Health Care Policy Achievement and Initiatives Update

You may want to highlight health care reform achievements and unveil "next-step" initiatives concurrent with, or soon after, the signing of the Kennedy-Kassebaum bill and the Democratic Convention. This memo outlines: **Health Reform Achievements, Pending Proposals, and New Reform Options.** These could be highlighted as part of any major health message.

I. Health Reform Achievements: Because the Health Security Act was not enacted, there has been a perception that the Administration has had few health care achievements. As the following summary attests, this perception is a mistaken one. The enactment of the Kennedy-Kassebaum bill and a more forceful effort to highlight our achievements will help turn this perception around. In the first term, you have:

- **Passed portability, guarantee issue and guarantee renewal insurance reforms.** In response to your State of the Union challenge, the Congress finally passed long-overdue insurance reforms that will benefit as many as 25 million Americans. As a result, workers will no longer be locked into "second-choice" jobs because their (or their families') pre-existing condition make them live in fear of losing health insurance. Similar insurance reform provisions were included in the Health Security Act and your balanced budget proposals.

- **Eliminated the discriminatory tax treatment of the self-employed.** You have advocated eliminating or reducing the 100 percent vs. 30 percent disparity between large employers and the self-employed for years (the 1992 Campaign, the Health Security Act, and your two balanced budget proposals). The Kennedy-Kassebaum bill increases the deduction to 80 percent for the 3 million self-employed Americans now purchasing health care, (which is close to parity since most employers do not pay for more than 80 percent of their employees' premiums).

- **Strengthened fraud and abuse prevention and enforcement initiatives.** The Kennedy–Kassebaum legislation included provisions long sought by Secretary Shalala that strengthen our ability to target and prosecute "bad apple" health providers who are bilking the system of billions of dollars from Medicare, Medicaid, and private insurance. The bill expands penalties and provides for permanent funding to build on our already successful efforts to combat fraud. The Congressional Budget Office conservatively estimates that these provisions will save over $3 billion.

- **Provided tax incentives for private long–term care policies and consumer protections to go along with them.** The Kennedy–Kassebaum bill included the tax clarifications for private long–term care policies and many of the basic consumer protections that were in the Health Security Act. These provisions should increase the sales of private long–term care policies, which should reduce future financial burdens on our public programs caused by an fast aging population.

- **Provided the tools to simplify the health care system and reduce paperwork, while still protecting the privacy of patient records.** The Kennedy–Kassebaum bill included provisions you have long called for that would modernize, streamline and cut the costs of insurance paperwork by providing standards for a common electronic system for paying health claims that most private insurers would use. The bill also provides the Secretary the authority to establish Federal privacy protections that would prohibit inappropriate disclosure of information.

- **Strengthened Medicare Trust Fund by 3 years.** Your 1993 economic package included policy and structural changes that extended the life of the Trust Fund by three years and were enacted without one Republican vote.

- **Preserved and protected the Medicaid guarantee of health coverage, while providing more flexibility to states to expand coverage.** You successfully defeated the Republican Leadership's proposal to block grant the Medicaid program, thus assuring that millions of vulnerable Americans would not lose guaranteed health care coverage or benefits. At the same time, you presided over the rapid approval of 12 thoughtful Medicaid waivers that, when completely implemented, will provide health coverage to 2.2 million previously uninsured Americans.

- **Contributed to getting health care inflation under control.** Your efforts to assure that all Americans have affordable, quality health care focused the nation's attention on the problem of health costs. This attention expedited the private sector's interest in implementing approaches to slow cost growth. This, along with the improvements in the economy, helped slow medical inflation to 3.9 percent in 1995 -- the lowest rate in 23 years. In the first 6 months of 1996, medical inflation is running at less than 2 percent and may actually grow below the general inflation rate for the year.

- **Increased investment in biomedical research at the National Institutes of Health (NIH) by an impressive 16 percent at a time when many other programs were being cut.** Funding for breast cancer research at NIH has increased by 76 percent and support for AIDS research funding has increased by 25 percent.

- **Funding for AIDS prevention and treatment has been increased to historic levels.** Support for AIDS prevention programs has increased by 19 percent, and support for treatment programs, primarily through the Ryan White Care Act, has increased by an extraordinary 95 percent. In addition, earlier this year, the Congress responded to your request to increase the Federal commitment to the State AIDS drug assistance programs (ADAP) by $52 million. This funding will be used to help AIDS patients buy expensive, new protease inhibitor drugs. Combined with the increases in our AIDS research investment, total funding for HIV/AIDS programs in fiscal year 1996 was $2.86 billion; this represents a nearly 40 percent increase since you took office.

- **Established a comprehensive childhood immunization initiative to ensure vaccinations and healthy futures for all children.** The proposal includes: a major community-based outreach effort to educate parents and providers about the need for vaccination; better detection of vaccination levels and outbreaks of infection; and a standardized immunization schedule to make it easier for parents to know when vaccinations are due. This program contributed to the immunization rate of 75 percent of 2-year old children in 1995 -- an historic high.

- **Expedited the FDA review and approval of new drug products.** U.S. drug approvals are now as fast or faster than in any other industrialized nation. Average drug approval times have dropped since the beginning of the Administration from almost three years to just over one year. In 1997, virtually all breakthrough drugs will be approved within 6 months.

- **Protected kids from tobacco products and advertising.** Issued a proposed regulation to eliminate easy access to tobacco products by children and to prohibit companies from advertising to make tobacco appealing to kids. The goal is to reduce smoking by children by 50 percent within seven years after the plan goes into effect.

- **Increased funding for the VA health system by nearly two billion dollars.** This support will provide the resources necessary for the treatment of 94,000 more veterans.

- **Significantly reduced the regulatory burden of the Department of Health and Human Services for providers and consumers.** The Vice President's reinventing government initiative has resulted in the elimination of 1,600 pages of regulations, a 23 percent reduction.

II. Currently Pending Health Care Proposals: Unnoticed by much of the public, you unveiled an extraordinary number of substantive health reform proposals which in any other Congress would have been viewed as aggressive and quite ambitious. No other President has put as many public (Medicare and Medicaid) health savings dollars on the table, and no other President has proposed to so significantly alter and modernize the Medicare and Medicaid programs. However, relative to the Republican proposals, your proposals have been mistakenly viewed by the media (and thus the general public) as modest. Despite the fact that anyone who knows these programs knows better, the media has either ignored your proposals or has chosen to classify them as protecting the status quo.

We have never strongly promoted the private insurance reform initiatives you advocated that go beyond the Kennedy-Kassebaum bill because we feared they had the potential to undermine our Hill negotiations on the bill. The good news about this is that these initiatives will appear to be new to the public and the media, and -- with the exception of the $1 billion over seven years mental health parity initiative -- they are paid for in the context of your previous omnibus balanced budget proposals. Your major currently pending proposals include:

- **Extending the life of the Medicare Trust Fund until 2006.** Your Medicare savings ($124 billion/CBO estimates it to be $116 billion), combined with the home health care expenditure transfer (previously passed by the House), extends the Trust Fund for ten years from today while also making a significant deficit reduction contribution. It is a responsible savings package that would hold the Medicare per person growth rate just under what CBO numbers assume is equivalent to the private sector growth rate. [NOTE: Because the Medicare baseline is increasing, we may be able to squeeze more savings from the program in next year's budget.]

- **Modernizing the Medicare program and beginning to prepare it for the retirement of the baby boom population.** Your Medicare plan would increase choice of plans for beneficiaries (by adding a new Medicare Preferred Provider Organization option, a new Provider Sponsored Organization alternative, and a new HMO with a point-of-service option). It also would add important and potentially cost-effective preventive benefits (by providing for full coverage of mammography screenings, adding a colorectal screening benefit, and providing for diabetes case management.) It takes the first step toward providing for a long-term care benefit by establishing a respite benefit for families of Medicare beneficiaries afflicted with Alzheimer's Disease. Lastly, it includes a number of market-reform-oriented "competitive-bidding" initiatives that would make Medicare a more prudent and effective purchaser of health care services.

- **Liberating the states in their desire to have more flexibility to manage Medicaid.** Your Medicaid proposal (which provides for $59 billion/CBO estimates $54 billion in deficit reduction through a per person cap) would eliminate the burdensome waiver process for managed care, eliminate the waiver process for home and community-based care alternatives to institutionalization, and eliminate the Boren requirement. It would also make it easier for states to spend money in an attempt to expand coverage. [NOTE: Because the Medicaid baseline is declining, the fiscally aggressive policy we are now advocating would likely be scored lower on both the CBO and OMB baseline next year; in other words, it will be difficult to get the same deficit contribution from Medicaid next year.]

- **Building on Kennedy-Kassebaum by providing for a "Workers' Transition Insurance" benefit.** This proposal would help assure that previously insured people who are looking for a new job could afford to keep their health insurance and thus retain their portability protections. It would cost about $2 billion a year, would annually help approximately 3 million temporarily unemployed Americans, and would illustrate our resolve to still expand coverage within a balanced budget context.

- **Empowering small businesses to gain market-leverage to access more affordable insurance through the use of voluntary health purchasing cooperatives (HPCs) by providing access to FEHBP plans, overriding restrictive state laws, and giving financial assistance for the establishment and operation of HPCs.** We have been studying a series of options about how best to use the FEHBP and the limited political and financial resources we have available to empower voluntary HPCs to purchase more affordable, accessible health insurance for small businesses.

  Based on extensive conversations with public and private sector insurance analysts, we continue to believe that, in the absence of universal coverage, the potential for serious risk selection is too great to recommend that FEHBP's current insurance pool be opened to other purchasers. Since the Kennedy-Kassebaum bill does not include rating/price bands, there will continue to be significant premium price variation in the insurance market. As a result, a health plan that charges average premiums for larger populations -- like FEHBP -- would become a magnet for poor risk employers who are currently charged higher than average premiums in the market place. This would increase FEHBP plan costs as well as Federal employee hostility towards us. If we held Federal employees harmless, this could significantly increase the Federal costs of running FEHBP. Whether the Government picked up these costs or not, opening up the FEHBP insurance pool would attract extremely loud Government union opposition.

  The risk selection issue could be addressed by requiring OPM to administer a separate insurance pool in FEHBP for the non-Government employees. While this could be done, we are hesitate to recommend this option primarily because we are skeptical that OPM could administer an effective FEHBP alternative without a significant and politically risky infusion of money and talent. Second, based on what people in the field are telling us about what is actually happening in the marketplace, it seems much more likely that private, locally-administered HPCs (perhaps certified by the state) are better positioned to negotiate more effectively than an OPM employee who has little knowledge of plan rates within a particular geographic area. And finally, without a large number of small group enrollees in a particular geographic area, it is highly unlikely that FEHBP would negotiate attractive arrangements with insurers.

  Having said this, using FEHBP and other changes to the law to empower small businesses can and should be done. We would suggest that you strongly promote a proposal that would give private or state-run HPCs the ability to require that health plans participating in FEHBP (who also operate in the small market) must also offer coverage (in a separate risk pool) in HPCs. In addition, since one of the greatest hurdles HPCs face in becoming viable is their difficulty in attracting capital for their formation and operation, Federal grants would be made available to either state or private run HPCs who met certain standards (including that they are regulated by the state.) This proposal also would incorporate the Kennedy-Kassebaum purchasing cooperative provisions, which were dropped in conference, that: (1) Override state "fictitous group" laws (which prevent non-associated employers from purchasing insurance together), (2) Allow HPCs to negotiate price reductions even in states where community rating laws would preclude them from doing so, and (3) Allow HPCs to offer the same insurance packages for small businesses that bypass state benefit mandates that the state has authorized other insurers to sell.

- **Providing mental health parity across health insurance products.** The Republican Leadership rejected all attempts by Senator Domenici to come up with a compromise on the mental health parity issue and dropped it from the Kennedy–Kassebaum conference. They would not even support an Administration–endorsed Domenici alternative that dropped all parity provisions other than those related to lifetime and annual caps. This approach reduced the proposal's costs by 90 percent and would have assured that premium increases to pay for this benefit would not exceed .4 percent. This issue may come before the floor of the Senate again this Fall.

- **Protecting mothers and their newborn babies from premature discharges from hospitals.** You endorsed this proposal in your Mothers' Day Radio Address. Similar to legislation sponsored by Senator Bradley, it requires health care plans to allow mothers to remain in the hospital for at least 48 hours. There have been cases where plans have required a discharge within 8 hours of birth. Premature discharge can lead to serious health consequences for both mothers and children. Like the mental health parity provision, this popular initiative may come up for a vote in September.

- **Expanding health care options for older veterans.** This summer you proposed the "Veterans Medicare Reimbursement Project of 1996," a proposal to open the VA system to Medicare–eligible veterans at a number of cities. This measure, sometimes known as Medicare "subvention," would allow VA to receive reimbursement from Medicare, improving access to care for older veterans while lowering VA costs.

- **Contributing to the World Health Organization's initiative to eradicate global Polio by the Year 2000.** This proposal -- advocated strongly by Rotary International -- would increase spending on global polio eradication efforts by $20 million. The Centers for Disease Control (CDC) has estimated that adequate funding and intervention could achieve the goal of eradication within one or two years. If successful, the United States alone could save more than $230 million per year after polio eradication is achieved and vaccinations are no longer needed. It appears that your request may well be included in the FY '97 Appropriations bill.

III. Options for New Health Reform Initiatives: There are three additional health care reform issues that we believe merit particular consideration for possible future Administration involvement. The initiatives are: (1) Appropriate oversight over managed care and other health plans; (2) Proposals aimed at providing children with greater access to affordable insurance; and (3) Initiatives designed to provide more independence for people with disabilities. With the exception of the managed care/health care delivery oversight issues, these proposals are quite preliminary and have yet to be formally scored and fully reviewed through normal interdepartmental process.

The public, consumer advocates, health care providers (academic health centers in particular) are increasingly fearing that the cost containment successes of managed care are the result of cuts in quality care, research and training, and questionable financial incentives between insurers and providers. The trick for developing politically viable policy alternatives is to strike the balance between the desire to enhance consumer protections with the need to avoid micromanagement of the health care system. What follows is a package of proposals that we believe achieves the appropriate balance.

Because the House Democratic Leadership and a number of health policy advocates are very interested in children's insurance coverage initiatives, we are also including a range of potential policy options. And finally, we believe that there a couple of disability empowerment initiatives that are worth seriously considering. As you know, people with disabilities have a heavy reliance on public health programs, particularly Medicare and Medicaid. As a result, since the only way to retain benefits is to stay eligible for SSI and/or SSDI cash benefits, they have overwhelming incentives to not seek gainful employment. In addition, there is a growing frustration within the disability community that the institutional bias of the Medicare and Medicaid programs are also undermining the potential for people with disabilities to be more independent.

- **Building on your managed care/health care insurance oversight record** (mental health parity provisions, 48–hour rule and a recent Medicare/Medicaid regulation to monitor excessive financial incentives for physicians to underutilize health care), **consider becoming active on three visible fronts: (1) sign the "gag" rule; (2) further define the appropriate role of the Federal government in regulating managed care; and (3) develop approaches to protect the academic health center community in this period of unprecedented changes in health care delivery.**

  (1) **Push for and sign the "gag" rule into law.** Consider immediately calling on the Congress to move to pass the "Patient Right to Know Act." In response to concerns about health care plans prohibiting physicians from advising their patients about alternative treatments, Congressman Ganske (R–IA) and Congressman Markey (D–MA) introduced legislation prohibiting any health plan from restricting medical communications, oral or in writing, between health care providers and their patients. This bill was unanimously reported out of the Commerce Committee in late July and may well pass the House prior to adjournment. If you push the Congress, you may ensure that they pass the bill before they leave. OMB and HHS support this provision.

  The only possible downside of endorsing the bill is that it will strain our relationship with the managed care community, but even they are now beginning to accept the fact that this bill and the 48 hour rule proposal will likely pass with little to no opposition.

  (2) **Establish an advisory board to make recommendations about the appropriate Federal role in monitoring managed care, assuring quality, and protecting consumers.** Consider establishing a bipartisan working group of public and private appointees (with representatives of consumers, unions, providers, insurers, businesses, and the government) to evaluate the shortcomings of consumer/quality protections/access in managed care and other health delivery systems, and to make recommendations about the appropriate role of government in regulating these plans. You may recall that you and the Vice President discussed a similar initiative with John Sweeney and Gerry McEntee earlier this year. (They are particularly concerned about the impact of managed care on the workforce and would strongly support this proposal.) The Vice President, OMB, HHS and Labor support this initiative.

There are a number of advantages of this route. First, it would be an initiative that illustrates you want to act, but act thoughtfully in this area. Second, if controversial recommendations were made from the perspective of the insurer, managed care, and business community, there would be policy and political cover for proceeding. Third, the fact is we need better information to make thoughtful recommendations that do not unintentionally hurt the positive elements of managed care. And finally, if we are visibly associated with the "gag" rule bill and the 48-hour protection measure, we will have shown our commitment in this area without having to go further at this time.

The disadvantage of this approach is that it may appear we are either ganging up on the industry or, conversely, delaying necessary action. Some proponents of intervention would probably suggest that the delay in the report was nothing more than a stalling mechanism designed to stop necessary intervention.

(3) **Host a Presidential forum on the impact of managed care on the declining private sector financial contributions for research and training at academic health care centers and on possible approaches to reverse this trend.** The managed care community is being (fairly) charged with not adequately supporting its share of the new health care research that is necessary to sustain the nation's overwhelming lead in health care technology/research. We propose that you consider hosting a "challenge" event to get the managed care and the research community together to engage in constructive conversations about an issue that neither is effectively addressing. The event would be designed to discuss how centers of excellence can produce the type of research HMOs and other managed care plans are interested in seeing and, conversely, how these health plans can better financially support the work academic health centers are undertaking.

There are no disadvantages to this proposal as long as it is not the only managed care oversight initiative you pursue. (If that were the case, it might seem too insignificant a step relative to the perception of problems with managed care.)

- **Consider options that assist children in terms of access, affordability and/or coverage.** We are looking at four options: (1) investments in community health centers and school-based health centers; (2) health care financial assistance through the tax code; (3) premium subsidies; and (4) empowerment of states to design kid coverage programs. Cost and coverage estimates are unavailable, but are expected in short order. However, while all four options would increase access to care and -- to some extent -- affordability, it is clear that only the last two options would significantly increase coverage. Most importantly, with the exception of the modest public health investment outlined in option one, <u>they all will require significant investments -- probably in excess of $15-$20 billion over 7 years. Unless we drop some other priority, it is difficult to see "credibly" financing any significant proposal in the context of a balanced budget</u>.

(1) **Introduce legislation to invest in public health initiatives to expand access to children.** This proposal could be pursued on its own or in addition to any of the other three options. Targeted investments would be made to community health centers and school-based clinics to provide preventive and other services to children. Health centers participating would aggressively undertake outreach activities aimed at signing up eligible children for Medicaid.

The advantages of this proposal are: it builds on an existing system that serves many of the most difficult to reach children; it is cost effective to provide health services in these settings; and it could be achieved with a relatively modest investment. The disadvantages are: it does not significantly increase health insurance coverage; school-based clinics have been controversial because they often provide family planning services, (but any proposal could be targeted at clinics in elementary schools); and States may oppose circumventing their own outreach efforts and undermining the control of their program.

(2) **Provide tax relief for families purchasing health insurance for their kids.** This proposal, fathered by the House Democratic Leadership, would require all health plans doing business with the Federal government to offer health insurance policies for uninsured children. Working families with incomes below a certain level would be given premium assistance through a tax deduction or credit if their employer does not contribute toward dependent coverage. To keep costs low and to prevent substitution of tax subsidized coverage for employer-sponsored coverage, the subsidy would be set at a low percentage of the premium. As a result, the primary benefactors of this option would be those who already have insurance. Therefore, this proposal can be best described as addressing affordability more than coverage problems.

The advantages of this proposal are: it is easy to administer because it uses the existing structure of the tax system and middle-class families will benefit the most. The primary disadvantage of the proposal is that initial estimates show that few uninsured children would gain coverage.

(3) **Provide Federal premium subsidy assistance.** This proposal would subsidize families below certain income levels (on a sliding scale) to purchase health insurance for their children. Eligible populations include uninsured and state optional Medicaid children. Because they would receive a full subsidy, the primary benefactors of this program would be lower-income children.

The advantage of this proposal is that it would significantly expand coverage for children. Old estimates projected that 6 million children would receive benefits, although only 2 million children would have been previously uninsured. The disadvantages of this proposal are that it would be costly, inefficient, difficult to administer, duplicative of Medicaid, and would create incentives for employers to drop children who currently have coverage.

(4) **Empower states to design an innovative program that supplements Medicaid to expand coverage for children.** This proposal would give states a Medicaid per capita amount to expand coverage to children. This could be done by: (a) giving states more flexibility to use different delivery systems, including managed care, without seeking waivers but leaving current benefit rules in place; or (b) allowing even more flexibility by permitting states to require contributions from higher income Medicaid eligibles. Using savings from these premium and cost-sharing requirements, states could expand coverage to additional populations of children. Populations eligible to receive benefits would be uninsured children in low-income working families.

The advantages of this proposals are: it builds on existing state structures; it limits Federal cost to the Medicaid matching amount versus a full premium subsidy; and it gives Governors much desired flexibility to increase coverage for children in working families.

The disadvantages of this proposal are: Although limited to lower-income populations, it will still likely induce some employer dropping of coverage; its cost-sharing requirements would impose burdens on some beneficiaries that have none now.

- **Consider options that increase the independence of people with disabilities,** including breaking the health coverage link to public cash assistance programs and creating more incentives to use home- and community-based services in lieu of institutional care.

(1) **Unveil a proposal to allow people with disabilities the opportunity to retain, or in return for a sliding scale premium, purchase Medicare or Medicaid.** Because private insurance is often not available or affordable to people with disabilities, many people choose to remain on the rolls rather than take the risk of working and losing coverage. This proposal, which we are designing with the Social Security Administration, would allow disabled social security clients the opportunity to purchase Medicaid or Medicare on a sliding scale as their income from employment rises. The primary potential downside is that this option might create unintended consequences of attracting many more people with disabilities to the subsidized Medicare/Medicaid programs than are currently being served. We are still waiting for final OMB estimates and will obviously rethink this option if it is cost prohibitive.

(2) **Consider additional ways to reorient the Medicaid program towards home- and community-based care and away from its institutional bias.** The disability community hates the fact that nursing home coverage within Medicaid is defined as a mandatory service, while home- and community-based care services are optional. We are currently evaluating options (that go even beyond your current proposal to eliminate the waiver process for States who wish to implement a home- and community-based service option). We will keep you informed of developments.

ACHIEVEMENTS IN HEALTH REFORM

President Clinton's numerous achievements in health care reform include:

- **Passed portability, guarantee issue and guarantee renewal insurance reforms.** In response to the President's State of the Union challenge, the Congress finally passed long-overdue insurance reforms that will benefit as many as 25 million Americans. As a result, workers will no longer be locked into "second-choice" jobs because their (or their families') pre-existing condition make them live in fear of losing health insurance. Similar insurance reform provisions were included in the Health Security Act and the President's balanced budget proposals.

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- **Established a comprehensive childhood immunization initiative to ensure vaccinations and healthy futures for all children.** The President's proposal includes: a major community-based outreach effort to educate parents and providers about the need for vaccination; a program designed to make vaccinations more affordable; and better detection of vaccination levels and outbreaks of infection. In 1995, 75 percent of two-year old children were fully immunized -- an historic high.

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- **Funding for AIDS prevention and treatment has been increased to historic levels.** Support for AIDS prevention programs has increased by 19 percent, and support for treatment programs, primarily through the Ryan White Care Act, has increased by an extraordinary 95 percent. In addition, earlier this year, Congress responded to the President's request to increase the Federal commitment to the State AIDS drug assistance programs (ADAP) by $52 million. This funding will be used to help AIDS patients buy expensive, new protease inhibitor drugs. Combined with the increase in our AIDS research investment, total funding for HIV/AIDS programs in fiscal year 1996 was $2.86 billion; this represents a nearly 40 percent increase since the President took office.

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PENDING HEALTH CARE PROPOSALS

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- **Modernizing the Medicare program and beginning to prepare it for the retirement of the baby boom population.** The President's Medicare plan would increase choice of plans for beneficiaries (by adding a new Medicare Preferred Provider Organization option, a new Provider Sponsored Organization alternative, and a new HMO with a point-of-service option). It also would add important and potentially cost-effective preventive benefits (by providing for full coverage of mammography screenings, adding a colorectal screening benefit, and providing for diabetes case management.) It takes the first step toward providing a long-term care benefit by establishing a respite benefit for families of Medicare beneficiaries afflicted with Alzheimer's Disease. Lastly, it includes a number of market-reform-oriented "competitive-bidding" initiatives that would make Medicare a more prudent and more effective purchaser of health care services.

- **Liberating the states in their desire to have more flexibility to administer Medicaid.** The President's Medicaid proposal (which provides for $59 billion/CBO estimates $54 billion in deficit reduction through a per person cap) would eliminate the burdensome waiver process for managed care, and home and community-based care alternatives to institutionalization. It would preserve the Federal guarantee of health coverage, and also make it easier for states to spend money in an attempt to expand coverage.

- **Building on Kennedy-Kassebaum by providing for a "Workers' Transition Insurance" benefit.** This proposal would help assure that previously insured people who are looking for a new job could afford to keep their health insurance and thus retain their portability protections. It would cost about $2 billion a year, would help approximately 3 million temporarily uninsured Americans a year.

- **Empowering small businesses to gain market-leverage to access and purchase more affordable insurance.** This would be accomplished through the use of voluntary health purchasing cooperatives (HPCs) by providing access to Federal Employees Health Benefit Plans, overriding restrictive state laws, and giving grants for the establishment and operation of HPCs.

- **Providing mental health parity across health insurance products.** The President has endorsed the compromise mental health parity initiative proposed by Senator Domenici. It would require that health plans who use lifetime and annual spending caps for covered services could not treat the coverage of mental illness in a different and discriminatory manner.

- **Protecting mothers and their newborn babies from premature discharges from hospitals.** The President has endorsed proposals that require health care plans to allow mothers to remain in the hospital for at least 48 hours. There have been cases where plans have required a discharge within 8 hours of birth. Premature discharge can lead to serious health consequences for both mothers and children.

- **Expanding health care options for older veterans.** This summer the President proposed the "Veterans Medicare Reimbursement Project of 1996," a bill to open the VA system to Medicare-eligible veterans at a number of cities. This measure would allow VA to receive reimbursement from Medicare, improving access to care for older veterans while lowering costs to the VA system.

- **Contributing to the World Health Organization's initiative to eradicate global polio by the year 2000.** This proposal would increase spending on global polio eradication efforts by $20 million. If successful, the United States alone could save more than $230 million per year after polio eradication is achieved and vaccinations are no longer needed.

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file
health
Commission

MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris J.
RE: Quality Commission

December 13, 1996

Following up on our telephone conversation last night about the Advisory Commission on Quality and Consumer Protection, I discussed the issues you raised with Bruce Reed. Here's a summary of our conversation and our suggestion about a possible alternative approach.

We both agreed with you that the Commission's very existence has the potential to undermine managed care/quality assurance initiatives that we may want to pursue. Bruce also raised the point that, from a communications perspective, it has always been difficult to say we support certain quality initiatives in the same breath we talk about a Commission to look into the problem. He cited our Florida event when we tried to combine our message on an anti-gag initiative with the President's announcement on the establishment of the Commission. Having said the above, we both concluded that we were probably too far down the road on the announcement of this Commission to totally turn it off. The release of the Executive Order on the Commission and the President's commitment to Labor to establish it are particularly problematic in this regard. We did come up with an alternative strategy, which we offer for your consideration.

First, rather than quickly release the names of the Commission (as we were planning to do at the end of this month or in early January), we think it would be wise to hold off on the announcement until after the State of the Union Address and the release of the budget. Delaying the release will allow us to focus on our anti-gag and other quality initiatives, which we plan to include in the budget. It will help us avoid a mixed message.

Second, rather than keeping the Commission in existence for 18 months, amend the Executive Order to shorten its life-span to no longer than a year. This will allow us to push additional initiatives, hopefully with cover from the Commission, for the second session of this Congress. It also specifically addresses the concern you have about a long-lived Commission precluding our ability to advocate for additional initiatives until too late into the President's second term.

We have not raised these alternatives to anyone else within the Administration. Before we advance them, however, we wanted to make certain you were comfortable with these ideas. Please call me (or have Melanne do so) when you have the chance to discuss this. Thanks.

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CommonHealth

JOURNAL OF THE AMERICAN INTERNATIONAL HEALTH ALLIANCE

SPRING 1996

Beyond Hospital Walls: Creating Healthy Communities Through Partnerships

Observer

RUSSELL BAKER

Harry! Louise! You Lied

They told us that national health care would deprive us of the right to choose our own doctors.

So we said no to national health care.

And we found ourselves enrolled in something called an H.M.O. It gave you a list of doctors to choose from. If your doctor wasn't listed, they told you to forget him.

They told you to choose one of the doctors on the H.M.O.'s list, or else. "Or else" meant your health insurance wouldn't pay your doctor's bill.

They had deprived us of the right to choose our own doctors.

And they told us if we had national health care there would be Government bureaucrats interfering with our medical treatment.

Strangling us with red tape.

Burying us under tons of paperwork.

So we said no to national health care.

We said yes to the great insurance corporations of America, and perhaps of the entire planet now that conglomerated capital no longer recognizes national boundaries.

We said yes because we did not want Government bureaucrats interfering with our medical treatment.

Did not want to be strangled with red tape.

Didn't want to be buried under tons of paper.

So we said no to national health care and said yes to great-insurance-company health care.

And we found ourselves up to the neck bone in bureaucrats.

Not Government bureaucrats, to be sure.

That's right: The bureaucrats who occupied more and more of our lives were not Government bureaucrats. They were great-insurance-company-of-America-and-possibly-the-whole-darn-world bureaucrats.

In bureaucrats we were up to the neck bone.

The neck bone is the seat not only of the infamous pain in the neck, but also of three-day headaches, sour stomach, criminal dreams of blowing up the great insurance corporations of America, and hatred for our fellow man, though more often our fellow woman since the bureaucrats most often encountered in the typical soul-crushing struggle with a great insurance corporation of America seem to be female.

Whenever such a bureaucrat can be reached by telephone live.

By those with sufficient patience to press numbers 1 through 117 in search of a human voice.

And what was that red material so tightly wrapped around our necks? It was tape. Dreadful, terrifying red tape. But not the Government's red tape.

It was the red tape of great insurance companies, of H.M.O.'s, of various and sundry doctors and the squadrons of accountants who managed their vast files of paper.

Affidavits, certified X-rays, notarized doctors' statements, histories of previous ailments, professionally attested-to prospectuses of sicknesses likely to be incurred in futures both near and far, sworn evidence of abstinence from cigarettes, solemn oaths not to develop long-term diseases, F.B.I. records if available on

> Up to the neck in bureaucrats.

drinking habits and sexual proclivities in your youth, any and all records forecasting genetic tendencies to ill health, criminal activity, out-of-body adventuring and susceptibility to kidnaping by aliens conducting experiments on humans in U.F.O.'s. Such was but a small sampling of the privately contrived nongovernmental red tape that strangled us.

Paper! How thick it rose around us, how densely it filled the air. That's why we felt buried under a stifling, crushing tonnage of paper! We had said no to national health care to avoid being buried under tons of paper. And here we were. Buried.

Under tons of paper.

They told us that national health care would cost us billions in taxes. Leave it to the free market, they said, and it wouldn't cost us a cent to continue enjoying the best medicine in the world.

Provided we had private health insurance.

So we said no to national health care. We did not want to pay zillions in taxes. We did not even want to pay $1.79 in taxes, to be perfectly frank. Especially since we had health insurance, all but 30 or 40 million of us. We said the great free market should be allowed to do its work.

And that was the end of national health care. The health industry is cleaning up on Wall Street. The rest of us pray we may never get sick. □

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Hillary Rodham Clinton

From: Chris Jennings

Date: December 6, 1994

Re: Prescription Drug Background Information

cc: Melanne Verveer

Following up on our conversation last week, I have attached a narrative timeline of pharmaceutical cost containment initiatives. The information was compiled at my direction by John Coster, who worked for me at Senator Pryor's office and who is now a professor at the University of Minnesota, College of Pharmacy.

You will note that the information presented well illustrates the repeated pattern of policy makers attempting -- usually unsuccessfully -- to make the industry become more sensitive to prescription drug cost and coverage concerns. As you requested, we have tried to structure this document to show how the HSA proposal underwent changes that received little notice from the industry, but received rejections from Senator Pryor and other hill staff. (They indicated, as you recalled, their concern that we were going too far towards the industry).

I hope this information is helpful. If you need any additional information, please call me. As you know, this is my most and least favorite subject. I look forward to talking to you soon.

CHRONOLOGY OF CONGRESSIONAL PRESCRIPTION DRUG PRICING INITIATIVES

prepared by John M. Coster, Ph.D., R.Ph.
Assistant Professor, PRIME Institute
University of Minnesota College of Pharmacy
Minneapolis, MN

Introduction

Since the 1950's, various members of Congress have focused on the pricing practices of the pharmaceutical industry. Taking on the pharmaceutical industry is not an easy task. The drug industry is powerful, has significant resources at its disposal (including financial and personnel), and often time resorts to distasteful lobbying tactics to achieve its objectives. In spite of all the attention that the drug industry has received from both the Administration and the Congress over the past forty years, its prices remain relatively unregulated, its pricing behavior continues to shock many individuals, and the new political environment in Washington may well embolden the industry to seek legislation favorable to its causes. While the industry may attempt to "behave" during a period in which attention is focused on it, history shows that any negative publicity does not make a long term impact on the behavior of drug manufacturers.

In the 1950s', Senator Estes Kefauver (D-TN), was the first member of Congress to hold hearings on the pricing practices of the drug industry, focusing on the prices of antibiotics. In spite of all the attention that he focused on the drug industry, the industry argued that they needed their high prices for research and development, and little resulted from the hearings in terms of reduced prescription drug prices.

During the 1960s, the major health care focus was on Medicare and Medicaid. The drug industry opposed the addition of a Medicare prescription drug benefit because of their concern that the benefit would provide government with a foothold into their pricing practices. Therefore, most of the efforts of the industry during and after Medicare were directed towards defeating a Medicare benefit, which they ultimately did.

During the 1970s' there was serious talk of national health insurance, and the drug industry was concerned that a national prescription drug formulary would develop as a result of these discussions. Because of Watergate and other political factors, national insurance was never enacted, and the drug industry had avoided another potential challenge to its profitability. Senator Kennedy often criticized the drug industry during the 1970s for their pricing practices.

The drug industry enjoyed a very healthy period during the 1980s'. Profits achieved all time records, and drug prices were increasing three times the rate of inflation. Serious questions about the drug industry's pricing practices were raised in 1987, when AZT was first introduced to the market. The manufacturer, Burroughs-Wellcome, was subject to significant criticism from Congressman Henry Waxman, who believed that the company was charging excessive prices, and exploiting the situation. The company eventually lowered its price, but to add insult to injury, it was discovered that the NIH did the most work on developing AZT.

During the late 1980s, the Medicare Catastrophic Coverage Act (MCCA) was being developed. Congress added an outpatient prescription drug benefit to the MCCA, and once again, the industry's concerns about drug formularies and cost controls set their lobbying operation into motion. They heavily lobbied the drug benefit to assure that there were no cost controls on drug products (only on pharmacists), and that there was no formulary. Eventually, as described below, MCCA was repealed.

Section I - The Late 1980's (The Pre Clinton Years)

July 1989 - As new Chairman of the U.S. Senate Special Committee on Aging, Senator David Pryor holds first hearing on prescription drug price inflation in the United States. The hearing focuses on the reasons behind the skyrocketing cost of prescription drugs in the United States, with special focus on the sharp increases in drug manufacturer prices for prescription drugs during the 1980s.

Summer 1989 - Congressional hearings are held on the Medicare Catastrophic Coverage Act of 1988 (signed into law July 1, 1988), which has become very controversial because of the financing provisions of the legislation. Some of the hearings also focus on the solvency of the new Medicare outpatient prescription drug trust fund, which is projected to be underfunded because of the anticipated continuing sharp increase in manufacturers' prescription drug prices during the 1990s.

November 1989 - Under extreme political pressure, Congress repeals the Medicare Catastrophic Coverage Act (MCCA) of 1988, and with it, the Medicare outpatient prescription drug benefit. The benefit would have provided prescription drug coverage to about 17 percent of Medicare beneficiaries each year. The drug industry apparently spends significant sums of money to support the senior groups who are opposed to MCCA so that they can repeal the drug benefit along with the rest of the bill. While the drug benefit was ultimately crafted with all the industry's demands met, it was still better for the industry to have no drug benefit at all to avoid any potential government oversight of drug industry pricing practices.

November 1989 - Senator Pryor holds second hearing on prescription drug prices, focusing on the prices that federal health care programs pay for prescription drugs, in particular the Medicaid outpatient prescription drug program. During the hearing, it is determined that some federal health care programs, such as the Departments of Veterans' Affairs and Defense, pay extremely low prices for prescription drugs, while other federal programs, such as Medicaid, pay the highest prices for prescription drugs. The hearing questioned the equity and fairness of drug manufacturers charging these various prices.

Manufacturers justify these differences by contending that, while VA and DOD are direct purchasers and bulk buyers of pharmaceuticals, Medicaid is a reimburser, and does not buy pharmaceuticals in bulk and therefore is not entitled to any price discounts.

March 1990 - Senator Pryor introduces legislation to require drug manufacturers to negotiate lower prescription drug prices with the state Medicaid programs. The legislation, the Pharmaceutical Access and Prudent Purchasing Act (PAPPA) of 1990, would provide state Medicaid programs with the same tools used by private purchasers, such as hospitals and HMOs, to negotiate lower prescription drug prices with drug manufacturers. Manufacturers argue that the legislation is too bureaucratic and would result in many prescription drugs NOT being covered for Medicaid recipients, creating a two-tier system of medicine.

April 1990 - In response to Senator Pryor's legislative initiatives to contain Medicaid drug program expenditures, and to avoid any legislative action at the federal level, Merck Sharp and Dohme proposes an "Equal Access to Discounts" program. Under the program, state Medicaid programs would receive the lowest price for a Merck drug that Merck offered to any buyer in the United States, such as hospitals and HMOs. Merck's "break" with the drug industry help to divide the opposition and weakened the industry's case against being able to give lower prescription prices for Medicaid programs.

In response to this Merck initiative, several other manufacturers began to negotiate with state Medicaid programs to lower the cost of their prescription drugs to Medicaid. However, not all manufacturers participated in these types of programs, and these savings were not "scorable" according to CBO without federal legislation. (The issue of "scoring" became very important as this issue moved through the process. Note that the Bush Administration and the Congress were in the early stages of negotiating a $500 billion deficit reduction package, and these Medicaid drug program savings were going to be part of the overall deficit reduction package.)

Summer 1990 - Bush Administration's Office of Management and Budget (OMB) supports Senator Pryor's initiatives to reduce Medicaid drug program expenditures, and targets $1.6 billion in Medicaid savings over 5 years (1991-1995) from drug manufacturers. This gives Senator Pryor's initiatives a strong bipartisan boost.

Summer 1990 - Many African-American, latino, and other minority groups adamantly oppose the Pryor/OMB initiatives under the presumption that these Medicaid prescription drug program cost management mechanisms would create a "second class system of medicine" for poor people. It was argued that many state Medicaid programs would use restrictive drug formularies, and not list many drugs on these formularies, making them unavailable for poor people. It is suspected that the drug industry is funding these initiatives. These groups makes reference to those advocating the Pryor/OMB policies as "mean spirited bigots".

September 1990 - Senator Pryor introduces second Medicaid prescription drug pricing bill (S. 3029), based on the proposal made by Merck. Under this approach, drug manufacturers would be required to give discounts on their products to Medicaid as a condition of coverage of their products under Medicaid. This second bill helped to diffuse criticism of the first bill, and co-opted some of the manufacturers' own initiatives to provide lower prices to the Medicaid programs.

October 1990 - After much political wrangling, Congress enacts Medicaid Prudent Pharmaceutical Purchasing Provisions of Omnibus Budget Reconciliation Act (OBRA) of 1990, and includes federal Medicaid savings of $1.9 billion over 5 years from drug manufacturers. ($300 million more than the original OMB target to pay for other Medicaid expansions.) Under the legislation, drug manufacturers are required to give Medicaid a minimum rebate OR the same price discounts they give to their best customers, whichever is lower. Total federal/state Medicaid savings from drug manufacturers are expected to be $3.1 billion over 5 years. Drug manufacturers warn that they will be unable to give Medicaid the same price breaks that they give hospitals and HMOs, and therefore drug prices to these buyers might increase.

January 1991 - Reports from hospitals and HMOs indicate that some drug manufacturers are raising prices to these institutions to circumvent the intent of the rebate legislation. Remarkably, some of these price increases were to the VA and DOD for drugs, such as painkillers and blood thinners, which were being stockpiled in heavy supply by VA and DOD for potential use in the Persian Gulf War. By attempting to eliminate these very low drug prices to these institutions, manufacturers would not have to give the same deep discounts to Medicaid, and indirectly, would help to build a case for the law's eventual repeal.

Reports came into many Congressional offices during the early part of 1991 from hospitals, HMOs, nursing homes, and other pharmaceutical buyers that many drug manufacturers were eliminating discounts arbitrarily and cancelling long-standing purchasing contracts.

January 1991 - Merck announces that, as a policy, it will increase its weighted average manufacturers' price in 1991 for its line of pharmaceutical products by no more than the projected increase in the Consumer Price Index (CPI-U). Several other manufacturers also announce that they will hold prescription drug price increases to some variable of CPI-U. While the voluntary initiatives on the part of the industry were welcome (and good for the industry's battered public image), these approaches were criticized as being ineffective because they limit "average" price increases rather than "actual" manufacturer's retail price increases, the part of the market where relief is needed the most. When lower manufacturers' hospital prices are "averaged" with higher retail prices, the result would have little affect on manufacturers' retail drug price inflation.

November 1991 - Senator Pryor introduces the Prescription Drug Cost Containment Act of 1990 (S.2000), which would reduce a drug manufacturer's Section 936 tax credits in Puerto Rico if the manufacturer's annual price increases for retail prescription drug products exceeded the increase in the general rate of inflation. (The Section 936 Credit, also known as the Possessions Tax Credit, was developed in the early 1900s as an incentive for American manufacturers to establish manufacturing operations in the Commonwealths of the U.S. The overwhelming majority of the credit - 97 percent - goes to companies located in Puerto Rico.)

This bill was introduced to try to lower prescription drug price inflation in the segment of the market in which older Americans purchased their prescription drugs. The industry lobbied heavily against this proposal, arguing that the loss of the credit would hurt the Puerto Rican economy, and result in a loss of revenue necessary for new drug research and development. Many latino and other minority groups also opposed the legislation, contending that it would reduce R&D investment.

March 1992 - Senator Pryor offers S.2000 as an amendment to the Tax Equity and Fiscal Responsibility Act on the floor of the Senate. After eight hours of debate, the Senate tables the amendment, 61-36.

May 1992 - A GAO report finds that drug manufacturers disproportionately benefit from the Section 936 Tax Credit program in Puerto Rico. Drug manufacturers receive 56 percent of the credits - about $3 billion a year - but only produce 18 percent of the jobs in Puerto Rico. Senator Pryor attacks the credit as the "mother of all tax credits".

Summer-Fall, 1992 - Health Care Refom becomes a central focus of the 1992 Presidential canmpaign. Candidate Clinton issues specific initiatives relating to prescription drug prices. For example, he says that Americans shoul pay no more for prescription drugs than citizens of other industrialized nations; that prescription drug inflation in the United States should not exceed the increase in the general inflation rate; and that Medicare should provide prescription drug coverage. Clinton visits Merck during the campaign, and commends them on their policy to increase their prices by no more than inflation.

November 1992 - Congress enacts the Veterans Health Care Act of 1992, which extends drug manufacturer discounts to other federal programs. Under the law, drug manufacturers are now required to give deep discounts on their products to VA, DOD, Public Health Service Clinics, and certain Disproportionate Share Hospitals. This legislation was enacted in response to certain drug manufacturers' price increases to VA and DOD subsequent to the enactment of the Medicaid rebate law.

Section II - The Clinton Years and Health Care Reform

February 1993 - President and Mrs. Clinton announce national childhood immunization initiative, and criticize the pricing policies of drug manufacturers. Industry says that these comments help to send drug and biotechnology stocks into a tailspin.

February 1993 - Senator Pryor hold hearing on the Federal Government's Investment in new drug research and development. The hearing seeks to determine whether drugs which are developed in whole or in part by the federal government, and then licensed to private drug manufacturers, are priced fairly.

February-May, 1993 - Pharmaceutical working group of President's Task Force on Health Care Reform meets to develop prescription drug proposals for potential inclusion in Health Security Act. Before formulating its recommendations, the working group meets with representatives from the brand name and generic industry, the biotech industry, pharmacy practitioner and trade associations, and other groups.

The group consists of eight individuals from a wide ideological spectrum. In order to reach consensus on certain issues, the segment of the group advocating stronger cost controls on drugs had to compromise to a weaker point. This occurred in spite of the fact that it was likely that the industry would oppose (and ultimately dilute) anything that was proposed.

In the long run, in order to diffuse criticism by the drug industry that the proposals in the President's plan would be too draconian on the industry, the group does not recommend any price controls on prescription drugs, opted for a "price review" for new drugs that are breakthroughs, used "rebates" and "Secretarial negotiations" to contain Medicare drug program costs, and attempted to moderate prescription drug prices in the retail sector by requiring drug manufacturers to offer discounts to all purchasers on equal terms (also known as "equal access to discounts").

August 1993 - Congress enacts the Omnibus Budget Reconciliation Act (OBRA) of 1993, which contains several provisions modifying the original Medicaid rebate provisions of OBRA 90, allowing state Medicaid programs to use formularies, and repealing the requirement that all new drugs be covered for a period of six months. Congress also reduces the value of the Section 936 tax credit in Puerto Rico, which largely affects drug manufacturers. As a result of the change, Section 936 companies will earn $3.7 billion less in tax credits in Puerto Rico over the 5 year period of the budget deal.

September 1993 - President Clinton announces health care reform plan, which contains several provisions relating to prescription drugs: a Medicare outpatient prescription drug benefit, an Advisory Council on Breakthrough Drugs, and a provision requiring drug manufacturers to provide equal access to discounts to all purchasers. President indicates that there will be no interim "cost controls" on health care products or services, including prescription drugs. In fact, in a Rose Garden appearance, President appears to back off of criticism of drug industry by saying that they need adequate resources for new drug R&D.

Drug manufacturers are concerned about provisions in the plan, but express willingness to work with Administration and Congress on providing prescription drug benefits to all Americans. Position of the Pharmaceutical Manufacturers Association at this point is that they support comprehensive health care reform, the inclusion of prescription drug benefits as part of the standard benefits package, and the use of market forces -- rather than cost controls -- as the mechanism to lower prescription drug prices. PMA supports movement of Medicare beneficiaries into managed care plans as the mechanism for this group to obtain outpatient prescription drugs, which, they are told, is not feasible.

At this point, PMA does not support a separate outpatient prescription drug benefit as included in the President's plan because of the cost management provisions in the bill (rebates, negotiations). PMA calls the Advisory Council on Breakthrough Drugs "price controls", calls the Medicare rebates in the plan "taxes" on the drug industry, refers to the Secretary's authority to negotiate and subsequently exclude certain new drugs from Medicare prescription drug coverage as "blacklisting", and refers to the provision requiring manufacturers to provide equal access to discounts to all pharmaceutical purchasers as "anti-competitive." PMA begins to meet with Congressional offices about their concerns.

Senator Pryor sends letter to Mrs. Clinton, expressing concerns that the prescription drug provisions in the Health Security Act do not go far enough in controlling the cost of prescription drugs. In particular, he is concerned that there are no interim prescription drug price increase restraints, and that the Advisory Council on Breakthrough Drugs has no real "authority" to control the prices of new, innovative prescription drugs. Concerns are expressed from House and Senate staff that too many concessions had already been made to the drug industry, and that staff had little room to negotiate with and had little leverage over the drug industry.

September 1993 - In response to manufacturers' "voluntary" initiatives to limit price increases to general inflation, Senator Pryor challenges drug manufacturers to sign a "meaningful" agreement with the Secretary of HHS to limit the annual price increase to the CPI-U for each prescription drug product distributed to the retail class of trade. Only one biotech manufacturer - Genentech - indicates interest. The other 49 manufacturers do not respond at all or decline.

Fall 1993 - Biotechnology industry lobbies heavily against the Advisory Council on Breakthrough Drugs, and Secretarial "blacklisting" authority, saying that it unfairly singles out biotech products, was the same as "price controls", and was making it very difficult for biotech firms to raise capital to keep their operations going. Eventually, Senator Kennedy drops the Council from the legislation that he reports out of Committee, and replaces it with a process to determine the cost effectiveness of pharmaceuticals relative to other health care services and treatments. (There are many biotech companies in Massachusetts). Key Committee Chairmen in the House (Rep. Dingell in particular because of Reps. Eschoo from San Diego and Rep. Margolies-Mezvinsky from Pa, where there are several large biotech and pharmaceutical companies) agree to remove the Advisory Council from any legislation that might move through their jurisdiction, and remove the Secretarial blacklisting authority from the Medicare program.

Spring 1994 - As it becomes evident that health care reform is becoming less likely, PMA changes position on a Medicare drug benefit, indicating that it supports a limited drug benefit, only for those Medicare beneficiaries that are not poor enough for Medicaid, but still have trouble paying their prescription drugs.

June 1994 - Senator Pryor introduces the "Pharmaceutical Marketplace Reform Act of 1994", which would have established several federal initiatives to help private payers and the federal government better manage prescription drug expenditures and improve the quality of pharmaceutical care for all individuals. The legislation was never considered by the Finance Committee or the full Senate.

Summer, 1994 - Democratic leaders of the Senate and House develop comprehensive health care bills to be considered by the full chambers. On the Senate side, Senator Mitchell includes a Medicare outpatient prescription drug benefit in his legislation that would give Medicare beneficiaries a choice of methods by which to obtain their prescription drug coverage. The Mitchell Medicare drug benefit closely follows the benefit proposed by Merck, under which most Medicare beneficiaries would receive their prescription drug benefits through Pharmacy Benefit Management Companies (PBMs), one of which Merck owns (Medco).

Congressman Gephardt includes an outpatient prescription drug benefit largely modelled after the proposed outpatient prescription drug benefit in the Health Security Act. Under pressure from the Massachusetts Congressional delegation, Gephardt announces that he will not require biotechnology drugs to pay rebates to Medicare under his outpatient prescription drug benefit.

Senator Pryor indicates his intention to offer an amendment to the Mitchell bill that would require drug manufacturers to offer equal access to discounts to all purchasers, a very important issues for the community pharmacists. (This provision was included in the Gephardt, but not the Mitchell bill.) Drug manufacturers mobilize to oppose the potential amendment. As it appears that health care reform will go down in this session of Congress, PMA changes position on Medicare prescription drug benefit once again, and opposes the addition of any Medicare outpatient prescription drug benefit, even one for the poorer elderly. PMA is, however, split on this position, with companies like Merck, Smith Kline, and Glaxo still supporting the addition of a Medicare prescription drug benefit.

By this time, the drug and biotech industry was very successful at lobbying the Congress and had won significant victories: the President decided not to include any interim cost controls on health care products and services; the Advisory Council on Breakthrough Drugs had been dropped in both the Senate and House bills; the blacklisting authority had been removed from the House bill; biotech manufacturers were excluded from rebates in the House bill; the Senate drug benefit was largely written by Merck, to benefit those manufacturers, such as Merck, Smith Kline, and Lilly, that had purchased Pharmacy Benefit Management (PBM) Companies; and, the equal access to discounts provision was included in the House, but not the Senate bill, and faced an uphill battle as an amendment in the Senate.

Fall, 1994 - Drug industry has successfully avoided any type of cost controls or additional federal government intervention in their business from health care reform. One by one, the drug and biotech industries "picked-off" issues during health care reform, was successful for the most part in defeating them, and then moved on to the next issue on their priority list.

The new issue for the drug industry is now "unitary pricing" or "equal access to discounts", which will continue to be a significant issue for the community pharmacy groups in the next Congress and in the state legislatures. This issue was initially a low-priority issue for the drug industry during health care reform, and has now become an important issue for them to oppose at the state and federal level.

120694/JMC

KEY SENATORS ON THE RECORD FOR UNIVERSAL COVERAGE AND THE EMPLOYER MANDATE

CONNECTICUT

Senator Joseph Lieberman:

- "I think we have to continue to stress to the public that universal coverage is... as good for those who are insured as for those who are not insured. That we want to have a system of universal coverage because it is one measure of how civil, how decent, and literally healthy a society we have. That it's not good that there are people who want health care and cannot afford it." [Remarks to the Democratic Leadership Council, 4/13/94]

- "...We have to broaden our vision of the paths to universal coverage. The discussion too often is frozen at incomplete polls... a lot of the parts of the plans which we tend to agree on are roads to universal coverage. On the political premise that the employer mandate -- to add to the political premise that I've stated that the employer mandate doesn't have enough votes as constructed now to pass -- I would also add a growing understanding that at some point we may need an employer mandate of some kind down the road." [Remarks to the Democratic Leadership Council, 4/13/94]

KANSAS

Senator Bob Dole:

- "I think everybody ought to be covered." [Remarks to the National Governors' Association, USA Today, 2/2/94]

- "We do believe in universal coverage. I think that's the consensus on both sides of the aisle. We're not certain how to get there, not certain how long it will take to get there, but at least we believe in that one basic principle." [Remarks to the Atlantic Information Services Corporation, 9/28/93]

- "Senator Chafee and others who worked long and hard -- we both want universal coverage -- I think that's one thing we have in mind." [CNN Moneyline, 9/16/93]

- "Well, first, our goal is universal coverage. I think that's the goal of everybody." [CNN Newsmaker Sunday, 8/29/93]

- "...we believe in the goal of universal coverage." [Face the Nation, 8/22/93]

Senator Nancy Kassebaum:

- "There is much in the President's proposal with which I disagree, but I share his fundamental goals of providing health security for all Americans and significantly reducing health care costs." [The Witchita Eagle, 9/23/93]

- "...I think it's important to understand why the uninsured should be covered and that universal coverage is important. We are in many ways paying for that coverage today. Twenty to thirty percent of the private insurance premiums is due to cost shifting, and so when you get patients who go into the emergency room who have no insurance, that's shifted off to someone else. That's why many of us believe it is important to have a more stable system, without federal micromanaging, which I think can be done. I think it's important to know why universal coverage is important..." [The MacNeil/Lehrer NewsHour, 10/27/93]

- "I think you have to have everybody in it together in order to get some of the savings that are important. I still believe that an individual mandate works best...That's something we can debate, whether it should be an employer mandate or an individual mandate." [The MacNeil/Lehrer NewsHour, 10/27/93]

MINNESOTA

Senator Dave Durenberger:

- "The consensus, as in most things, lives in the bill, and I hope that as soon as possible the folks that are in the middle can get their act together so that the folks on either side who may be waiting for them to fail can join them and join the President in guaranteeing that every American will never have to, in the future, go without the security of access to needed health care and medical services and long-term care service in this country." [Congressional Record, 2/7/94]

MISSOURI

Senator Kit Bond:

- "Fidgeting around the edges is not going to be enough. If you don't have universal coverage, I don't see how you can stop cost shifting." [Houston Chronicle, 3/5/94]

- "We have to get everybody covered if the system is going to work." [Remarks at the Boston Globe Health Care Summit, Boston Globe, 12/12/93]

- "[Successful health care reform] must be bipartisan, provide universal coverage so everyone can have personal health security, knowing they will be covered." [Remarks at the announcement of outline of GOP health care reform plan, St. Louis Post-Dispatch, 8/31/93]

Senator John Danforth:

- "I think that covering everyone is important...I think the general approach is make sure that there aren't people who are just hanging out there, people who change jobs and lose their insurance, that there is real security that's provided is something that most people would agree about." [Hearing of the House and Senate, 10/22/93]

- "'I am for universal coverage' in health care, Danforth said. 'That's a very good thing to do.'" [St. Louis Post-Dispatch, 1/16/92]

NEW JERSEY

Senator Bill Bradley:

- "Indeed, in the interview (Bradley) expressed some puzzlement at why requiring employers to pay the bulk of health care costs had become such an anathema. He also said he thought employers and workers must share the costs, and would not rule out forcing employers to pay for health care if such a measure managed by some miracle to make it to the Senate floor." [The New York Times, 6/27/94]

- One of the seven members of the moderate group, Senator Bill Bradley, Democrat of New Jersey, distanced himself from the proposal, saying, 'I regret this plan did not do more to achieve universal coverage through a shared responsibility by individuals and employers.'" [New York Times, 6/25/94]

- "It is my own personal conviction that all Americans should have a basic right to health care. Every major nation we're competing with assures that to every citizen and we a have very difficult case arguing leadership by example when we have so many people in this country without any health coverage at all." [Reuter Transcript Report, 9/24/92]

- "Now, the approach that I would suggest has several key elements. One is that it be employer-based health insurance, employer-based health insurance, which would enlarge the private sector's role in providing health insurance, not build a large public plan for the uninsured. The plan should require businesses to buy insurance for their employees from private providers not by having the government provide health care. Ninety-nine percent of businesses with more than 100 employees already provide health insurance. The federal

government would buy private insurance for those who are not working or are unable to afford insurance. This approach also would minimize disruption to those who already receive high-quality health care now, which is a very large majority of Americans...

We should not throw out the system of employer-based health insurance that provides that quality care for all Americans. So the first principle should be employer-based health insurance." [Reuter Transcript Report, 9/24/92]

OKLAHOMA

Senator David Boren:

- [Comments on the Chafee bill] "For example, Boren said he wants to leave the door open for the possibility of some kind of employer mandate, which Chafee and other Republicans oppose. 'I also think we need to move more quickly towards universal coverage than the Chafee bill allows," Boren said. [Tulsa World, 5/5/94]

- "While I believe in reform, including universal coverage and portable benefits, we must be very careful not to destroy the good parts of our system... " [Daily Oklahoman, 1/18/94]

RHODE ISLAND

Senator John Chafee:

- "It seemed to me there were three challenges we had. First of all, we wanted to cover everybody. And we are deeply concerned about that 15 percent of Americans, that's some 35- 37 million Americans, at any one time don't have health care coverage. And the added of all that is that some many of them are children. So that's the first challenge. We want to get everybody covered." [NPR, All Things Considered, 3/10/94]

- "I personally feel you have to go the route of universal coverage..." [Capitol Gang, 3/5/94]

- "Congress will pass comprehensive health reform that provides universal coverage." [New York Times, 1/3/94]

- One of the things I've been struggling with -- we have a bizarre situation in the United States now where the federal government will pay for people to be in hospitals, pay for people to be in nursing homes, but not pay for someone to come in and give a hand -- someone to help with respite care, just a hand... We're working our way toward that." [Remarks at New England Speaks: Our

Hopes for Health Care Reform, 10/8/93]

- "We've got to move forward with 100% coverage for everybody..." [Washington Post, 9/23/93]

- "Certainly we'll be talking with the administration because we all, we have the same three objectives: The objectives are to keep the quality of care in America; secondly, to see that everybody's covered; and thirdly, to do something about these incredible price increases." [Washington Times, 9/6/93]

TEXAS

Senator Phil Gramm:

- "I've always said that I'm all for universal coverage, if someone would just show me how to pay for it." [Dallas Morning News, 6/21/94]

PROVISIONS

Clinton's Health-Care Bill

President Clinton's health-care bill (S 1757; HR 3600), formally introduced Nov. 20, would change the roles of consumers, doctors, nurses, hospitals, governments, insurers and technologists. The bill is complex, but its goal is clear: to guarantee health-care coverage for all Americans while limiting costs. The bill's promise is that everyone would be covered from birth to death.

Most people would have controversial new financial obligations: Those who could afford to pay would subsidize those who could not. Funding would come from mandatory employer contributions, taxes, individual payments and cuts in Medicare, the government-funded health insurance program for the elderly, and in Medicaid, the program for the poor. Making this system work would require a new framework for the purchase and regulation of health insurance and delivery of health care.

The bill would create that new framework. It would require the federal government to determine health benefits, set the standards of care and reorganize the market. Once the system was in place, the government would be its watchdog and enforcer. Consumers would be organized into large purchasing blocs to bargain for lower prices from medical providers. Instead of buying health insurance through employers or on their own, consumers in a geographic area would become part of a large group known as a "health alliance."

The alliance would have the role currently played by insurance companies and employee benefits managers: negotiating with health-care providers for the best deals. Providers, instead of working individually, would be organized into "health plans" — groups of doctors, hospitals and other caregivers — who could offer the guaranteed package of benefits to consumers. The alliance would help members choose among plans by supplying them with consumer information. Consumers would pay insurance premiums to the alliance, which would funnel the money to the providers.

Key to Clinton's plan are checks and balances designed to protect consumers' rights and ensure that all players fulfill their responsibilities. For instance, health plans would be monitored by health alliances and by states. Providers would be monitored by health plans but protected — by alliances and states — if plans went bankrupt. Consumers could pursue claims against health plans and would have access to administrative review mechanisms coordinated by alliances and state agencies.

The following are highlights of the bill:

By Alissa J. Rubin with David S. Cloud, David Masci, Thomas H. Moore, Paul Nyhan, Elizabeth A. Palmer, Ryse J. Veron and Brad Wong

The New Framework (From Title I, II, V and VIII)

Universal coverage

Affordable health insurance would be available to all citizens, and everyone would be required to enroll in a health plan. Payments would vary according to means. Employers would pay about 80 percent of the average local cost of their employees' health plans; employees would pay the balance. The government would subsidize low-income individuals and families, as well as businesses with fewer than 75 employees. Premiums would be more expensive for families than for individuals.

The bill would:

- **Guaranteed coverage.** As of Jan. 1, 1998, guarantee health-care coverage to every American citizen, every legal national and every alien permanently residing in the United States, such as a refugee or a long-term non-immigrant, such as a diplomat.

The bill would not cover prisoners, undocumented aliens or Americans over 65 eligible for Medicare, the government's health insurance program for the elderly and disabled. It is not clear how the bill would treat illegal immigrants' children born in the United States, because children generally enter alliances through parents.

- **Individual mandate.** Require that all eligible people enroll in a health plan and pay their share of insurance premiums.
- **Exceptions to the individual mandate.** Provide exceptions for military personnel, veterans and American Indians. Members of the armed forces could select a Defense Department plan. Veterans and their families could enroll in a veterans plan. Indians could enroll in the Indian Health Service plan.
- **Disenrollment.** Prohibit people from being forced out of any plan unless they enrolled in another plan or became eligible for Medicare. Even if people defaulted on premiums, no provider could refuse to treat them, nor could they be dropped from an alliance.
- **Purchasing insurance outside the system.** Allow people to purchase supplemental insurance for services not covered in the guaranteed benefits package. Those not eligible for coverage could purchase insurance in the private market. Employers could offer additional insurance.

Benefits

Only the Clinton plan and one other plan (the single-payer Canadian-style proposal) spell out which medical services would be covered. The Clinton benefits package is generally as generous as those currently offered by most large companies.

All health plans would have to offer comprehensive benefits including mental health care, preventive dental care for children and some long-term care. Plans could not charge extra for particular benefits nor could they limit the use of benefits. However, some benefits would be covered fully only with the consent of the plan, meaning that the plan could limit or delay access to that benefit.

The following benefits would be covered:

- **Hospital services.** Unlimited inpatient, outpatient and 24-hour emergency services.
- **Health professionals.** The services of doctors, nurses and other licensed providers.
- **Emergency services.** Emergency and ambulatory medical and surgical services provided by a health facility that is not a hospital — such as a community-based clinic.
- **Clinical services.** Preventive services including all immunizations, AIDS tests and clinician visits, Pap smears and pelvic exams. Annual screenings for women at risk of having venereal diseases. Individuals over 20 would receive booster immunizations and cholesterol screening every five years. Women over 50 would receive mammograms every two years. Women over 65 would receive

flu and pneumonia shots.

• **Mental illness and substance abuse services.** Clinton's goal is to cover mental illness as comprehensively as physical illness. But treatment would be limited for the first four years. Patients would be referred by their health plan for treatment. Outpatient therapy would be limited to 30 visits or 120 visits if the therapy would enable the patient to avoid hospitalization. Inpatient treatment would be limited to 30 days, with another 30 days if necessary.

• **Family planning.** Voluntary family planning services, contraceptive devices dispensed by prescription — such as diaphragms, birth control pills and Norplant — and pregnancy services. Abortion is not mentioned specifically in the bill, but administration officials have testified that they expect it to be covered under the benefits package.

• **Home health care.** Medically necessary, skilled services delivered at home, including nursing and physical therapy services and necessary supplies such as equipment to administer intravenous drugs and food.

• **Extended care.** Medically necessary services given in a nursing home environment. Includes skilled services such as nursing and physical therapy needed to recover from an acute illness or avoid hospitalization. Limited to 100 days annually.

• **Medical devices.** Durable medical equipment and prosthetic and orthotic devices such as braces for legs, arms, back and neck; artificial limbs, pacemakers, ventilators and colostomy bags.

• **Dental care.** Cover people under 18 for preventive care, and children 3 to 13 for some orthodontic procedures. Adults would receive emergency dental care only. After 2001, dental care — including checkups, routine cavity fillings and root canal work — would be fully covered for children and adults.

• **Vision care.** Routine eye exams, diagnosis of eye diseases and treatment of defects in vision, such as cataracts.

• **Investigational treatments.** These treatments are primarily for people with terminal diseases, such as AIDS and cancer. They consist of therapies whose effectiveness has not been determined. Coverage would include treatment and other routine care.

• **Other types of care.** Hospice care; ambulance services; extended care limited annually to 100 days in a nursing home or rehabilitation center; outpatient laboratory, radiology and diagnostic services; outpatient prescription drugs and biologicals; outpatient rehabilitation services, including occupational therapy, physical therapy and speech pathology.

• **Optional coverage.** Health education classes, including courses on how to stop smoking, nutrition counseling, stress management, support groups and physical training classes.

• **Not covered.** Services that are not medically necessary or appropriate, such as elective cosmetic surgery, would not be covered. Other items that would not be covered include: custodial care — meaning long-term care for non-medical needs such as companionship — hearing aids, eyeglasses and contact lenses for adults, in vitro fertilization, sex change operations and related services, private duty nursing, or comfort items (such as a television or a telephone in a hospital room).

Long-term care

No one would be guaranteed coverage for long-term care. However, the bill would create a federal entitlement program for states to pay for home health-care services for eligible individuals. The program would be financed predominantly by the federal government; states would pay a 5 percent to 22 percent match. The administration views this as a down payment toward full-fledged long-term care coverage. Eligibility would not be based on income but would depend on whether an individual met the federal criteria of needing help with at least three activities of daily living, such as eating, going to the bathroom and getting dressed. Nursing home care would not be covered, but the grants would cover an extensive list of home health-care services and adult day care.

Beneficiaries would be charged sliding fees of up to 25 percent of the cost of care if they had an annual incomes that exceeded 250 percent of the federal poverty level, which is now $7,360 for a single person and $14,800 for a family of four. People at or below the poverty line would owe nothing. The administration expects that about 70 percent of beneficiaries would be elderly.

Cost sharing

Clinton's plan would standardize the prices consumers pay for their health care, limiting health insurance premiums to 3.9 percent of their income. Most consumers would choose among three payment formulas. The low-cost plan would most likely provide care through a health maintenance organization with a limited choice of doctors. The midprice plan would offer care through a loose network of doctors with an option for consumers to go outside the network, similar to a preferred provider organization. The high-cost plan would allow consumers to choose their own doctors. Costs would vary by region and by family status, meaning whether a person subscribed as an individual, a couple, a single parent with children or a couple with children. Complex formulas would determine exact payment rates. The amount, however, that each American would pay would be pegged to employment status.

The bill would:

• **Low-cost plan.** Offer a low-cost plan with no deductible (no minimum payment before coverage starts), a $10 co-payment for outpatient services (such as doctor visits), $25 for hospital emergency room care and outpatient psychotherapy, and $5 for prescriptions. All low-cost plans also would allow subscribers to use providers outside the network — for a higher premium.

• **High-cost plan.** Offer a more expensive cost-sharing plan with a $200 deductible ($400 for a family) and a $250 deductible for prescription drugs. Enrollees would pay 20 percent of the cost of doctor visits, 50 percent for psychotherapy and 40 percent for dental services.

• **Combination plan.** Offer a combination plan in which enrollees would pay a nominal co-payment when using network providers. But when they used providers outside the network, they would pay the same deductible and other payments as under the high-cost plan.

• **Spending limits.** The plan would limit out-of-pocket spending to $1,500 for an individual plan and $3,000 for a family plan. Co-payments and co-insurance for medical services and prescriptions would count toward an individual's annual limit. But neither the premium nor the deductibles would count.

Employer and employee responsibilities

Employers would be responsible for about 80 percent of the costs of the average health insurance plan in their area for employees. Employers who already pay for employee health benefits would likely pay less than they pay now because other employers would shoulder some of the burden. Premium prices paid by employers and employees in the regional health alliances would reflect several costs, including premiums for those who default on alliance payments, alliance administrative costs, premiums for non-working family members, graduate medical education and federal subsidies for the so-called teaching hospitals, where doctors do their training.

The plan would divide employers into three categories: small, defined as those with fewer than 75 employees; large, defined as those with more than 5,000 employees; and all others. Taxes, subsidies and other financial responsibilities would vary widely among these groups. Self-employed people would be treated as small businesses and would be eligible for the same subsidies on the employer share (80 perecent) of the premium as other small businesses.

Employees would be responsible for about 20 percent of the cost. However, the portion of the premium paid by employees would vary depending on employment status (full time, part time, self-employed or retired), income and family status — single, married or married with children.

The bill would:

• **Employer payments.** Require employers to pay 80 percent of the area's average insurance premium cost for full-time employees and a pro-rata amount for part-time workers.

• **Additional benefits.** Allow employers to supplement employee health benefits by paying more than 80 percent of the average premium or by providing coverage for services not covered under the uniform benefits package. Supplemental benefits would be exempt from taxation until 2003. It is expected that most employers operating unionized workplaces would continue to cover any benefits that they now cover regardless of whether they were in the standard benefits package.

• **Caps.** Cap the premiums of employers with fewer than 5,000 workers who are in regional alliances at 7.9 percent of payroll. Premiums for employers of more than 5,000 who opt to join regional alliances would not be capped for the first five years that the plan was in effect, from 1998-2002. There would be no cap on employers of more than 5,000 in a corporate alliance. *(Corporate alliances, p. 496)*

• **Large companies.** Allow certain large employers to form their own alliances, to be known as corporate alliances. Such employers would include those with more than 5,000 workers, large union self-insurance plans, rural electric and telephone cooperatives and the Postal Service. Corporate alliances would contract with health plans themselves instead of going through regional alliances. This would allow large multistate corporations to avoid keeping track of different regional alliance systems. They would have to follow the same rules as alliance plans. Alternatively, large firms and unions could opt to join the regional alliance.

• **Mandatory participation.** Require firms with fewer than 5,000 workers to join regional health alliances.

• **Small-business subsidies.** Offer subsidies to firms with fewer than 75 workers if average annual wages were below $24,000. Such firms would have to spend 3.5 percent to 7.9 percent of their payroll on health insurance. The bill contains no adjustment to reflect the effect of inflation on wage levels over time, so fewer and fewer employers would qualify for the subsidies over time. Despite the cap, employers would have to pay a charge known as the "employer collection shortfall add-on" to help alliances cover premiums owed but not collected. No one knows how much this might be.

• **Offsets.** Require all employers to pay an additional charge to offset amounts owed to alliances but not collected. This would be known as the "employer collection shortfall add-on."

• **Cafeteria plans**. End the tax deductibility of health benefits currently offered through company-sponsored "cafeteria" plans, in which employees choose from a list of covered benefits. Both employers and employees enjoy tax benefits from cafeteria plans because the money spent on the plans is deducted before federal and state taxes are levied. Thus a tax such as FICA (the 15 percent Social Security tax), jointly paid by employers and employees, would be levied after reducing total wages by the amount the employee spent on the benefits. Federal agencies have different estimates of how much money the government does not get annually in tax revenues as a result of deductions through cafeteria plans. The General Accounting Office estimates $3.1 billion; the Congressional Budget Office estimates that the amount will rise from $1 billion in 1997 to $4 billion in 2000. The administration has even higher estimates.

• **Flexible spending accounts**. Eliminate the option of paying for health care with flexible spending accounts. Such accounts are similar to cafeteria plans. They must be set up by employers and allow employees to use pre-tax dollars to pay for health care. They reduce the taxable income of both employers and employees.

• **Employee premiums.** Require full-time workers to pay about 20 percent of the average premium in their area. ("Full time" includes anyone who works more than 30 hours a week.) Employees who enroll in a plan with a premium above the average would pay the difference between the employer's share and the premium. Employees could enroll as individuals, as a couple or as a single parent or couple with children.

• **Part-time workers.** Require part-time workers to pay both the 20 percent (individual) share of the premium and the portion of the employer share that the employer does not pay. For instance, someone who works 60 hours a month would be responsible for half the employers' share of the premium; the employer would pay the other half. However, anyone who earns less than 250 percent of the federal poverty income would be eligible for subsidies on the employer share. It is expected that many part-time workers' insurance policies would be subsidized. Part-time employees are those who work 10 to 30 hours a week.

• **Early retiree plans.** People ages 55 through 64 who retire would pay no more than 20 percent of the cost of health insurance. If they worked for a company currently providing health insurance, the government would pick up the employer's share (80 percent) and the company would pay 20 percent. If the retiree had no coverage, the government would pay 80 percent and the retiree would pay 20 percent and would be eligible for subsidies. To avoid giving a windfall to companies with early retiree programs, the government would recapture some of the savings those companies would realize by imposing an assessment on them from 1998 through 2000 that would be equal to about half their 1993 retiree health costs.

• **Wealthy early retirees.** Require early retirees who earn more than $90,000 as individuals or $115,000 as couples to pay 80 percent of the premium; their former employers would pay 20 percent.

National Health Board

A new federal entity, known as the National Health Board, would oversee the new system, setting quality standards and reviewing the benefits packages. It would act as a clearinghouse for information about the new system's problems and would approve state plans. Without National Health Board approval, no state could receive federal subsidies.

The bill would:

• **National Health Board.** Require the president to appoint the seven-member board with the advice and consent of the Senate to serve overlapping terms lasting four years each, except in the initial years. Board members would be selected on the basis of their experience in relevant subjects, including medicine, nursing, health-care financing and delivery, state health systems and consumer protection and delivery of care to vulnerable populations. However, no member of the board could have a financial interest or any official relationship with any health-care plan, health-care provider, insurance company, pharmaceutical company, medical equipment company or other affected industry. The board would have a staff of more than 200 employees. All states would submit their plans to the national board for approval. The board would make recommendations to Congress on changes in the new system.

• **Risk adjustment.** Require the board to design a financial system to do risk adjustment — the accounting method used to determine how much each health plan must be paid, based on patients' health status. Risk adjustment is a poorly understood science, and in the early years of the plan it would be difficult to determine how much to adjust premiums.

• **Assessment.** Require the board to design a method of measuring and interpreting the quality of care received by consumers from health-care plans nationwide. The system would be used by health alliances nationwide.

• **Grievances.** Require the board to design a health plan grievance procedure.

• **Benefits.** Require the board to decide which of the benefits scheduled for expansion in 2001 and 2002 could be expanded and to what extent they should be dropped or made optional.

• **Data collection.** Require the board to set up a vast health-care data collection system so that the federal government could measure how the new system was working and its cost-effectiveness. The presentation of data would have to be as uniform as possible. The board's standards would pre-empt any existing state laws on data collection.

Other federal responsibilities

The Department of Health and Human Services and the Department of Labor would oversee the new system jointly. Health and Human Services would oversee alliance enrollment policies, premium and cost-sharing discounts and the alliances' overall

financial management. The health department would set up a board, called the Advisory Council on Breakthrough Drugs, to review new drug prices. It would publish information about the reasonableness of prices and the cost-effectiveness of new products compared with existing treatments. The Labor Department would enforce the sections of the bill that deal with employer premium payments and the creation and operation of corporate alliances. The department also would set up an insolvency fund. If a corporate alliance failed financially, the fund would be able to pay providers and ensure that enrollees continued to have care. The fund would be paid for with an assessment on corporate plans not exceeding 2 percent of their premiums.

The bill also would establish a National Quality Management Council charged with developing national performance measures to be used to assess every health plan in the country and its provision of health-care services and consumers' access to those services. In consultation with states, health plans and others, the council would collect data and disseminate information in the following areas: access to health services by consumers, appropriateness of health-care services, outcomes of health-care services, prevention of disease, consumer satisfaction and health promotion. The council would take periodic surveys of consumers to get information on health care. All health alliances would have to publish clear information for consumers on how local health-care plans were doing in terms of the national quality measures.

State Role

States would have new powers and responsibilities, including the power to choose between a single payer, Canadian-style system or a managed-competition system. Once a state chose a system, state flexibility would be limited by federal rules and standards designed to ensure that despite state differences, residents would have comparable choices.

States would have an ambiguous role: They would be responsible for making the new system work but would have little latitude to adjust the system's design. States would monitor the local health-care industry, enforce new laws and continue to finance health-care services for poor Americans. However, several state laws would be pre-empted.

The bill would:

- **Setting up the new system.** Require states to submit a proposal to the National Health Board explaining how they would comply with the national system to give all eligible residents access to a choice of health plans. Each state would first decide whether to set up alliances, a single-payer system (in which the state is, effectively, the only health alliance) or an all-payer system (in which all payers — government and private insurers — pay the same amount for the same service). It would designate an agency to oversee the program. Each state would decide whether to allow its legislature to draft its plan or implement it by gubernatorial fiat. Federal matching grants totaling $50 million would be available to help states plan their systems. Federal matching grants would also be available to help states implement their plans. The bill would authorize $313 million in fiscal 1996, $625 million in fiscal 1997 and $313 million in fiscal 1998.

- **Timetable.** Require all states to join the national system by Jan. 1, 1998. If a state did not have a plan by 1998, the federal government would step in to ensure that the nationally guaranteed benefits package was available to all state residents. If a state's certification were taken away or if the government had to run the state's system, the federal government would charge as much as an additional 15 percent on premiums to cover the administrative costs.

- **Setting up alliances.** Require a state that elected to set up an alliance system to incorporate one or more regional alliances within its borders. The alliances' geographic boundaries could not overlap. They would have to be drawn so as not to discriminate by age, race, language, religion, national origin, socioeconomic status or disability. The number of alliances in a state would depend on its population. Most alliances would have at least 1 million enrollees.

No portion of a state could be outside an alliance. However, neighboring states could coordinate their alliance boundaries and collaborate on contracting with health plans and setting fees for providers within their respective alliances. The collaboration might be helpful when, for instance, metropolitan statistical areas are located on state lines such as in Kansas City, Cincinnati, New York, Philadelphia and St. Louis.

- **Certification of health plans.** Establish standards for certifying health plans, which would include criteria for assuring that plans are financially solvent (plans would have to have capital funds of at least $500,000) and staffed well enough to offer the benefits package. The alliance would have to accept all health plans that met state criteria. It could refuse to accept a plan only if its premium rates exceeded by 20 percent the average rate set by the alliance. *(Health plans, p. 496)*

- **Alliance support in income evaluation.** Require states to aid health alliances in determining whether a person qualified for subsidies under the Clinton plan. In addition, states could offer financial incentives to people who live far from medical care or do not speak English.

- **Guarantee fund.** Establish a guarantee fund that could pay providers if a plan failed. A state could assess up to 2 percent of premiums on other plans within the alliance to generate revenues to cover outstanding claims against a failed plan.

- **Alliance assistance in enrollment.** Require states to help alliances enroll all eligible citizens. States could supply financial incentives if necessary to ensure that alliances enrolled the disadvantaged.

- **Subsidy programs.** Require states to administer subsidy programs for low-income residents and ensure that Medicaid beneficiaries have access to the same benefits they now have. Under Medicaid, ancillary services such as translation and transportation to health-care providers are covered. These services would not be covered in the national standard benefits package.

- **Quality control.** Require states to monitor the quality of the health-care services provided by the plans and ensure that the plans are providing the benefits package.

- **Cost containment.** Permit states to assume responsibility for health-care cost containment.

- **State pre-emption.** Pre-empt certain state laws. *(Antitrust provisions, p. 500)*

Health Alliances

Set up by the states, the alliances would be quasi-governmental entities that would coordinate the health-care system for consumers in a region, replacing the current role of insurance companies and employee benefits managers. A regional alliance could be set up as a private nonprofit corporation or as a state agency. Generally, a regional alliance's enrollees would primarily be full-time and part-time employees of businesses of fewer than 5,000 workers, the self-employed, and both the working and non-working poor, whose health care would be subsidized by the government. The alliance would be the fiscal heart of the new system, in many states handling hundreds of millions of dollars annually.

All states would permit "corporate alliances" — health-care buying groups set up either by companies with more than 5,000 employees, by unions or by the Rural Electric and Rural Telephone Cooperatives. The rationale would be to allow large multistate employers to avoid having to keep track of many different states' health insurance laws.

The bill would:

- **Alliance governance.** Require alliances to have a board of directors consisting of an equal number of employers and consumers. No health-care provider, employee of a pharmaceutical company or medical supplier, insurer or insurer's representative could sit on the board. However, the alliance would have to have a provider advisory board consisting of providers such as doctors or representatives of local hospitals or clinics.

- **Alliance enrollment.** Require alliances to enroll all eligible members of the area and allow family members to enroll in the same plan. Alliances would set up a system to ensure that new alliance

residents enrolled in a plan.

• **Switching plans.** Allow alliance members an annual open enrollment season when they could switch plans.

• **Health security cards.** Require the alliance to issue health security cards to all alliance members. Each card — likely to resemble the kind used in automated teller machines — would have information about the identity of the cardholder, the health plan in which the individual is enrolled and supplemental policies that the individual maintains. The bill would give the National Health Board leeway to decide how much health-care information could be encoded into a health card. The card could be used only to help an individual obtain health-care services.

• **Contracting with health plans.** Require the alliances to contract with eligible health plans to provide the standard benefits package to all alliance members. No plan could be turned down unless its premium was more than 20 percent above the per capita premium target set by the federal government or it had a history of failing to adequately provide services. One of the health plans would have to be a "fee for service" plan unless alliance members expressed too little interest in subscribing to one. (The fee-for-service option would allow enrollees to choose their own doctors but likely would require higher out-of-pocket payments.)

• **Limits on plan enrollment.** Allow alliances to stop oversubscription in health plans. If a plan was filled, the alliance could ask enrollees to select another plan.

• **Setting fee schedules.** Require alliances to negotiate a fee schedule for providers who participate in the fee-for-service plan unless the state negotiated a fee schedule for all fee-for-service plans in the state.

• **Consumer information.** Require alliances to supply information to consumers about the plans offered through the alliance, including comparative data on price, the availability of health professionals, any limits on access to providers and services, and a summary of each plan's rating according to federally set quality standards whose measures would include outcomes of treatment and surgical procedures and access to services.

• **Review of plans' advertising.** Require alliances to approve all plans' marketing materials and ensure that they meet federal guidelines.

• **Ombudsman.** Require alliances to set up an office of ombudsman to handle complaints from alliance members.

• **Plans to serve disadvantaged, inner-city or rural areas.** Allow alliances to create a health plan to serve disadvantaged or remote areas and to arrange favorable financing to encourage the formation of such a plan.

• **Premium collection.** Require alliances to collect premium payments from individuals and employers and subsidy payments from the state and federal governments to help low-income workers, non-workers and small businesses.

• **Premium calculation.** Require alliances to calculate the amount that workers and employers would have to pay based on the price of each plan, the amount needed to contribute to academic medical centers whose services would be available to all Americans, the amount needed to subsidize the needy and the amount needed for staffing.

• **Risk adjustment and health plan payment.** Require alliances to pay health plans after making risk adjustments reflecting the number of people enrolled in a plan and their health status.

• **Alliance administrative costs.** Allow alliances to charge up to 2.5 percent of the total premiums to finance the cost of staff and services.

• **Corporate alliances.** To ensure the solvency of corporate alliances, require the federal government to set up a guarantee fund, financed by an assessment of no more than 2 percent of the premium payments for each plan offered through an alliance. Corporate alliances would also have to pay an additional assessment to help fund academic medical centers.

• **Revisions in the Employee Retirement Income Security Act (ERISA.)** Revise the 1974 ERISA law, which pre-empts state law and regulates worker benefits — including benefits from self-insured health plans sponsored by multi-state companies. The revision would require companies of more than 5,000 workers that want to operate self-insured plans to form "corporate alliances." These alliances would have to ensure that the comprehensive benefits package is available to their employees. Companies would have to offer employees a choice of at least three health plans. Companies forming corporate alliances would continue to have the right to avoid state regulation under ERISA — so that they could avoid dealing with different states' health-care systems. The Department of Labor would oversee compliance of corporate alliances with the law. Corporate alliances may be able to purchase insurance based on the health status of their employees — thus avoiding community rating, which bases premium prices on the health status of the insured population in an area. If the corporate alliance's workers were young and healthy, this would be an economic advantage.

• **Single-payer states and ERISA.** Allow states that adopt a single-payer health insurance system to apply to the Department of Health and Human Services for permission to require corporate alliances to become part of the state health-care system. In other words, the ERISA pre-emption of state law would not necessarily apply in single-payer states.

Health Plans

The Clinton plan would spur dramatic changes in the current health-care marketplace. Currently, most people who have insurance select a doctor, who then can recommend specialists and hospitals; patients send the bill to their insurer, who generally pays at least half the cost.

Under the Clinton bill, most consumers would select a health plan rather than an individual doctor. The plan would be required to offer a package of guaranteed benefits. To do that, a plan would provide subscribers with access to a group of doctors (primary care physicians and specialists), hospitals, non-physician care providers such as physical therapists and outpatient clinics that offered services such as mental health treatment. Several plans probably would organize as health maintenance organizations (HMOs) or similar networks. Plans could be organized by health-care providers or by an insurance company.

Plans could not turn down any subscriber for any reason, nor could they force anyone to pay a surcharge because of an illness or disability.

The bill would:

• **Benefits.** Require all health plans to offer the comprehensive benefits package.

• **Exclusions.** Require plans to accept every applicant. Plans could not target their marketing to attract or exclude anyone on the basis of personal characteristics such as age, race, occupation or health status. The only permissible limit on enrollment would be if a plan had more subscribers than its staff and resources could handle.

• **Discrimination against providers.** Prohibit plans from engaging in any form of discrimination against a provider on the basis of sex, age, language, race, national origin, disability, socioeconomic status or the health status of the provider's current patients. The goal is to ensure that a doctor who treats AIDS patients could join a plan even though the patients might drive up the plan's costs.

• **Unintentional discrimination.** Allow a plan or plan director to take an action that results in a discriminatory practice if the action is the result of a business judgment and not intentional discrimination. This provision appears to contradict the anti-discrimination and exclusion provisions. The reason is not clear.

• **Permanent coverage.** Prohibit plans from terminating, restricting or limiting coverage for any reason, including non-payment of premiums.

• **Doctor choice.** Require all plans to offer the option of using doctors outside the group, although plans could charge more for that option. This would allow subscribers to choose their own

specialists at the same time they went to a primary care doctor within the group.

• **Grievance procedures.** Require plans to set up a grievance procedure for consumers. Consumers also would be able to lodge grievances with their regional alliances.

• **Community rating.** Prohibit plans from charging subscribers higher rates because they have illnesses or disabilities. The only variation in charges permitted would be to reflect differences in family status (single, couple, one-parent family, two-parent family). No providers could charge amounts in excess of the fee schedule negotiated with the health alliance.

• **Supplemental insurance.** Require plans to offer a supplemental insurance policy to cover deductibles and co-insurance — but not co-payments.

• **Additional benefits and services.** Allow health plans to offer additional insurance for benefits that are not covered in the basic package or for which coverage is limited (such as mental illness or dental care). The bill would set standards and regulations for the sale of supplemental policies.

• **Workers' compensation and auto insurance.** Require health plans to supply the medical services offered as part of workers' compensation and auto insurance plans at the rate paid for fee-for-service providers.

• **Community providers of medical services.** Require plans to contract with "essential community providers" to offer health care to people who are difficult to reach. Alternatively, plans would have to pay community providers on a fee-for-service basis for each visit by an enrollee.

Community providers include migrant health centers, community health centers, homeless program providers, family planning clinics, AIDS providers under the Ryan White Act and rural health clinics. Also included are private and nonprofit hospitals that care for underserved populations.

• **Pre-emption of existing state laws.** Overturn state laws that inhibit the formation of HMOs. These include state laws that prohibit plans from limiting the number and type of providers; requiring enrollees to obtain care from participating providers; requiring enrollees to obtain referrals for specialty treatment; establishing different payment rates for network and non-network providers; creating incentives for the use of participating providers; and using one source for pharmacy services, medical equipment and other supplies. The goal is to remove any legal barriers to the formation of HMOs. The bill also would overturn state restrictions on the independent practice of non-doctor health professionals (such as nurse practitioners) and allow them to perform any duties for which they are trained.

• **Abortion waiver.** Permit doctors, nurses or other health professionals to decline to perform any service if they objected to doing so on the basis of a religious belief or moral conviction.

• **Truth in advertising.** Prohibit false or misleading information in health plans' marketing materials and require plans to submit advertising material to the regional alliance for approval before distribution.

• **Selective advertising.** Prohibit plans from targeting advertising campaigns at selected groups or areas. All advertising would have to circulate across the alliance area.

• **Marketing information.** Require plans to provide all eligible enrollees with information about plan cost, participating providers, cost control procedures that doctors would be required to follow, quality management programs, rights and responsibilities, and information on the rate at which people dropped out of the plan.

• **Quality standards.** Require all plans to measure and disclose their performance rating, which would be based on criteria set by states, regional alliances, corporate alliances and the National Quality Management Council. The council would develop performance measures for assessing health services and access. The council's measures would have to provide information about access to health services, appropriateness, outcomes, prevention of disease and consumer satisfaction.

Physician Training and Public Health (Title III)

Doctor Training

The Clinton health-care system would require a transformation in the culture of the medical profession. Instead of rewarding medical specialists, the new system would reward physicians who practice preventive medicine and primary care. The bill aims to force hospitals that train doctors to reverse the current 70-30 ratio of specialists to primary care doctors. By 2000, the bill would require that the percentage of doctors completing their residencies be 45 percent specialists and 55 percent primary care physicians. Hospitals that did not comply would be prohibited from participating in regional alliances. The administration aims to encourage doctors to enter primary care areas by providing financial incentives. However, the bill would finance such doctor-training subsidies through appropriations, which means they would compete for dollars with existing programs.

The bill would ensure that sophisticated medical centers received a steady flow of financial support, but it would reduce funding. To rationalize giving public funds to academic centers, the bill aims to ensure that all citizens would have access to academic center resources. But it is unclear how that would work: Under the bill, many Americans likely would be in managed-care health plans, such as HMOs, which generally restrict the use of the kind of sophisticated care offered by academic centers.

The bill would:

• **National council of graduate medical education.** Create a national council to oversee the transition of the medical profession from specialty practice to primary care. The council would designate the number of people who could enroll in each specialty annually, starting in the 1998-99 academic year. It would recommend to each residency program how many places to reserve for each specialty. In recommending slots, the council could consider the underrepresentation of minorities in the field of medicine generally and in the specialties.

• **Primary care.** Require that by 1998, at least 55 percent of all graduate medical students (students out of medical school who are entering hospital residency programs) train in the field of primary health care. Primary care includes internal medicine, family medicine, pediatrics, and obstetrics and gynecology. Individual programs could have a different ratio because the bill requires 55 percent only in the aggregate — not program by program.

• **Physician training.** Create a health profession work force account that would partially pay the cost of training doctors in residency programs. This fund would replace the direct medical education account that currently funds medical education. Hospitals with residency programs would have to apply for grants from the fund. The fund would be fed by three sources: the premiums charged by health alliances, a 1 percent tax on corporate alliance premiums and a transfer from the Medicare program's trust fund. Set up as an automatic payment, it would not require an annual appropriation. It would pay out $3.2 billion in 1996, $3.6 billion in 1997, $4.8 billion in 1998 and $5.8 billion in 1999. It is not clear whether this would funnel more money into physician training.

• **Nurse training.** Create a graduate nurse training program parallel to the physician training program. It would be coordinated by a similar advisory council and would allocate slots for nurse practitioners, nurse midwives, nurse anesthetists and other clinical nursing specialties. It would be funded starting in 1996 at $200 million annually.

• **Academic health centers.** Entitle academic health centers — meaning hospitals affiliated with medical schools or other training institutions — to apply for payments to help cover costs associated with their specialized research and care. Teaching hospitals generally incur higher costs than do other institutions for two reasons: Residents tend to order more tests than do experienced physicians, and severely ill patients who need the most care are often referred to academic centers. These payments would replace Medicare's

indirect medical education payment, which currently helps teaching hospitals pay for costs associated with residency programs and highly specialized care. The entitlement would be $3.1 billion in the 1996 calendar year, rising gradually to $3.8 billion in 2000. The funds would come from the Medicare trust fund, a tax on corporate alliances and payments to regional health alliances.

• **Access of patients to academic health centers.** Require regional and corporate alliances to ensure that health plans contract with centers so that consumers could be referred to them when they had conditions needing specialized treatment.

• **Research on health reform, health promotion and disease prevention.** Authorize appropriations of $150 million in fiscal 1995 and $500 million in each fiscal year from 1996 through 2000 for research on health reform by an arm of the Department of Health and Human Services (HHS). The bill would also authorize $400 million in fiscal 1995 and $500 million annually for each fiscal year from 1996 through 2000 for the National Institutes of Health for behavioral research on promoting health and preventing disease.

• **Additional primary care training.** Authorize an additional $400 million annually for HHS to further encourage training or retraining in primary care for midcareer physicians and physician assistants. It would also fund programs to increase the number of minority doctors and to support midlevel nursing training and some nursing specialties.

• **Health-care work force retraining.** Authorize $200 million a year for the Department of Labor to create retraining programs for health-care workers to help them adjust to changes in the work force under the bill.

• **National institute for health-care work force development.** Create a national institute, jointly under the secretaries of Labor and HHS, to make recommendations regarding the supply of health-care workers needed to staff the new system and the impact of the bill on health care, health-care workers and their training.

Public Health

The bill would redesign funding of the public health-care system to create a block grant program for states. The grants could be used for collecting health data, environmental protection (such as lead hazard abatement), violence reduction programs and public education about the hazards of tobacco, drugs and behavior that increases the risk of AIDS. States already engaged in those activities would be required to maintain the same level of funding that they had in the year before the first year in which they received a grant. The total authorized for grants would be $325 million in fiscal 1996, $450 million in fiscal 1997 and up to $750 million in 2000.

A separate program would allow the secretary of Health and Human Services to authorize grants to encourage the prevention of disease. The grants would be available to state and local government agencies, private nonprofit organizations and group coalitions to create community programs on health promotion and disease prevention. The bill would authorize $175 million in fiscal 1996 and $200 million from fiscal 1997 through 2000.

Health Services for Medically Underserved Populations

Because rural areas and inner cities often lack medical services, it will be difficult to ensure that people in those areas get care, even if they have guaranteed coverage. To help ensure that services are available, the bill would augment funds to train providers to work in such communities and create loan and grant programs to enable community health centers to set up networks and expand programs.

The bill would:

• **Migrant and community health centers.** Authorize an additional $100 million for migrant and community health centers for fiscal years 1995 through 2000. In fiscal 1994, migrant health centers received $59 million, and community health centers received $604 million.

• **Community health plans and networks.** Authorize grants to help providers form health plans and networks to serve individuals in areas where there is a shortage of doctors, nurses and medical facilities. Loans also would be available to public and private entities for the capital costs of developing qualified community health plans. The plans would have to eliminate local barriers to care. For example, if clients did not speak English, the plans would need staff translators. Grants would be authorized at $200 million in fiscal 1995, $500 million in fiscal 1996, $600 million in 1997 and $700 million in 1998. Then funding would drop, on the assumption that plans had been formed, to $500 million in 1999 and $200 million in 2000.

• **Enabling services.** Authorize the HHS secretary to make grants to community health groups to provide services to help poor people obtain health care. Such services would include transportation to and from clinics, translation, community and patient outreach, and patient education.

• **National Health Service Corps.** Authorize additional funds for the corps. The program would pay — through grants and loans — to educate doctors and other health professionals in exchange for their promise to practice in underserved rural or urban areas or on Indian reservations. Beyond existing appropriations ($127 million in fiscal 1994), the bill would authorize $50 million in fiscal 1995, $100 million in fiscal 1996 and $200 million from 1997 through 2000.

• **Payments to hospitals serving vulnerable populations.** Limit to $800 million the amount that hospitals serving low-income patients could receive. Under current law, hospitals with a disproportionately high number of poor and uninsured patients can get money through a federal-state program known as the disproportionate share program. Designed to cover hospital shortfalls, it currently spends $16 billion to $17 billion annually in federal dollars. Under the new system, the disproportionate share program would be eliminated and all hospitals would be covered. But the administration would leave in place a small fund to help hospitals that serve a disproportionate number of illegal immigrants who would not be covered under the national program.

• **Mental health and substance abuse.** Authorize grants to states for substance abuse and mental health-care services of $100 million in fiscal 1995, $150 million in fiscal 1996 and $250 million in fiscal years 1997 through 2000. These funds would augment spending through the Substance Abuse and Mental Health Services Administration, which received $2.1 billion in fiscal 1994.

School Health Services

The bill would encourage healthy behavior at an early age by establishing health education programs in schools and by authorizing up to $400 million annually by 1999 for school-related health services. Priority would be given to communities with the highest level of need among 10- to 19-year-olds as measured by poverty, the presence of a medically underserved population, a shortage of doctors and other health providers, and a high proportion of children with special needs, such as those who are pregnant, members of gangs or exposed to drugs and alcohol.

Medicare and Medicaid (Title IV, Title II)

Medicare

The framework of Medicare, the government's health insurance program for the elderly, would remain unchanged. Beneficiaries would have additional coverage for prescription drugs and access to expanded home health-care funding. However, the price of Medicare coverage would rise sharply for wealthier beneficiaries. The program's rate of growth would be sharply reduced, with most of the cuts to be borne by doctors and hospitals. The working elderly and their spouses would be required to buy health care through alliances rather than through Medicare. *(Long-term care, p. 493)*

The bill would:

• **New benefits.** Provide coverage for prescription drugs, which

would be financed in part by charging beneficiaries for the first $250 of drug costs and 20 percent of all subsequent prescriptions. The bill would also expand coverage for home care through the expanded home and community care benefit. The bill also would allow the elderly poor who are eligible for Medicaid to keep more of their savings while still qualifying for Medicaid-subsidized long-term care.

- **New charges.** Increase the premiums charged to wealthy beneficiaries for Medicare Part B, which covers physician services. Individuals who earn more than $90,000 a year and couples who earn more than $115,000 would pay 75 percent of the premium's cost instead of the approximately 25 percent they pay now. Most beneficiaries would also be required to pay a 20 percent co-insurance fee for all laboratory services (such as X-rays) and a 10 percent co-payment for the average costs of home health visits. Currently, Medicare requires no payment for either service.

- **New Medicare-related taxes for state and local employees.** Require those state and local employees who currently are exempt from paying the hospital insurance tax that pays for Medicare Part A to pay the tax. This would affect only those employees hired before 1986. Others already pay the tax.

- **Reductions in reimbursements for physicians.** Reduce the annual increase in physician payment rates (except for primary care physicians) and other payment rates by $38 billion between fiscal 1995 and 2000.

- **Reductions in reimbursements for hospitals.** Require reductions in payment rates for hospital care totaling $59.1 billion from fiscal 1995 to 2000. About 30 percent of the savings would come from a new system for paying hospitals to train physicians.

- **Other Medicare savings.** Reduce payments for programs in Medicare that are paid for jointly by Medicare Parts A and B by $15 billion from 1995 to 2000.

- **Coverage of working Medicare beneficiaries through health alliance.** Require all workers over 65 and their spouses to be covered through health alliances, but entirely subsidize their insurance. Employers would pay 80 percent of premiums, and Medicare would cover the balance. Workers who retired at 65 but who wanted to continue to be covered through an alliance plan could stay in it rather than switching to Medicare.

- **State option to allow all Medicare beneficiaries to enter alliances.** Permit states to apply to the secretary of Health and Human Services to integrate Medicare beneficiaries and payments into the regional alliance system over time.

Medicare Outpatient Prescription Drug Benefit

The bill would provide coverage for prescription drugs for Medicare beneficiaries for the first time. This is the only major change to Medicare benefits in the bill. Under the existing system, patients buy prescription drugs, and insurance companies reimburse them to the extent of their coverage. Under the new system, the federal government would pay drug manufacturers directly.

The bill would:

- **Included drugs.** Cover most outpatient drugs approved by the Food and Drug Administration — including insulin — for uses approved by the government.

- **Deductible and co-payment.** Require the patient to pay for the first $250 in drug costs each year, then require the government to cover 80 percent of any costs beyond that until the patient reached the out-of-pocket limit.

- **Out-of-pocket limit.** Include an out-of-pocket limit, set at $1,000 in 1996. The government would cover 100 percent of a patient's drug costs after a patient had paid out the year's limit.

- **Drug manufacturer rebates.** Require drug manufacturers to refund at least 17 percent of the average manufacturer's price to the federal government for drugs bought through the Medicare benefit. In other words, the government is mandating that it gets a 17 percent discount on drugs. The rationale is that the government, by offering prescription drug coverage, is increasing the number of people who will be able to afford drugs.

Medicaid

Medicaid, the federal-state health insurance program for the poor, would be subsumed by the new health alliance system. Medicaid currently pays for medical care for: families that receive welfare through Aid to Families With Dependent Children (AFDC); people who receive Supplemental Security Income because they are aged, blind or disabled as well as poor; and low-income pregnant women and children from low-income families whose incomes are too high for AFDC. Overall, the federal government pays about 57 percent of Medicaid costs, and states pay about 43 percent. Medicaid beneficiaries must go to a doctor who accepts Medicaid patients — and many physicians decline to accept them because the program reimburses doctors at a much lower rate than private insurance. *(State maintenance of effort, p. 501)*

Under Clinton's bill, everyone would receive care through a health plan offered by a health alliance. Medicaid patients would receive the same benefits package as other Americans. That would mean fewer services for some Medicaid beneficiaries who currently receive assistance with transportation, translation and rehabilitation. Those benefits either are not part of the national benefit package or are not covered to the same extent. Medicaid patients would be likely to enroll in the least expensive plan offered by an alliance.

The payment mechanisms for each class of Medicaid beneficiary would vary, but overall, spending for Medicaid would be sharply reduced. However, since many former Medicaid beneficiaries would be eligible for government subsidies, it is unclear how much the government would save. For instance, all working beneficiaries (such as low-income and pregnant women) would be covered by their employers. But if they earned less than 150 percent of the federal poverty level, they would still qualify for subsidies.

The bill would:

- **Cash, welfare beneficiaries.** Require that the state and federal government pay health alliance premiums for families on AFDC, but only totaling 95 percent of the premium cost for the average benefits package. The government would pay less than 100 percent to keep spending down.

- **Supplemental Security Income.** Treat people on SSI the same as those on AFDC.

- **Low-income children, pregnant women and other beneficiaries who are not on welfare.** Cover low-income pregnant women through a combination of employer contributions and government subsidies. States would continue to contribute to their care indirectly through payments into the subsidy pool. The amount would match what the state currently pays, updated for inflation.

- **Changes in spend-down provisions for long-term care.** Allow states to increase to $12,000 the amount that a recipient could keep in savings and still be eligible for Medicaid-subsidized long-term care. Under current law, Medicaid pays for long-term care for the extremely poor, but has stringent eligibility rules requiring people to spend all but $2,000 in savings before they can receive the subsidy. States would also be required to allow Medicaid beneficiaries who are nursing home residents to keep at least $50 a month of their Medicaid payment for personal needs. Currently, about half the states allow residents to keep only $30. Because this provision would mean that some beneficiaries would contribute less to the cost of their care, the federal government would pick up any additional cost in Medicaid.

- **Extra benefits for children.** Create a program for poor children with special needs to ensure that disabled children now covered under Medicaid continue to have access to coverage to help deal with long-term disabilities.

- **Disproportionate share hospital payments.** Terminate all but $800 million annually of the $16 billion to $17 billion disproportionate share payments to hospitals that treat a high number of uninsured people and Medicaid patients. The rationale is that everyone would be insured, so these hospitals would no longer need additional federal aid for uncompensated care. The $800 million would be used primarily by hospitals that care for high

numbers of illegal aliens, who are not covered by the bill.

Legal Issues (Title V)

Medical Malpractice Claims

Under the Clinton plan, each health alliance would seek to avoid going to court over malpractice claims by adopting an "alternative dispute resolution" system. These systems could include mediation, arbitration or early offers to settle out of court.

The bill would:

- **Alternative dispute resolution.** Prohibit medical malpractice claims against a regional or corporate health alliance from going to court until final dispensation of that claim under the alternative dispute resolution system adopted by each alliance. Such a system could include mediation, arbitration or early offers of settlement. An enrollee dissatisfied with the outcome could then bring suit in state court if a qualified medical specialist determined that the enrollee had a reasonable and meritorious claim.

- **Limitations on contingency fees and awards.** Limit attorney fees in a medical malpractice case to one-third of the amount recovered by judgment or settlement. A plaintiff's monetary damages in a malpractice liability case would be reduced — dollar for dollar — if the plaintiff also received payments from federal, state or private benefits programs as a result of the same injury.

Fraud and Abuse

The Clinton plan would set up a program aimed at preventing health-care fraud and abuse. The bill would:

- **Fraud and abuse control.** By Jan. 1, 1996, create a program to coordinate efforts between the Justice Department and the Department of Health and Human Services to prevent, detect and control health-care fraud and abuse. Activities would be coordinated with other federal, state and local agencies and with each health alliance and plan.

- **Anti-Fraud Account.** Create an Anti-Fraud Account to fund the fraud and abuse control program. It would include money from health plan criminal fines, civil penalties and damages. The fund could accept outside gifts.

- **Exclusion from health plans.** Exclude individuals or entities convicted of health-care crimes or patient abuse from participating in any health-care plan for no less than five years. Those convicted of health-care fraud could be excluded from participating in any health-care plan for a certain period, depending on the severity of the offense.

- **Civil penalties.** Impose civil penalties for such infractions as: denying enrollment on the basis of medical condition; inducing enrollment under false pretenses; providing incentives to enroll in a plan; and unlawfully terminating enrollment. Generally, penalties would not exceed $50,000 for each offense. The secretary of Labor and each state could also initiate civil actions against health-care alliances or plans, with the approval of the attorney general and secretary of Health and Human Services.

- **Criminal penalties.** Impose fines or prison terms up to 10 years for people convicted of defrauding or attempting to defraud a health alliance, health plan or someone connected with the delivery of health care. Anyone convicted of making false statements or falsifying information could be fined and sentenced to no more than five years in prison. Anyone convicted of bribing or attempting to bribe health-care officials could be fined and sentenced to prison for no more than 15 years. The same would hold true for those health-care officials demanding bribes. Anyone convicted of stealing or embezzling the property of a health alliance or health plan could be fined and sentenced to no more than 10 years in prison. Anyone convicted of requiring the use of the health security card or health identification number for a purpose not intended under the Health Security Act — to prove legal status, for example — could be fined and sent to prison for no more than two years. Proceeds derived from health-care fraud or other health related crimes would be forfeited and returned to the injured party.

Antitrust Exemptions

The bill would repeal the McCarran-Ferguson Act of 1945, which exempts the insurance industry from federal antitrust law if the industry is regulated by a state. In fact, all 50 states do regulate their insurance industries, effectively supplanting federal antitrust law nationwide. Under the Clinton bill, insurance companies would be subject to federal antitrust law.

The bill would also:

- **Loosen some antitrust rules.** Allow doctors and other health-care providers to join together to negotiate fee schedules for the fee-for-service plans offered by health alliances. The aim is to even the playing field so that doctors bargaining individually with the large alliances would be at less of a disadvantage. They would be prohibited, however, from colluding on a boycott or threat of a boycott of an alliance because they felt its proposed fees were too low.

Finance (From Title VI, VII, IX)

Premium Caps

The bill seeks to reduce government health-care spending as well as overall national spending. It takes two approaches to reducing national spending: market reforms and caps on the amount that health insurance premiums could rise annually. To reduce government spending, the bill would limit the amount the government could spend annually on subsidies for employers and individuals.

The controversial premium caps would limit the annual rise in consumers' costs by controlling the percentage that premiums could rise. The health-care industry dislikes the caps because they would force health plans to limit payments and profits to doctors, hospitals and suppliers of medical equipment and pharmaceuticals. Although the Clinton proposal would give the marketplace the flexibility to decide where to make cuts, the caps would leave little room for industry expansion and would reduce its rate of growth by half in the first year. No health-care system in the developed world and no other reform bill has as tight a limit on annual cost increases.

The only other method of cost containment that Clinton could have selected would have been to have the government set reimbursement rates for doctors, hospitals and all other health-care goods, as it does for Medicare. Clinton opted for the cost containment method that would leave many cost-cutting decisions up to market forces.

The bill would:

- **National baseline premium.** Require the National Health Board to determine the average premium nationwide by Jan. 1, 1995. Based on medical expenditures in 1993 and inflated to 1995 costs, the amount would be used to calculate a target premium for each alliance.

- **Regional alliance premiums.** Require the national board to determine a target premium for each alliance (about 200 expected), including an inflation factor and taking into account the percentage of people who are uninsured or underinsured in the region and variations in the proportion of expenditures for academic health centers. If the average premium bid made by a health plan (a network of doctors and hospitals) and accepted by a regional alliance for a year exceeded the target, then for the next two years the target would be reduced.

- **Premium inflation factor.** Require the National Board to publish each year an inflation factor for each alliance. The inflation factor would be the general health-care inflation factor, adjusted to take into account changes in the demographic and socioeconomic characteristics of the alliance population and to reflect any changes in the value of the benefits package. The general health-care inflation factor from 1996 to 2000 would be the increase in the Consumer Price Index — 2.7 percent in 1993 — plus: 1.5 percent in 1996; 1.0 percent in 1997; 0.5 percent in 1998 and nothing in 1999 or

2000. This is one of the bill's key cost containment provisions.

• **Health plan bidding.** Require regional health alliances to obtain bids from health plans to provide the benefits package at a certain price. The alliance would report to the national board, which would determine the average premium that had been bid for the alliance. If the amount was greater than the alliance's premium target (set by the board), the board would notify the alliance with the aim of reducing the premium bids from plans that were above the target. Once a plan started bidding, it would have to accept any reductions demanded by the alliance — making the system unlike bid negotiations in the business world. If an alliance reduced a bid, affected plans would reduce providers' pay rather than reducing services to consumers.

• **Cost containment authority.** Allow states to decide whether they would enforce the cost containment measures or leave that responsibility to the federal government.

• **Cost control enforcement for health plans.** Require alliances to reduce payments to plans to bring per capita payments in line with the target set by the National Health Board.

• **Corporate alliance payments.** Require the National Health Board to calculate a formula by 1998 for computing the annual amount per person that corporate alliances would have to spend for the benefits package and the amount that corporate alliance premiums could rise annually. If a corporate alliance's premiums exceeded the corporate inflation rate, the employers would be forced to join the regional alliance and would not be eligible for premium subsidies for the first four years.

• **Single-payer states.** Require the board to compute a statewide per capita premium target in the same way that it would determine the regional alliance premium.

Premium-Related Financing

The bill lays out the formula that would be used to determine the amount of the premiums that would be paid by individuals, families and employers. Individuals would be responsible for their health insurance premiums but also would receive a credit from their local alliance covering 80 percent of the average cost of their premium. Employers would pay 80 percent of the average cost of workers' premiums. Smaller employers would qualify for subsidies.

The bill would:

• **Family payments.** Require every family enrolled in an alliance health plan to pay the "family share" of the premium — about 20 percent of the cost. It would be calculated by adding the cost of the family's health plan plus a small charge to help alliances pay for premiums owed but not paid. It would subtract the "regional alliance credit," equal to 80 percent of the average alliance premium. In addition, low-income families (earning up to 150 percent of the federal poverty level, now $14,800 for a family of four) would qualify for income-related subsidies on the family share (20 percent) of the premium. For working families, the alliance credit would be paid in large part by employers.

• **Employer payments.** Require employers to pay about 80 percent of the average cost of insurance for all employees, based on their family enrollment status. Employers would pay different premiums for each class of employee: individuals, couples, single parents with children and couples with children. The amount an employer paid would be adjusted to reflect the average number of workers in each class. For instance, if the average number of workers per couple in the regional alliance were 1.5, the employer would pay the premium for the couples class, divided by 1.5. The result is that two-worker couples and their employers would subsidize the cost of insurance for one-worker families.

• **Self-employed individuals.** Classify self-employed individuals as "small businesses," making them eligible for subsidies on the 80 percent employer share of the premiums, the same as businesses of fewer than 75 employees. They also would be eligible for subsidies for the 20 percent individual share if they earned less than 150 percent of the federal poverty level. A self-employed person earning $10,000 a year (which is less than 150 percent of the poverty level of $7,360 a year) would be eligible for subsidies as a small business and as an individual.

• **Corporate alliance employers.** Require corporate alliance employers to pay for at least 80 percent of an employee's benefits either through payments to a corporate alliance health plan or to a regional alliance plan, if an employee is enrolled in a regional alliance.

• **Payments to health plans by regional alliances.** Require alliances to pay plans on a per capita basis a premium that reflects both the price the plan charges working people for their premium and the amount the government pays to subsidize poor people. Since the per capita amounts that the government would pay for the poor would be only 95 percent of the plans' costs, plans would always have a shortfall.

They presumably would be expected to economize to make up the difference. The amount a plan would be paid would be adjusted to reflect the health status of its subscribers minus the administrative allowance for the regional alliance (not to exceed 2.5 percent) and the 1.5 percent of alliance premiums that go to finance academic medical centers and graduate medical education. In addition, states could charge plans directly up to 2 percent of premiums to pay for the guarantee fund that states would maintain to cover the costs of failed plans.

Government Payments

The existing mix of programs that distributes state and federal dollars for health care for the poor would be reshuffled. Overall, states would pay less than they do now. But some states could pay more, particularly for services no longer convered by Medicaid, such as transportation to clinics. States and local governments also would face new spending as employers, because they would have to pay for their employees' health insurance. The federal government's subsidy payments for the poor and for low-wage firms would be capped.

The bill would:

• **State maintenance of effort.** Require states to continue to contribute to the cost of care for Medicaid beneficiaries who under the bill would no longer receive coverage through Medicaid. These beneficiaries would include low-income children, low-income pregnant women and several other groups.

States also would contribute to the cost of additional services, such as translation and transportation to clinics, for children of welfare beneficiaries. Those services would not be covered in the benefits package. The state contribution, which would be paid to the regional alliances, would equal the amount that states paid in 1993 for those beneficiaries' care, increased to reflect inflation and other factors.

• **Federal subsidy cap.** Limit the amount the federal government would pay for welfare and Social Security insurance recipients and for subsidies for the poor and small businesses. The capped amount would be allocated among the regional alliances on a per capita basis. The amount would be capped at $10.3 billion in fiscal 1996, $28.3 billion in fiscal 1997, $75.6 billion in fiscal 1998, $78.9 billion in fiscal 1999 and $81 billion in fiscal 2000. This is one of the key provisions to control government spending.

• **Subsidy shortfalls.** Require the secretary of Health and Human Services to alert the president, Congress and regional alliances of shortfalls in the amount of subsidies available. The president would have to submit legislation that would eliminate the shortfalls, presumably either by reducing federal responsiblities for payment or by increasing revenues. Congress could consider the president's proposal on an up-or-down vote.

• **Borrowing authority.** Authorize the HHS secretary to make loans to the regional alliances to cover cash-flow shortfalls. The total amount that could be borrowed at any one time would be $3.5 billion. The interest rate would be determined by the secretary of the Treasury based on the current average rate on U.S. Treasury notes — a rate well below that set by commercial lenders.

• **Women, Infants and Children (WIC) fund.** Set up a special fund that would make automatic payments annually to ensure full funding for the Women, Infants and Children program, which gives poor women vouchers to buy food, diapers and other child-care

provisions. The fund would be used only if Congress appropriated an insufficient amount to fully fund the WIC program.

Taxes

The bill would:

• **Cigarette tax.** Raise the excise tax on cigarettes by 75 cents a pack, effective Oct. 1, 1994, bringing the federal tax on cigarettes to 99 cents. Taxes on other tobacco products, including cigars, pipe tobacco, snuff, chewing tobacco and cigarette rolling papers, would be subject to comparable increases. A tax would be instituted for so-called roll-your-own tobacco, equal to $12.50 per pound. The bill would also change the way the tobacco excise tax is applied. For example, the bill would repeal tax-exempt sales to cigarette manufacturers' employees.

• **Corporate alliance tax.** Require corporations of more than 5,000 employees that choose to provide health care through their own alliance to pay a tax equal to 1 percent of their total payroll. The assessment would begin Jan. 1, 1996. It would help fund academic medical centers, which are now funded through Medicare.

• **Early retirees.** Impose an assessment on employers who currently pay health insurance for early retirees, ages 55 to 64, but would not pay it under the Clinton plan. The assessment would be equal to 50 percent of a retiree's average health costs in 1991-93, or the amount by which the employer's health costs were reduced by enactment of the Health Security Act, whichever is greater. The assessment would apply in 1998, 1999 and 2000.

• **Wealthy elderly.** Require wealthy taxpayers who enroll in Medicare Part B, the portion of the government's insurance program for the elderly that subsidizes physician care, to pay more on their individual income taxes. The additional amount in effect would raise the amount these taxpayers pay for Medicare Part B from roughly 25 percent of the program's costs to about 75 percent. Individuals with income of $90,000 or more and joint filers with income of $115,000 or more would be affected. Those thresholds would be determined by combining adjusted gross income (including taxable Social Security benefits) and tax-exempt interest income. This would take effect Jan. 1, 1996.

• **Subchapter S.** Require shareholders in certain service industry Subchapter S corporations, which are closely held businesses, to pay self-employment Social Security tax on non-wage income from the corporation. Shareholders with 2 percent or more of an S corporation stock would be eligible, and limited partners who materially participated in the business would be taxed similarly.

• **State and local government employees.** Require all state and local government employees and their employers to pay the hospital insurance portion of the FICA (Social Security) tax, making them eligible for Medicare coverage. Currently, some state and local government employees are covered by separate health insurance plans. This would take effect Oct. 1, 1995.

• **Academic medical centers.** Impose a 1.5 percent assessment on premiums purchased through regional alliances to help underwrite academic medical centers and medical education. This would begin Oct. 1, 1995.

• **Income calculation.** Require individuals who receive certain health benefits from their employers to include them in their annual income for the purpose of calculating taxes owed. The aim would be to promote cost consciousness. Beginning Jan. 1, 1997, individuals would have to count health benefits delivered through cafeteria plans as income. In cafeteria plans, employees choose specific kinds of coverage from a range of choices. Beginning in 2003, employees would be taxed on supplemental health coverage paid by employers.

• **Self-employed tax deductibility.** Permit self-employed people to deduct the entire cost of premiums paid to a health alliance for the benefits package. The current 25 percent deduction would continue until a taxpayer's state of residence established a regional alliance, at which time the 100 percent deduction would take effect.

• **Independent contractors.** Give the secretary of the Treasury authority to issue regulations defining who is an independent contractor. That provision is intended to prevent employers from avoiding health-care premiums for employees they illegally classify as independent contractors. The penalty for not reporting a payment made to an independent contractor would be set at $50 or 5 percent of the payment, whichever was higher.

• **Retiree health premiums.** Require higher-income taxpayers who retire between the ages of 55 and 64 to repay subsidies provided for the employer share of their health insurance premiums. Repayment would be required for individual taxpayers with incomes over $90,000 and couples making above $115,000. Calculation of income includes the taxpayer's adjusted gross income (including taxable Social Security benefits) and tax-exempt interest income. Repayment of the premium subsidy would be carried out through tax returns. This would take effect after Dec. 31, 1997.

• **Retiree medical accounts.** Prevent employers from receiving a tax break for contributions to so-called retiree medical accounts, used for medical expenses as part of a pension plan. Funds already contributed would continue to receive beneficial tax treatment.

• **Blue Cross/Blue Shield.** Remove certain special tax benefits provided for Blue Cross/Blue Shield organizations, which they currently receive because they provide open enrollment on a community rated basis. The bill would eliminate a provision in which Blue Cross/Blue Shield plans are taxed at the alternative minimum tax rate of 20 percent, rather than the full 35 percent corporate tax rate. Certain Blue Cross/ Blue Shield organizations with high community ratings would receive special tax treatment that would allow them to continue to receive the 20 percent tax rate for an additional two years after enactment of the bill. In addition, Blue Cross/Blue Shield would be required to include 20 percent of the annual change in unearned (or uncollected) premium reserves in its taxable income. Currently, Blue Cross/Blue Shield may deduct all unearned premiums.

• **Leaving a job.** Eliminate the requirement that companies offer continuing health coverage to employees who leave their jobs. The repeal would take effect on Jan. 1, 1998, or on the date that all states have a regional alliance in effect, whichever is earlier. Prior to repeal, coverage for affected employees and their beneficiaries would end when they were eligible to receive health care through an alliance.

• **Alliance tax exemption.** Exempt regional health alliances established under the bill from federal income tax.

• **Bond rules.** Specify that bonds used by a health-care alliance or state guarantee fund would be for private business use. That means that proceeds of bond issues more than 10 percent of which went to finance activities of the alliances would not be tax-exempt.

• **Tax deductibility of long-term care insurance.** Permit individuals to claim a tax deduction on premiums for qualified long-term care insurance. This would be effective Dec. 31, 1995. In addition, taxpayers would be permitted to exclude from their taxable income up to $150 a day for benefits paid through long-term care policies. The $150 cap would rise with inflation.

• **Employer tax deductibility.** Allow employers to claim a tax deduction on premiums paid on behalf of employees for long-term care coverage. The employees would be able to exclude the value of such employer-paid coverage from their income for tax purposes.

• **Disabled people.** Permit incapacitated people to claim a deduction for qualified long-term care expenses.

• **Terminally ill patients.** Lift income taxes on accelerated payments of life insurance benefits to terminally ill patients. This would be effective Jan. 1, 1994.

• **Tax credits for physically impaired.** Provide a tax credit of up to $7,500 to help defray the cost of certain services related to daily living purchased by the physically impaired. The credit, which provides a dollar-for-dollar reduction in taxes owed, would be equal to half the taxpayer's earned income but no more than $7,500. Taxpayers with adjusted gross incomes of more than $70,000 would not be eligible. The credit would be non-refundable, meaning it would not be available to taxpayers too poor to owe taxes.

• **Underserved areas.** Provide a tax credit to encourage physicians to practice in areas that are short of doctors. The credit, which would provide a dollar-for-dollar reduction in taxes owed, would be for up to $1,000 per month for up to 60 months. Qualified doctors would have to work in the area for five consecutive years to receive

the full credit, although a partial credit would be available for two consecutive years. A less generous credit would be available for nurse midwives, nurse practitioners and physician's assistants in underserved areas.

• **Medical equipment.** Increase the amount that purchasers of medical equipment could deduct from their taxes in the first year to $27,500, an increase of $10,000.

• **Prepaid health-care premiums.** Limit the deduction that taxpayers could claim for prepaying health-care premiums. Specifically, if a taxpayer paid a premium for medical care which provided benefits beyond 12 months after the payments, the deduction would have to be claimed over the full period of the coverage. This provision, which would take effect after Dec. 31, 1996, would not apply to qualified long-term care premiums.

Other Government Health Programs (Title VIII)

Military Health Care

The bill would not establish a new military health-care system, but would give the secretary of Defense authority to design a new system once a national health system was in place.

The plan gives wide discretion in fashioning a new system, allowing the secretary to use existing military hospitals and clinics in conjunction with civilian health plans.

The bill would set basic ground rules for any new military health-care system. It includes a provision that would, for the first time, allow the Defense Department to be reimbursed by outside health plans, including Medicare. Military family associations have been fighting for years to allow retirees eligible for Medicare to continue using the military health-care system after they turn 65.

The Pentagon currently operates a two-tiered military health-care system. Active-duty military personnel get free care at Defense Department facilities. Military retirees and their dependents and spouses of active-duty members can use those medical facilities if there is room. If not, they use the military's insurance system, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). They pay no annual premiums for CHAMPUS, but do pay up to 25 percent for doctor visits and procedures.

The bill would:

• **Active-duty soldiers.** Maintain virtually free health care for active-duty soldiers. Members who have been on active duty for at least 30 days would pay only "subsistence charges" for their health care. Out-of-pocket expenses for spouses, children and retirees would be capped. The military health-care plan could not charge more than other health plans.

• **Uniform benefits.** Require any military health-care system to provide beneficiaries with the same benefits package available under the overall national health plan.

• **Waivers.** Allow a Defense secretary who decided to include a civilian health plan as a part of the new military health-care system to award the contract without going through the usual Pentagon competitive-bid process.

• **Medicare recipients.** Allow Medicare recipients who are military retirees to use the military plan. It also would require Medicare to pay the Defense Department for all beneficiaries who use the military health system. Under current law, military retirees who become eligible for Medicare may no longer use CHAMPUS, although they may use military hospitals if there is room.

• **Pentagon payments.** Require the Defense Department to pay the employer's share of insurance premiums for people eligible for the military health-care plan who choose to join another plan. But if, for example, the spouse of an active duty soldier were employed, the employer would have primary responsibility for paying the employer share of the premium.

The Defense Department would not make such premium payments for people enrolled in the Department of Veterans Affairs or the Indian Health Service plans.

• **Pentagon financial account.** Establish a financial account at the Pentagon to take in all money paid to the Defense Department by Medicare and other health services.

• **Congressional report.** Require a secretary of Defense who chose to establish a new plan to describe the plan to Congress 30 days before issuing the rules to carry it out.

• **State pre-emption.** Pre-empt state laws. A state could not impose its standards on the military plan nor deny it certification.

Federal Employees Health Benefits

Federal civilian employees worldwide would be able to keep their current health-care coverage until 1998, when all regional alliances are due to be running. Unlike other Americans, the 9 million federal employees, retirees and their dependents would not have to join the new state-based plans as they become available.

The administration proposed such a phaseout in 1993, but unions partial to the highly praised Federal Employees Health Benefits Plan (FEHBP) fought to keep it as long as they could. FEHBP annually offers federal workers up to a dozen choices of fee-for-service and health maintenance organization (HMO) plans. Each year workers can switch plans during "open season" month.

After 1997, federal employees will have to enroll in one of their home state's health plans. About 200,000 employees living in Washington will choose from the District of Columbia plans. Temporary and lower-paid federal workers will receive discounts to pay for health insurance.

Administration officials say FEHBP subscribers will not experience a significant change because the alliances and state single-payer plans are supposed to operate much like the federal government. They will provide consumer choice and ban waiting periods or exclusions because of pre-existing conditions or new illnesses.

Under the Clinton plan, the government will contribute 80 percent of the premium, rather than an average of 72 percent currently provided to FEHBP subscribers.

However, unions fear that the premium savings could be offset by higher deductibles and copayments. D.C. residents also wonder if the city's high-risk population will force premiums up.

The bill would:

• **FEHBP termination:** Terminate the Federal Employees Health Benefits Plan (FEHBP) on Dec. 31, 1997.

• **Enrollment:** Require the government to treat federal employees and others who would have been eligible for FEHBP — such as retirees and dependents — as any other non-federal employees when they leave the FEHBP plan.

• **Supplemental plans:** Allow current retirees to enroll in government subsidized supplemental plans — such as dental or prescription drug plans — that would maintain or "reasonably reflect" their current level of health coverage even if Medicare coverage changes. Future retirees and current employees would not necessarily be offered subsidized supplemental plans.

• **Non-U.S. residents:** Require the Office of Personnel Management to establish a program that would replace health coverage for eligible federal workers living abroad once FEHBP is terminated.

• **Funding:** Require the government to pay for the premium contribution from the appropriation or fund that currently pays for the government's part of FEHBP.

• **Transition:** Maintain the Employee Health Benefits Fund, which supports the government portion of FEHBP, after the insurance program is terminated for as long as the Office of Personnel Management considers necessary to satisfy outstanding claims.

Veterans Health Care

Under the legislation, the Department of Veterans Affairs' (VA) health system would be integrated into the new health-care structure through a network of VA doctors and hospitals within each health alliance. In essence, the VA plan would become one of several health plans offered by each health alliance, while remaining a

separate government-run system.

The VA administers the largest government-run health-care system in the nation, with 171 hospitals, 128 nursing homes and hundreds of outpatient clinics. It serves more than 2 million veterans annually.

Health alliances would offer veterans a VA health plan as an option, in addition to the other plans available to the public. The secretary also could offer the plan to veterans' family members.

Those who receive free care from the VA — mostly poor veterans and those with service-connected disabilities — would retain free VA services. Others, who are currently required to pay some of the cost of VA treatment, would pay premiums, deductibles and other charges, as if the VA were a private health plan.

The secretary would have greater flexibility to restructure the VA's health system by, for example, closing a facility or reconfiguring it to meet different needs. In addition, the secretary could apply for outside grants and advertise for potential customers.

The bill would:

- **Enrollment:** Allow veterans and the dependents of those with service-connected disabilities to enroll in the VA health plan. The VA secretary could authorize the enrollment of spouses and children of veterans in the plan.
- **Benefits:** Require the VA to provide each enrollee with at least the same comprehensive benefits package offered under the national health-care plan. The VA also would provide eligible veterans with all health services currently authorized by the VA but not included in the comprehensive benefit package. Veterans not enrolled with the VA could still receive VA services, but only if the VA plan were reimbursed for costs by that veteran's health-care plan.
- **Costs:** Require the VA to offer free care to certain veterans, including former prisoners of war, the indigent and those with service-connected disabilities. All others would pay premiums, co-payments and deductibles based on rules established by the health alliance under which the VA plan operated.
- **Medicare reimbursement:** Require the Department of Health and Human Services to reimburse the VA for treatment of enrollees who are eligible for Medicare but are not eligible for free VA treatment. Veterans who fell into this group would pay any deductible or co-payment not covered by Medicare.
- **Supplemental insurance:** Allow the VA to be reimbursed for treating any enrollee in the VA plan who is covered by supplemental insurance plans to the extent of that person's coverage.
- **Health-care fund:** Establish a revolving VA health plan fund to receive payments from enrollees in VA health plans. The fund would be available to cover the plans' expenses. Payments from enrollees for VA health plan treatment in which the costs already were covered by appropriations would be transferred to the Treasury Department. This last provision is intended to reimburse the federal government for the start-up cost of new VA services that eventually would be paid for by the enrollees.
- **Organization:** Organize VA health facilities within the general structure of health plans established under the Health Security Act. VA facilities in each region would be organized to operate as one or more health plans.
- **State pre-emption:** Pre-empt state laws that impose any requirement on a VA plan that is inconsistent with federal laws. States could not deny certification of a VA health plan because of a conflict between state and federal laws.
- **Contracting:** Allow the secretary to contract with other health providers for services the VA cannot provide or cannot provide as cheaply.
- **Resource sharing:** Allow the secretary to enter into agreements with other health providers to share resources.
- **Administrative flexibility:** Allow the secretary to: reorganize the VA; contract for services previously provided by VA employees and establish procedures for VA health plan employees.

The secretary also could use non-appropriated funds, such as payments by enrollees, for promotion, advertising and marketing of the VA health plan.

- **New funding:** Authorize creation of a fund from fiscal 1995 to to 1997 to aid in the operation of new VA health plans. The fund would receive $1 billion in fiscal 1995, $600 million in fiscal 1996 and $1.7 billion in fiscal 1997 — but only if the appropriation for VA medical programs each year matches or exceeds the president's budget request.

Under the bill, VA health plans could accept outside grants and other funds not normally available to government-run health plans if the money were intended to meet the needs of special populations, such as veterans who are homeless or who have AIDS.

Indian Health Care

To provide health care to the nation's Indian population, Clinton has proposed expanding and improving the Indian Health Service (IHS), the primary provider of health services to Indians. The IHS would operate outside Clinton's proposed system of regional health alliances, but eventually would offer the same benefits. Indians could elect to enroll with either the IHS or an alliance. The plan would include powerful financial incentives to encourage Indians to select an IHS health program.

Through a series of treaties and agreements, the federal government has been obligated to provide health services to Indians since the 1830s. That commitment manifests itself today as the IHS, a comprehensive health system of more than 40 regional hospitals serving 1.3 million of the approximately 2 million Indians. In fiscal 1994 Congress appropriated roughly $1.9 billion for the IHS.

Last March, tribal leaders announced that they opposed folding the IHS into a national system of regional health alliances that would be subject to state oversight. They feared they would lose some authority over health programs.

The bill would:

- **Purchasing health insurance.** Provide Indians with the choice of enrolling in an IHS health program or a regional health alliance. Indians who chose an IHS plan would not pay any premiums or other health-care costs. Those who enrolled in an alliance would pay premiums and other health-care costs.
- **Tribal governments.** Exempt tribal governments and organizations from making employer premium payments to providers.
- **Indian Health Service improvements.** Provide for the renovation, improvement and construction of hospitals and other IHS health facilities using authorized appropriations and guaranteed loans offered by a revolving loan fund created under the plan.
- **Guaranteed benefits.** Guarantee that by 1999 the IHS would provide the same comprehensive benefits provided by regional health alliances. Indians also would continue to qualify for free supplemental benefits. The bill would authorize $180 million for supplemental benefits in fiscal 1995, $200 million in fiscal 1996 through 1999 and unspecified funds in fiscal 2000.
- **Contracting.** Allow IHS programs to provide services on behalf of other health plans, as long as the service did not affect IHS' care of the Indian population.
- **Consultation.** Require the Health and Human Services secretary to consult with Indian representatives every year about health-care initiatives.
- **Authorized appropriations.** Beyond supplemental benefits, the bill would authorize $40 million in fiscal 1995, $180 million in fiscal 1996 and $200 million in fiscal years 1997 through 2000 to improve and expand IHS facilities and programs.

Workers' Compensation, Auto Insurance

The bill would require that health plans provide care or arrange for care when individuals have a workers' compensation claim or an auto insurance medical claim. Initially, the financing for workers' compensation and auto insurance would not change; those carriers would pay the injured person's health plan to provide the care.

The bill also would:

- **Commission on Integration of Health Benefits.** Establish a 15-member commission that would study whether the responsibility for workers' compensation and the medical portion of automobile insurance should be transferred permanently to health plans. The commission would report to the president by July 1, 1995. ■

Mel Arnie

Tuesday, January 18

TO: Selected Individuals
From: Walter Zelman
RE: Op ed pieces on the alliance

Attached are drafts of two potential op ed pieces, both focusing on the health alliance. The first focuses primarily on the alliance as we have structured it, and tries to answer certain criticisms of the approach. The second tries to reveal some of the problems with alternative alliance approaches.

In both articles I have refrained from mentioning any particular alternative plan authored by any particular legislator.

If these are deemed valuable it can then be determined who might sign them and to what purposes they might be put.

Comments are welcome.

Please do no circulate.

Substitute
This for
the op eds
I gave you
yesterday —
I have redone them —
Walter

Op Ed I:

(The goal of this article is to demonstrate the value of the health alliance: the article makes no effort to criticize other models. It does attempt to address some of the major, general concerns about alliances)

DRAFT

THE HEALTH ALLIANCE: MAKING ENDS AND MEANS COME TOGETHER

At the center of the Administration's health care plan stand large purchasing pools known as health alliances. The alliance is a primary mechanism by which the insurance market place is restructured and new insurance reform rules imposed.

Perhaps because the alliance occupies so central a position in the President's plan it has also become one of the more controversial elements of the plan. No doubt, some of that controversy stems from opponents who may genuinely disapprove of the concept, or see value in undermining it. But some of the controversy may also be due to misunderstandings about the alliance, its role and its powers.

In the President's plan, and in many other reform plans, the restructuring of the insurance marketplace, and imposition of new reform rules are designed to serve several goals, including: (1) force health plans (insurers, HMO's, and other health care providers) to compete on how efficiently they can deliver quality care, rather than on how effectively they can avoid insuring higher risk individuals; (2) secure than change in competitive

orientation and promote security for all by requiring health plans to offer the same price for all, rather than basing charges on job, health, or other "experience"-related measures; (3) increase the purchasing power of consumers, and better enable them to compare health plans: (4) increase the "portability" of insurance so that families don't have to change health plans or doctors due to changes in job or family status: (5) expand the health plan choices available to families, giving them (not their employers) more ability to choose health plans that are delivering better value. (6) reduce administrative burdens on all, but especially small and mid-sized employers.

Under the President's plan, employers of over 5000 full time employees may operate their own alliance, but all other individuals, excluding those in Medicare, get their insurance coverage through a regional health alliance. That alliance offers each family the choice of all the qualified health plans in the region. Each plan offers the same comprehensive benefits package and must accept any family that wishes to enroll, at the same price, and with no pre-existing conditions or waiting periods. Families receive information about each plan --its quality ratings, and any restrictions it may impose on rights to see physicians. Families enroll through the alliance, not health plans, greatly reducing the ability of the latter to select enrollees on the basis of risk.

Concerns about the role of the alliance seem to stem, in large part, from the assumption that any entity capable of

serving so many goals must inevitably need or acquire a great deal of power. Thus, some have the impression that the alliance may represent the long arm of bureaucracy and government, and the potential for abuse that comes with it.

But the capacity to implement change should not be confused with the capacity to assert discretionary authority. In fact, the alliance does not need, (and in the Clinton plan does not have) such power or discretion. That power comes from the new insurance reform rules --one price for all, no selection based on risk, choice to all individuals, no pre-existing condition exclusions, etc., around which, it should be noted, there is considerable agreement amongst reformers of many political stripes.

What the alliance offers is a unique, largely self-enforcing mechanism that is specifically designed to implement those new rules without the need for intensive government regulation or micromanagement. The alliance collects bids from all qualified health plans, communicates the price of each plan and other information to all consumers, and implements a one-step enrollment and payment process for employers, individuals, and health plans. In performing these tasks it assumes various responsibilities --but according to very clearly defined parameters. Its purpose is not to make the new system work, but to enable it to do so.

By contrast, in the absence of a market restructuring mechanism such as the alliance, attempts to implement the new

insurance rules may be far more complicated and bureaucratic, and far less effective.

Consider, for example, the key goal of replacing competition based on risk-selection with competition based on price, service and quality. In the absence of an alliance, individuals or employers would enroll, as they do today, through health plans. The new rules might instruct those plans to accept all groups or individuals at the same rate, but plans would still have multiple opportunities to pursue risk-selection activities. They could still market selectively, minimize their presence in areas where they didn't wish to attract enrolles, discourage high-risk groups from enrolling, or encourage them to disenroll. A government-run effort to monitor and prevent such risk-selection --practiced in innumerable forms by dozens of plans-- would likely be ineffective and/or very expensive and intrusive.

In an alliance-based system, by contrast, individuals and families enroll through the alliance, and changes or unusual enrollment patterns are easily monitored. In such an environment, health plans would have much less control over who they enroll, and much less capacity to engage in risk-selection activities.

Similarly, the alliance mechanism can more efficiently serve the goals of reducing costs to employers, expanding choice and the flow of information to individuals, and increasing the capacity of individuals to change job status without changing health plans. Without an alliance, employers would either

continue to offer employees, at best, a very limited selection of health plans, or be forced to pay different premiums to many different plans. With an alliance, these employers pay just one premium to one alliance, and are freed of the burdens and administrative costs (30-40% of premiums for the smallest employers) of purchasing and administering insurance coverage. Without an alliance, individuals must either leave their choice of health plan to employers or sort through a complicated marketplace to determine prices and compare plans. With an alliance, all families can be given all the choices available, and all can be informed --in one brochure-- of all plan prices and other relevant information regarding plan quality, levels of consumer satisfaction, and any restrictions on access to physicians, etc.. Finally, without an alliance most individuals will be forced to change health plans when changing employers. With an alliance, it is much more likely that there will be no need to do so. Their choice of plan is not tied to their employer.

Admittedly, the alliance model outlined in the Clinton plan is not the only possible alliance construct. Other market reform-oriented models offer versions of the alliance mechanism that differ from the Clinton plan by size of the alliance, power of the alliance, and other variables.

But even in these models, as in the Clinton plan, the linkage between insurance market reforms and the alliance concept is clear. Rather than representing an additional and powerful

bureaucratic layer imposed on a series of reforms, the alliance is viewed as part and parcel of those reforms, and as specifically designed to achieve them. It is the non-alliance environment, by contrast, in which the implementation of reform may grow cumbersome and bureaucratic, and in which government might have to either assert more direct authority or allow reform to fall short of its goals.

Op Ed II

(The goal of this article is to examine and critique some alternatives to the alliance structure in the Health Security Act. The article is not aimed at, and does not refer to, any particular alternative offered by any particular elected official).

COMPETING CONCEPTS OF A HEALTH ALLIANCE

At the heart of President Clinton's health care reform proposal stands the health alliance, a large purchasing cooperative that pools consumers together and contracts on their behalf with a variety of health care plans --insurers, HMO's, and other networks of providers.

The alliance is central to the President's plan because it is the mechanism for achieving the primary goal of insurance reform; the substitution of competition based on which health plans can provide the best care at the lowest price for competition based on which plans can do the best job of selecting and maintaining the best risk pool.

In the President's plan, employers of over 5000 full time employees may operate their own alliance, but all other individuals, excluding those in Medicare, get their insurance coverage through a regional health alliance. That alliance offers each family the choice of all the certified health plans. Each plan offers the same comprehensive benefits package and must accept any family that wishes to enroll, at the same price, and

with no pre-existing conditions or waiting periods. Families are given information about each plan --its quality ratings, and any restrictions it may impose on rights to see physicians. Families enroll through the alliance, not through insurers, greatly reducing the ability of the latter to select enrollees on the basis of risk.

The President's plan thus envisions one, large market share alliance per region, through which most families would purchase insurance. Such a structure, the Administration believes, will minimize the capacity of insurers, or employers, to engage in risk selection, and promote longer term security -- in terms of coverage and prices-- for all.

Many other reform proposals also envision the creation of health alliances. But while agreeing with the principle, they articulate different notions of how the principle should be invoked. Overall, advocates of these alternatives suggest that their approaches would be more "flexible" and less "regulatory." But the promises may prove deceptive.

One alternative approach, for example, would leave alliances as voluntary organizations, with individuals and groups allowed, but not required, to join. Unfortunately, the risk-related traps of this approach are all too apparent. If allowed to do so, employers with lower-risk populations might self-insure, purchase their own insurance at lower rates, or band together with other lower-risk employers to form their own multi-employer alliance. Such strategies would leave higher cost groups and individuals on

their own, or in an alliance that would need to charge much higher rates. As a result, some might get lower rates --for a while-- but others would find insurance as unaffordable as ever. If government were subsidizing those unable to pay, its costs would climb. Risk selection and market segmentation would survive.

It is for these reasons that most reform proposals employing the alliance concept propose that all employer groups below a certain threshold obtain their insurance through the alliance. In this fashion all pay a fair price rather than run the risk of having a good price turn into an unaffordable price.

But where should that threshold be set? Some believe it should be much lower than the Clinton plan's proposal of 5000 employees, perhaps as low as employer groups of under 100 individuals. This approach has strong support amongst those who would prefer a more incremental approach to reform, in general, and to the alliance concept in particular.

Such incrementalism may, at first glance, appear prudent. But the smaller pool approach is fraught with problems. For one thing, it maintains limits on the portability of insurance. As employees move from employer groups purchasing insurance in the alliance to one purchasing outside the alliance, or vice-versa, they will need to change plans, and probably physicians. The smaller the alliance market share the more frequently this will occur.

More importantly, the small market share alliance runs the

risk of generating the appearance, and perhaps the reality, of a two-tiered system, with small employers, the unemployed, and perhaps Medicaid-eligible individuals in one pool, and all others in another. Under such circumstances many smaller employers and their employees might feel unfairly treated --indeed, some might experience significant increases in costs. Their comfort level, certainly, would be much higher --and for good reason-- if they were pooled with employers of larger size.

Additionally, the small market share alliance --while perhaps sounding less regulatory-- would, in fact, increase the need for more intensive government regulation. Especially if all employers are required to contribute towards insurance costs, government would need to carefully monitor thousands of employers to make sure they were, in fact, doing so. If these employers were allowed to self-insure, the regulatory burden would multiply, as government would have to monitor the solvency of thousands of employer-based insurance plans.

If there were reasons to believe that employers of over 100 individuals could somehow reduce their real insurance costs outside of the regional alliance, leaving them outside might be justified. But in fact, with the exception of very large employers, all most employers can do to reduce costs is to get a better deal, based, again, on having a better risk pool. If the goal is to gain more security for more of the public this is short term savings for some and long term foolishness for all. It allows insurers to continue segmenting the market, charging

some more and some less, and leaving all with insurance costs that can go dramatically up or down. If, to prevent such segmentation, insurers are mandated to give all employers the same rate, leaving these employers outside the alliance makes little sense, while folding them into the regional alliance makes imminent sense. In the alliance, their employees would get more choice, and the larger pool would put greater pressure on insurers to improve quality and service and to lower prices.

Another reform approach envisions competing regional alliances, as opposed to just one alliance per region as outlined in President's plan. Again, this is a positive sounding concept: but, like the alternatives outlined above, it can't overcome the risk-selection problem. If competing alliances formed by employers or other organizations can select who can join, then alliance organizers will be incented to engage in the same risk selection efforts now practiced by insurers --form a better pool, and get a better rate. If, to avoid this outcome, alliances are compelled to take all comers, then it is far from clear that price competition between alliances will long survive. It seems unlikely, for example, that many would continue to pay $180/month for an HMO in one alliance when they could join another alliance whose price for the same plan is $160.

Alternatively, risk selection could be minimized by making all health plans charge all alliances the same price. In which case, of course, the value of the competing alliance construct would limited indeed, its added complexity just muddying the

effort to clarify consumer choices.

And as would be the case with the small market-share alliance, the competing alliance approach --while sounding less regulatory-- could fast become a regulatory quagmire. With different organizations forming multiple alliances employing different structures, rules and processes, the capacities for financial mismanagement increase, while opportunities to game the system by seeking some inappropriate advantage (probably based on risk) remain limitless. Government regulators would have two choices: accept much of the risk-selection and cost-shifting that mark today's insurance market, or intensively regulate health plans, alliances and employers.

In the end, one must question how much competition competing alliances will produce. After all, the real competition will and should be between health plans, not those selling health plans. It is far from clear that more of the latter will produce more of the former. In fact, given the actual complexity involved in the multiple alliance arrangement it is very likely that more layers of apparent competition will produce less real competition.

As the analysis of each of these alternatives suggests, at the core of almost anything relating to insurance lies the issue of risk. Insurers select enrolles based on risk, charge them based on risk, and compete with eachother over who can best avoid insuring high risk individuals.

The essence of health insurance reform, then --in the Clinton plan and others-- is to reduce, if not eliminate this

kind of competition, and, as suggested above, to replace it with competition based on price, quality and service. In the Clinton plan this is achieved by creating one, large market share alliance per region through which almost all families purchase their insurance. Making participation in the alliance voluntary, giving the alliance a much smaller market share, or allowing multiple alliances to compete with eachother may, to some, appear less regulatory, and more compatible with market-based reform concepts.

But the appearance is wholly illusory. The effort to create more supposed "flexibility" allows risk selection and market segmentation to reemerge, leaving government regulators the choices of allowing the genie to escape the bottle, or engaging in futile regulatory efforts to cram it back in. While promising to make the market work, these approaches may allow the risk-based nemesis to survive. (Optional: It is all the flexibility a creative industry will need. Perhaps, therefore, it should come as no surprise that the prime advocate of these alternative alliance reform proposals is the insurance industry itself.)

HEALTH CARE
MESSAGE STATEMENT

Here's how the President's health reform works:

- **Guaranteed private insurance.** We want to guarantee private insurance coverage to every American. Comprehensive coverage that can never be taken away.

- **Choice.** We want everyone to have the right to choose their own doctor and their own health plan. We want to make sure you get high-quality care by giving you the choice, not your boss or insurance company.

- **Outlawing unfair insurance practices.** We want to make it illegal for insurance companies to jack up your rates or drop you if you get sick, charge older people more than younger, or take away your benefits. That's how you'll get affordable insurance you can depend on.

- **Protection of Medicare.** Medicare will stay as it is now. Older Americans have a right to count on Medicare and choose their doctor. We also want to cover prescription drugs and begin to cover long term care.

- **Health benefits guaranteed at work.** Every job should come with health benefits. Most jobs do today. And yet 8 out of 10 Americans who have no insurance do have jobs. We want everyone to have health benefits guaranteed at work. The government will provide discounts for small businesses and help cover the unemployed.

Everyone will be covered.
Everyone.
Everyday. Always.

THE PRESIDENT'S HEALTH CARE REFORM:
Understanding What It Means For You and Your Family

I. Introduction: The Health Care Crisis

II. A Vision of Health Security

1. Guaranteed private insurance for everyone

2. Choice of doctor and health plan

3. Outlawing unfair insurance practices

4. Protection of Medicare

5. Health benefits guaranteed at work

III. Conclusion: The President's Reform Works For You

Introduction: The Health Care Crisis

1. They say there's no crisis, but they're wrong.

   A. Even if you have good insurance today, you can lose it tomorrow.

      2 million Americans a month lose their insurance.

   B. You're getting cheated by insurance company fine print.

      81 million Americans have "pre-existing conditions" that insurers use to raise rates or deny coverage. 3 out of 4 insurance policies have lifetime limits that cut off benefits when you need them most.

   C. You're paying more and getting less. And your choices are declining.

2. The insurance companies don't like the President's reform. But the President didn't design his reform for the insurance companies -- he designed it for you.

3. So don't let the insurance companies tell you what to think. I'm here to tell you how the President's reform will protect you and your family from a future of being squeezed -- getting lower-quality care, fewer choices and higher bills.

4. The bottom line is this: the President wants to strengthen what's right about our health care system and fix what's wrong in order to guarantee private insurance to every American.

A VISION OF HEALTH SECURITY

Here's how the President's health reform will work.

1. **Guaranteed private insurance.**

The President's proposal will guarantee every American private health insurance. Comprehensive coverage that can never be taken away.

Everyone will get a Health Security card that will guarantee:

- Benefits as good as what America's biggest companies offer and what members of Congress get. Your benefits will include prescription drugs and preventive care -- things often not covered today.

- Protection against the devastating costs of serious illness. That means a low deductible and absolutely no lifetime limits on your benefits.

Contrast:
America faces 3 choices:
- government insurance for everybody
- leaving people without insurance
- guaranteed private insurance

The President has told the Congress he will veto a bill which doesn't cover everybody because it's not real reform.

2. **Choice of doctor and health plan.**

You will:

- choose your doctor
  and
- choose your health plan.

We want to make sure you get high-quality care by giving you the choice, not your boss or insurance company.

With your Health Security card, you'll be able to follow your doctor to any plan you choose:

- a plan where you can see any doctor in your community -- they call these "fee for service" plans
- a network of doctors and hospitals
- or an HMO

We're against forcing people into HMOs.

Contrast:
If we do nothing, more and more employers will try to cut costs by limiting your choice of plan and doctor.

3. **Outlawing unfair insurance practices.**

We need a system of coverage that guarantees affordable insurance people can depend on.

That's why the President's reform makes sure that insurance companies don't boost premiums faster than your wages go up.

It will also be illegal for insurance companies to:

1) increase your rates if you get sick
2) drop your coverage
3) use "lifetime limits" to cut off your benefits
4) charge older people more than younger people
5) take away your benefits
6) use more than one standard claims form

That's why the insurance companies have spent over $14 million on advertising to scare the American people and block the President's plan -- but you know, the President designed this plan for the American people, not the insurance companies.

Contrast:
You will continue to be at the mercy of the insurance companies -- which means they could raise your premiums unreasonably, increase your rates or drop your coverage when you get sick, take away your benefits or charge you more if you're older or have a "preexisting condition."

You will continue to pay more and get less.

4. **Protection of Medicare.**

The President believes very strongly that health reform must be good for older Americans. That's why his proposal preserves and protects Medicare.

The American Association of Retired Persons (AARP) says that the President's approach is the "best option for senior citizens."

Older Americans will have:

- the right to choose their doctor
- new prescription drug coverage
- some long term care protection

Contrast:
The President wants to make sure that every penny of Medicare money is used for seniors.
But others want to take Medicare money away from seniors.

5. **Health benefits guaranteed at work.** We want everyone who works to get health insurance at work, with employers and employees both paying part of the cost.

This is the best way to make sure everyone has coverage because:

- That's where nine out of ten Americans with private insurance get it today.

- Eight out of ten people without insurance are in working families.

Small businesses will get discounted insurance. And the government will help older Americans, the unemployed and people between jobs. It's not right that people who leave welfare for work are often forced to give up their benefits.

If you're working, your employer and you will share the costs. Your employer will pay at least 80% of the premium. You'll pay the rest.

Contrast:
Others want to encourage your boss to cut back your benefits and put the burden solely on your family.

III. Conclusion: The President's Reform Works For You

1. So that's how the President's reform works.

- Guaranteed private insurance.
- You choose your doctor and health plan -- not your boss or insurance company.
- Outlawing unfair insurance practices.
- Protection of Medicare.
- Health benefits guaranteed at work.

Now it's up to us to stand with the President against the special interests.

2. The President's reform works for you and your doctor. That's why the people on the front lines -- America's largest associations of nurses, family physicians, pediatricians and pharmacists -- support it and believe it will work.

3) Opponents will try to confuse the issue by making it seem more complicated, but it's really pretty simple:

- If the President's reform passes, you'll know this: You'll get a Health Security card which guarantees you that you can pick any doctor you want, fill out one form, and you're covered.

4) This is the right thing to do, and with your help, it's going to happen this year.

OUTSTANDING ISSUES--STATUS

Maintaining current coverage

Individual deduction--Mainstream has agreed to drop

Allowing subsidy to go to employer--Need to get more information from CBO.

Real Insurance Reform

Association plans--Mitchell will package together reducing the size of community-rated pool from 500 to 100 and dropping risk-adjustment from large employers to pool in return for tight controls on association plans.

FEHBP--Mitchell has proposed "cash and carry" option.

State flexibility--Remains difficult. Mitchell trying to reach an agreement with multi-state employers in order to isolate Durenberger.

Seniors--Unresolved. Likely compromise would drop prescription drug coverage, provide MItchell level for home care, without means test, and reduce overall Medicare cuts level.

Public health--Mainstream group has largely accepted Mitchell (Kennedy) language. Likely will be an agreement on mandatory funding at a lower level than Mitchell.

GME. Mainstream group has agreed to drop DME cuts. Current proposal (expanded all-payer funding for IME, work-force commission) seems reasonable. Mitchell is resisting additional money without stronger workforce controls.

Benefits--Many issues remain. Staff level compromise seems possible.

DSH hospitals. Compromise that would target reduced funding level on hospitals most in need seems possible.

Essential Community Providers--Mitchell has proposed a compromise. Waiting for Mainstream response.

Malpractice--Mitchell still holding firm on no caps on damages.

Fail-safe--Mainstream seems willing to apply reductions to Medicare as well as subsidy program. Mitchell holding firm on excluding Medicare but interested in applies Medicare overage to deficit reduction as fall-back.

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Distribution

From: Chris Jennings

Date: September 15, 1994

Re: Mainstream Group Options

Attached is a copy of a memo provided to Senator Mitchell last night from the Mainstream Group Senators (Senators' Chafee, Durenberger, Breaux, Kerrey). This document summarizes outstanding issues which have yet to be resolved before any agreement can be contemplated. In addition to the substance enclosed, the Mainstream Group will continue to push for assurances that any final agreement will be protected to the absolute extent possible from process interventions (eg. joint conference, significant amendments, etc...) that, in their view, would undermined the agreement.

The staffs are meeting today to go over this list. Later this evening and tomorrow each side will develop and exchange the options they believe will narrow or eliminate the disagreements between the two camps. On Monday, they will meet again with the intention of either coming to a final agreement or deciding that the differences are too great.

Lastly, in the context of these negotiations, it remains possible that the modest interim package could still emerge, such as one concerning kids and other vulnerable populations, along with very modest insurance reforms. I received this document only after committing that it would not be distributed widely and circulated beyond those who absolutely must have it. Please protect my commitment by holding close to this.

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MEMORANDUM

TO: Mainstream Senators
FROM: Staff
RE: Status of Discussions with Representatives of the Majority Leader and the Republican Leader
DATE: September 13, 1994

The Mainstream staff worked through the recess and was available to representatives of both the Majority Leader and the Republican Leader. Mainstream staff has met with staff from the Majority Leader's offices and representatives of the Republican Leader in an attempt to resolve and identify differences between our proposals.

Progress

1. Representatives of the Republican Leader

There have been two official meetings at which both substance and process were discussed. We answered questions and expressed the desire of Mainstream members to develop a list of areas in agreement and disagreement. The Republican Leader's representatives indicated that they were in the process of developing such a list to give to the Republican Leader. Mainstream staff suggested the possibility of attempting to discuss such issues to see if staff could work some of them out before the return of the Members. The Republican Leader's representatives felt that would be beyond the authority they had been given. Every attempt has been made, and will continue to be made, to involve the Republican Leader in ongoing discussions and to be responsive to his concerns.

2. Representatives of the Majority Leader

We have made a great deal of progress--probably 85% of issues could be resolved if an overall agreement were reached. Among the 15% or so issues that remain outstanding, there are only a few that Members will absolutely have to work out among themselves.

Senator Mitchell has accepted the Mainstream's position on a number of important issues, for example:

- o Agreement to work off of the language drafted by the Mainstream.

- o Willingness to negotiate on a "tax cap" as applied to large businesses, and abandonment of the notion of a tax on high cost plans which included a baseline set by the federal government.

- o Dropping his triggered employer mandate, his cost commission report (accompanied by expedited legislative procedures), and his new private right of action for potential civil rights violations.

- o Indication of some flexibility on issues related to the threshold for community rating/self-insuring.

Attached is a list of issues that remain outstanding, divided into two categories: (1) those that must be resolved by Members, and (2) those that staff could work out with some guidance from our respective Senators. On issues in both categories, Mainstream staff have had internal discussions to determine whether any possible compromises might exist.

ISSUES THAT MEMBERS MUST RESOLVE:

Issue: Individual deduction

Mainstream Position: The Mainstream proposal provides for an eventual 100% deduction for the self-employed and for individuals whose employers do not provide health insurance.

Mitchell Position: The Mitchell bill contains only a 50% deduction for the self-employed and no deduction for individuals.

Comments: Although fairness may dictate the need for the individual deduction in addition to the deduction for the self-employed, CBO and Joint Tax agree that the cost of the individual deduction is not justified by any real increase in coverage. They also have pointed out that, while the individual deduction will effectively do nothing to expand coverage, its likely real world effect would be to encourage employers to drop employees from company health plans. The cost of the individual deduction in the Mainstream bill is approximately 70% of the total estimated $29 billion over ten years for both deductions.

Issue: Risk Adjustment

Mainstream Position: The Mainstream proposal does not risk adjust from the experience-rated pool to the community-rated pool.

Mitchell Position: The Mitchell bill risk adjusts from the experience-rated pool to the community-rated pool.

Comments: It has been the Mainstream's position that a risk adjustment of this kind constitutes a hidden tax on large employer plans. This remains an essentially "either-or" proposition.

Issue: State Flexibility

Mainstream Position: For the sake of national uniformity, the Mainstream proposal would not allow states to implement state-level reforms either (1) ahead of the time frame in federal reform legislation or (2) that would affect ERISA plans. However, the Mainstream agreement retains current ERISA waivers for Maryland and Hawaii, and allows states to set up single payer systems with a carve-out for large multi-state employers (1,000 or more employees).

Mitchell Position: Mitchell wants to allow (1) and (2), and wants to allow states to impose additional or different requirements than those imposed by federal reform legislation. Specifically, Mitchell's bill grants waivers to certain states (Maryland, Hawaii and New York) to tax self-insured plans, impose employer mandates, and/or continue all payer hospital reimbursement systems. Also, it allows States to set up single payer systems without a carve-out for large employers and allows "Fast-Track" states to implement federal uniform standards in advance of their effective dates.

Comments: While the Mainstream and Mitchell approach agree on the grandfathering in of certain existing ERISA and Medicaid waivers and expanding both the Hawaii and Maryland waiver, there is still disagreement on the New York waiver, the "Fast-Track" states, and the single payer opt out for large companies.

Issue: Medicare Outpatient Prescription Drug Benefit

Mainstream Position: The Mainstream is opposed to a new non-means-tested entitlement but gives seniors access to certified health plans which would provide prescription drugs.

Mitchell Position: The Mitchell bill includes a new benefit under Medicare to cover prescription drugs.

Issue: Fail-Safe

Mainstream Position: The Mainstream bill provides for reductions in new spending programs enacted as part of health care reform to offset any unanticipated growth in total federal health spending, including Medicare. The bill requires that if Medicare spending causes the fail-safe to be triggered, the President must send a proposal to Congress that would reduce Medicare spending thereby preventing the fail-safe from being triggered. If such legislation is not enacted, the new reform programs would be sequestered.

Mitchell Position: The Mitchell bill prevents unanticipated growth in Medicare from triggering a subsidy cut, and therefore excludes Medicare spending from the current health spending baseline.

Issue: Malpractice

Mainstream Position: The Mainstream bill contains a $250,000 cap on non-economic damages.

Mitchell Position: The Mitchell bill does not contain a cap on non-economic damages.

Comments: Mitchell may also have some concerns about (1) mandatory fee shifting (English rule) in ADR cases and (2) Mainstream's provisions on several liability.

☎

ISSUES WHICH STAFF CAN RESOLVE WITH SOME GUIDANCE:

Issue: Limit on Tax Deductibility and Employer Deductions/Employee Exclusion for Cost-Sharing Supplementals

Mainstream Position:
(1) The Mainstream bill contains a dual formula for calculating the limit on deductibility for experience-rated plans, under which an experience-rated employer can choose a limit of either 110% of the average premium for community-rated plans in their area, or the level of that company's actual spending in 1997 not increased for growth.

(2) Mainstream would not allow an employer deduction or individual exclusion for supplementals that cover cost sharing under the standard plan (first dollar coverage) beginning in the year 2000.

Mitchell Position:
(1) Mitchell would like to change the formula that determines level of deductibility for experience-rated plans.

(2) Mitchell does not contain the provision which eliminates the deductibility and excludability of cost sharing supplemental plans.

Comments: Mitchell's staff has indicated a willingness to negotiate on the issue of the limit on deductibility for experience-rated plans. ~~and they have already agreed to the limit on deductibility for community-rated plans.~~

Issue: Insurance Reform

Mainstream Position:
(1) The Mainstream proposal limits community-rating to firms with fewer than 100 workers.

(2) The Mainstream proposal allows existing association plans to continue selling experience-rated and self-insured plans to their members, but does not allow new plans to develop.

(3) The Mainstream bill contains a provision that would allow large (over 100,000) purchasing cooperatives that serve public employees to continue offering experience-rated plans.

Mitchell Position:
(1) The Mitchell bill limits community-rating to firms with fewer than 500 workers.

(2) The Mitchell bill would effectively eliminate association plans with the exception of Taft-Hartley plans, rural electric cooperative plans and certain church plans.

(3) The Mitchell bill would not allow large purchasing cooperatives that serve public employees to continue offering experience-rated plans.

Comments: Staff has been considering some options that may lead to an agreement on these issues. The underlying issues require a balancing between the continued existence of current purchasing arrangements and the protection of the community-rated pools.

Home and Community-Based Long Term Care Benefit.

Mainstream Position: The Mainstream bill funds this capped entitlement to states at $10 billion over ten years.

Mitchell Position: The Mitchell bill funds this program at $47 billion over ten years.

Comments: Differences also remain in the level of income-related cost-sharing that would be required of beneficiaries. Mitchell favors a 50% cost share at 400% of poverty while the Mainstream favor a 100% cost share at a lower level of poverty.

Issue: Underserved/Public Health

Mainstream Position: The Mainstream bill does not include any mandatory spending for public health programs or programs to assist underserved populations.

Mitchell Position: The Mitchell bill provides for direct (mandatory) funding for a series of programs devoted to underserved populations and public health functions. The amount of direct funding that Mitchell ultimately wants is negotiable, but Mitchell's staff want some mandatory outlays for underserved programs (network development, enabling services, and capital), school based clinics, the National Health Service Corps, essential public health activities, the community based scholarship program, and additional funding for WIC.

Comment: The Mitchell bill originally contained $37 billion in mandatory funding; they have communicated they may be willing to accept significantly less.

Issue: Benefit Package / Role of the Health Board

Mainstream Position: The Mainstream bill contains three defined benefit packages and it provides more flexibility with regard to the nature of particular covered items and services within the nationally defined categories. The Board would define the limitations on specific items and services and would set cost-sharing for the benefit packages.

Mitchell Position: The Mitchell bill contains two defined benefit packages and it would have the Commission specifically define all covered items and services, and cost sharing. After the initial packages were defined, the Board would be able to change cost-sharing and covered items and services without Congressional approval.

Issue: Workforce / Graduate Medical Education

Mainstream Position: The Mainstream proposal does not include a specific workforce requirement, but would set up a commission to report on workforce reform (a proposal would come to Congress under expedited legislative procedures).

Mitchell Position: Mitchell wants to impose a national "workforce" goal of 55% primary care physicians to 45% specialty physicians and target new federal spending to the achievement of this goal.

Comments: Differences also remain in the amount of funding that would be raised through a new "all-payer" tax on health plans, but it is not clear if this is a major concern of Mitchell's.

Federal Employees Health Benefits Program (FEHBP).

Mainstream Position: The Mainstream proposal requires all locally-offered plans that participate in FEHBP to offer themselves to the community-rated market.

Mitchell Position: Mitchell would (1) require that all employers offer FEHBP to their employees and (2) blend the community rate and federal employee rate over time.

Comments: Mitchell's staff has suggested the following compromise: adding a "cash and carry" provision that would allow all employees of community-rated employers to choose an FEHBP plan and retain their employers' contribution.

Issue: Outcomes and Quality Research

Mainstream Position: The Mainstream bill would not devote part of its all-payer tax (.6%) for graduate medical education to increase funding for the Agency for Health Care Policy and Research.

Mitchell Position: Mitchell would devote a part of his 1.75% all-payer tax on premiums to increase funding for the Agency for Health Care Policy and Research. AHCPR is currently funded through discretionary appropriations and the Medicare trust fund.

Issue: Plans and HIPCs

Mainstream Position: Under the Mainstream bill, plans are not required to offer themselves to all HIPCs in the area, but all plans will be listed, comparative information will be available and individuals will be able to enroll in plans at a state designated site.

Mitchell Position: The Mitchell bill requires all health insurance plans to be offered through a HIPC, although there is no requirement for individuals to purchase through a HIPC.