

REGULATORY REFORM

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MEMORANDUM

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TO: Distribution
FR: Chris Jennings *WJ*
RE: **Impending Health Reform Bill Introduction by Senator Daschle**
cc: Carol Rasco, Bob Rubin

January 2, 1995

On Wednesday, January 4th, Senate Democratic Leader Daschle will introduce a health reform bill as part of his Leadership legislative package (S. 6-10). His bill, **the Family Health Access and Affordability Act**, *Insurance Protection* has not yet been finalized. However, it seems clear that its insurance reforms, kids and unemployed subsidies, and 100 percent tax deduction for the self-employed will fit within the "first steps" vision the President outlined in his December 27th letter to the Congressional Leadership.

Senator Daschle's staff report that the Senator is introducing this bill "to send a signal that Democrats do not intend to retreat from their commitment to reforming the health system." The health reform initiative will be purposely small in size (probably around 100 pages) and scope (probably just 4 titles). **It will be a Daschle, not an Administration, bill.**

Senator Daschle intends to challenge the Republicans to act immediately on his bill. He will suggest there should be broad, bipartisan consensus on this bill, since most of the provisions can be found in both Republican and Democrat proposals from the previous Congress. Senator Daschle will apparently call on Republicans to pass this "downpayment" bill within the first 100 days of the 104th Congress and then invite them to hammer out agreements on the more contentious issues that he will say must still be addressed.

As of now, in order to keep his options open and to protect the Democratic "Medicare edge," Senator Daschle's bill will NOT include a specific financing package.

Attached is a 2-page summary of the major provisions of the Senate Democratic Leader's bill. One provision worth noting that is NOT in the summary states: "Nothing in this Act shall be construed as prohibiting States from enacting health care reform measures that exceed the measures established under this Act..." Senator Daschle will get more specific later, but this one provision raises many questions, including but not limited to the touchy ERISA issue.

There is no doubt that the press and the Hill will be asking Administration representatives questions about how we feel about the Daschle bill. Some reporters may suggest that the new Leader is preempting the President, much like they said Gephardt did with his tax cut press conference. We will need to come up with a common set of talking points/Q's&A's. Laurie McHugh is working on such a draft that we plan on circulating tomorrow. If you have any questions, please call Jennifer Klein (6-2599) or me (6-5560).

THE FAMILY HEALTH ACCESS AND AFFORDABILITY ACT

I. INSURANCE REFORMS include:

- * **Guaranteed Issue and Renewability for Small Businesses and Individuals:** Insurers would be prohibited from turning down any small business (that has 1-50 employees) or individual who wishes to buy or renew insurance.
- * **Experience Rating Phased Out for Small Business (1-50 Employees) and Individuals:** Insurers would be prohibited from charging sick people more than healthy people (this prohibition would be phased in over 3 years), although premiums could vary by age, family type, and geography.
- * **Portability:** Would prohibit use of pre-existing condition exclusions for those changing insurance (usually through job switches) and would severely limit such exclusions for those newly purchasing insurance; (this reform would be applied to all plans, including self-insured plans offered by large business).
- * **Lifetime Limits Prohibition:** Would prohibit lifetime limits on benefits for both insured and self-insured plans, although limits on the scope and durations of particular services are permitted.
- * **Standards for Quality Assurance and Consumer Protection.** Would require that HHS Secretary establish minimum guidelines for states to implement; (these would include such things as quality/consumer satisfaction report cards.)
- * **Grants to States to Establish Purchasing Cooperatives.**
- * **Establishment of Health Care Cost and Access Advisory Commission.**

These reforms, like any insurance reforms, would result in losers as well as winners. For example, the attempt to provide desirable protections to the individual market as well as the group market is likely to raise premiums for small businesses. This disruption and/or fear of this disruption can be expected to attract opposition from small businesses and the insurance industry -- although the Dole bill had similar provisions last year. (This disruption could be minimized if the higher cost of insuring individual purchasers were spread to larger businesses as well, albeit with significant opposition from this influential community. Alternatively, the individual market could be dropped from the reforms altogether.)

II. EXPANDED COVERAGE and ASSISTANCE TO SMALL BUSINESS:

- * **Insurance for Children** would be provided through subsidies on a sliding scale basis up to 240 percent of poverty (\$35,500 for a family of four); the subsidy would be linked to the value of a standard FEHBP Blue Cross benefit package.

- * **Insurance for the Temporarily Unemployed** would be provided for six months for those who had lost their insurance when they became unemployed; the benefit would be provided through subsidies on a sliding scale basis up to 240 percent of poverty and, like the kids subsidy, would be linked to the value of a standard FEHBP Blue Cross benefit package.
- * **Self-Employed Tax Credit** would be reinstated to assist small businesspersons to purchase health insurance; the credit would be phased up to 100 percent by 1999.

The combination of these subsidies would expand coverage significantly for politically appealing populations of Americans. The kids benefit, however, would encourage some employers to drop dependent coverage (particularly for low income workers) under the assumption that these employees' children could qualify for subsidies for their children. (The dropping problem could be mitigated by lowering the thresholds for subsidy eligibility and prohibiting employers from discriminating against low income workers.)

III. **QUALITY AND CONSUMER PROTECTION: ADMINISTRATIVE SIMPLIFICATION, FRAUD AND ABUSE, and MALPRACTICE REFORM**

- * **Administrative Simplification** would be achieved by adoption of HHS guidelines to standardize health care financial and administrative transactions.
- * **Privacy Protections** assured through establishment of rules for provider and health plan access to medical data that ensures patient confidentiality.
- * **Fraud and Abuse Prevention** would be improved through establishment of a joint HHS–Justice Department health care fraud & abuse prevention program.
- * **Medical Malpractice Reform** would be achieved through limits on attorney contingency fees, periodic payment of awards, allocation of punitive damage awards to help fund efforts to improve quality of care, and through the use of state-based alternative dispute resolution systems.

Virtually all of these provisions were included, in some respect, in the Health Security Act, the Mitchell bill, the Mainstream bill, and the Dole bill. The Republican initiatives went further in their medical malpractice provisions, however (e.g., caps on damage awards).

IV. **IMPROVING ACCESS TO RURAL HEALTH CARE**

- * **Higher Profile/Priority for Rural Health** would be secured through establishment of Assistant Secretary for Rural Health within HHS and through grants for rural telemedicine and other innovations.
- * **Additional Anti-Trust Clarification** would be required to be provided from Justice Dept. and FTC for safe harbors for rural providers.

THE WHITE HOUSE

WASHINGTON

December 27, 1994

Dear Newt:

While we could not achieve broad-based agreement on a health reform initiative last year, there can be little disagreement that we still face the enormous problems of increasing health care costs and decreasing coverage. We need to confront these problems on a bipartisan basis and address the insecurities that too many Americans have about their health care. I am writing to reiterate my strong desire to work with you in this regard.

I remain firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses, and Federal, State, and local governments. In the upcoming session of Congress, we can and should work together to take the first steps toward achieving these goals. We can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term Federal deficit.

We look forward to talking with you in the upcoming weeks about a bipartisan effort to deliver health care reform to the American public. Hillary and I send our best wishes for a safe and happy holiday season.

Sincerely,



The Honorable Newt Gingrich
House of Representatives
Washington, D.C. 20515

Melanne -

FYI.

Jen

THE WHITE HOUSE

WASHINGTON

December 27, 1994

Dear Tom:

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Sincerely,

A handwritten signature in cursive script, appearing to read "Bill Clinton".

The Honorable Thomas A. Daschle
United States Senate
Washington, D.C. 20510

THE WHITE HOUSE

WASHINGTON

December 27, 1994

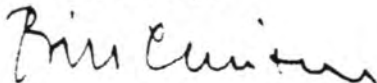
Dear Bob:

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The Honorable Robert Dole
United States Senate
Washington, D.C. 20510

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WASHINGTON

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Sincerely,

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The Honorable Richard A. Gephardt
House of Representatives
Washington, D.C. 20515

Business will spearhead Health Reform II

Old enemies of Clinton's plan in lead

By Hank Cox
THE WASHINGTON TIMES

President Clinton's health care plan may have died last year, but that doesn't mean reform is dead.

In fact, a number of free-market reforms that would have been considered radical only a few years ago are going to be actively promoted to the new Republican-led Congress. And, ironically, some of the toughest lobbyists for reform will be the same groups that blocked the Clinton plan.

The pressure for reform will come from business. The key issue is still the rising cost of medical care. Although the cost of care rose only 7.8 percent in 1993, the third-lowest increase in the last 33 years, it still was well above the rate of inflation.

As the nation's primary purchaser of health insurance, business feels the burden most keenly. A typical company spends an amount equal to half of its annual earnings on health insurance for employees and retirees. Many employers, especially smaller ones, cannot afford the cost.

Meanwhile, the number of citizens without health insurance continues to increase, workers still cannot take health insurance from one job to another and people with pre-existing conditions often cannot get insurance.

Simultaneously, a trend of increasing state involvement in health care confronts multistate employers and insurers with an administrative nightmare of conflicting state requirements, creating demand for a federal program to pre-empt the states.

At least 34 states now require insurers to accept any small group that applies for coverage, and 17 states prohibit wide variations in premiums linked to age or health status. Though some insurers accept these requirements, there is more resistance to laws enacted in at least 25 states that are deemed obstacles to managed care.

But the big problem lies with a few states, such as Washington, Oregon, Minnesota, Massachusetts, Connecticut, Florida and Hawaii, which either have adopted or are considering more far-reaching health plans. Currently, they are blocked from imposing comprehensive statewide health schemes

by the federal Employment Retirement Income Security Act, or ERISA, which exempts self-insurers, who cover 50 percent to 60 percent of all workers, from state regulation.

To achieve economy of scale, the states need to cover everyone, and several of them are pressing Congress for waivers from ERISA.

The prospect of increased state activity in health care alarms many, especially multistate corporations and insurers. And yet, despite the magnitude of the health care dilemma, an overwhelming consensus in favor of reform and a strong prejudice in favor of federal pre-emption, the Clinton administration bungled health care reform into a political disaster for itself and the Democrats.

It didn't have to be that way. Mr. Clinton's impassioned plea for health care reform before a joint session of Congress on Sept. 22, 1993, fell on receptive ears. According to a subsequent Gallup Poll, 56 percent of the American people supported the president's plan, while only 24 percent opposed it.

Whose plan is it?

But that support began to evaporate two months later when the public finally got a look at the plan. Part of the problem was that, from the outset, health care reform had been the first lady's pet project, not the president's, and Hillary Rodham Clinton was determined to launch a comprehensive nationwide health reform plan covering everyone.

Aided by Ira Magaziner, the White House's chief adviser on health care, the first lady convened an ad hoc task force of 500 policy advisers who met privately to plot a revolution in health care. But the secrecy alarmed business — any universal health coverage scheme clearly would be expensive, and there was a widespread presumption that whatever plan emerged would saddle businesses with the tab.

Occasionally, Mr. Magaziner emerged from the Old Executive Office Building to allay business anxiety. "We met with them several times, and Magaziner assured us the problems would be worked out," says Sharon Canner of the National Association of Manufacturers (NAM). "But it never happened."

For her part, the first lady only aggravated the business community's concerns. She dismissed

questions about the impact on small businesses, saying she could not accept responsibility for "every underfunded entrepreneur in America."

When the 1,364-page Clinton blueprint finally appeared, it looked like a cross between a Soviet five-year plan and an engineering schematic for the Trident nuclear submarine. It was, says Mike Russell of the Christian Coalition, "a byzantine nightmare of layer upon layer of government bureaucracy."

An extraordinary alliance of business, insurance and conservative groups coalesced to block the administration's plan. Between the appearance of the plan in November 1993 and the elections a year later, these groups energized grass-roots action on a level rarely seen, if ever.

The Clinton administration, recognizing the threat of business opposition to its health care initiative, tried to buy off large corporations, many of which must pay health costs of large groups of retirees.

"Early on they offered a federal takeover of health care costs for retirees as a sweetener," says NAM's Ms. Canner. "But as the thing progressed and we saw other parts of the plan, any support among our members evaporated."

"We have had a task force working on this for three years," says Johanna Schneider of the Business Roundtable, which speaks for 220 of the nation's largest corporations. "We want reform, but like most groups we want to see it built on the existing system. We have established principles for reform and the Clinton plan did not meet them."

After consulting its membership, the U.S. Chamber of Commerce added its opposition. More than 40,000 of its 220,000 members replied to a chamber survey, an extraordinary response reflecting the deep business concern about health reform.

"Their message was clear, direct and unequivocal," says chamber President Richard Leshner. "They said, no bureaucracy, no mandates and no hurry." Mobilizing its Grassroots Action Information Network and its more than 3,000 state and local affiliated chambers, the chamber launched an aggressive campaign to kill the Clinton plan.

Forming a coalition

Equally energized were the 618,000 members of the National Federation of Independent Business Inc. "It was the biggest issue for our members in decades," says NFIB's Mark Isakowitz. "They became very engaged. Many responded to our action calls several times over. It was really quite extraordinary."

NFIB, the U.S. Chamber of Commerce, NAM, the Business Roundtable and about 30 other groups opposed to the Clinton plan formed an ad hoc Coalition for Jobs and Health Care, which

GOP's Barbour gets bipartisan praise

By Ralph Z. Hallow
THE WASHINGTON TIMES

A1

Put excitement into listless party

Democrats searching for a new party chairman have found a leadership model in none other than the Republicans' Haley Barbour, who contributed far more to their election defeat than would be expected from a party executive.

"He is one of the best chairmen the Republicans ever had," Democratic campaign consultant Mark Mellman says. "He understands message and campaign, and he knows when to take risks and he did take risks."

"He went out and borrowed some money. And he put it to good use, I'm sorry to say," Mr. Mellman

adds.

When Mr. Barbour won election on the third ballot in a five-way race for chairman in January 1993, few in either party had great expectations for him. But at 47, he has demonstrated an ability to go beyond the traditional grip-and-grin role of chief fund-raiser and occasional mouthpiece for the party line.

As a result, veteran professionals in both parties say, the affable, slightly chubby GOP chairman worked on several fronts to help his party win both houses of Congress, 30 governorships, 24 state

senates and 25 state houses in the Nov. 8 elections.

Political professionals agree that party chairmen aren't by nature or job description risk-takers. Yet Mr. Barbour dived into the middle of fractious party disputes over policy and strategy.

On hot issues like health care and crime, fellow Republicans and admiring Democrats say he played the honest broker among competing GOP factions and elected power-weilders like Bob Dole and Phil Gramm in the Senate and Newt Gingrich and Dick Armey in the House. He managed

the role without any visible antagonisms.

Says Don Sweitzer, former political director for the Democratic National Committee: "We had our own frictions when Tom Foley was speaker and George Mitchell was Senate majority leader. From time to time they thought they were the party spokesmen. Yet I don't recall hearing Haley got his wrists slapped by Dole or [House Minority Leader Bob] Michel or Gingrich."

"That's one thing that has made Haley a great chairman — he fits into the leadership structure," says

see BARBOUR, page A10

BARBOUR

From page A1

David Wilhelm, who resigned as Democratic national chairman after the elections.

Most agree that Mr. Barbour made his mark on three fronts: message, messenger, money.

First came the message. Mr. Barbour set out from the day of his election to reverse the image the GOP had acquired in the years of the Bush presidency: standing for nothing very much different from what the Democratic Party stood for.

He announced that the GOP would have to be the party of ideas once again and that it was the conservative party in America.

"The first thing he did was encourage us to be partisan enough to define ourselves — to be different enough from the Democrats," says retiring Sen. Malcolm Wallop, Wyoming Republican. "He persuaded us not to compromise the successes we had gained on health care."

"Most important is that Haley has been able to portray the ideological distinctions between Republicans and Democrats," Mr. Wallops says.

But it's Democrats who are the

first to acknowledge in Mr. Barbour the messenger and message combined with near perfection.

"When you consider what happened to Republicans in '92, losing the White House for the first time in 12 years and again failing to take the House and Senate, '92 was a major setback," Mr. Mellman says. "He did a great job of very quickly reinvigorating the party and not letting Republicans wander around listlessly contemplating their disgrace."

"He got some level of excitement in a party that should have been very dispirited. Very quickly they had energy and enthusiasm again, because of Barbour," Mr. Mellman says.

Operatives in both parties say Mr. Barbour's ability as messenger lay in a disarming folksiness. He would cut a Democratic opponent's ideas down without making it personal, even as the bitterness of this year's campaigns approached epic proportions.

"We'd appear on TV shows together, and over time, my respect for him grew. I hope his respect for me did, too," Mr. Wilhelm says.

"Barbour mopped the floor with Wilhelm and [Tony] Coelho," says Ed Gillespie, policy director for House Majority Leader-elect Dick Armey.

Tony Coelho, the Democrats' designated hitter on the talk-show circuit during the campaign, acknowledges the concern with which he and his fellow Democrats approached a forensic outing with the GOP chairman.

"It became a major issue for us as to who was going to go on [television] with Haley, because he was that effective," Mr. Coelho recalls.

Mr. Schweitzer notes, "I appeared opposite him on radio and watched him on TV every time he went head to head with Wilhelm and others. He's good. He made his case directly and in a folksy manner — his phrases like 'running away like a scalded dog' were catchy."

Mr. Wilhelm also believes the key to being a successful national party chairman is the "ability to organize issues that have a relevance to the grass roots." He credits Mr. Barbour with having done that through his adroit use of television shows produced by the RNC.

He also credits the GOP chairman with tireless travels "to meet with state party chairmen and to solicit input from grass-roots activists on public policy issues through his national policy forums he instituted."

Some Republicans initially

greeted with skepticism, even suspicion, the Barbour idea of sending traveling teams of Republicans around the country to hold town meeting-style sessions with local GOP activists and supporters of Ross Perot to discuss crime, health care and many other issues.

But they concluded that he was not trying to use the national forums to sneak his own ideas into a premature rewriting of the GOP platform but rather to rekindle the loyalty of GCI voters and win over — or back — the Perot voters for the 1994 elections. Even Democrats came to admit it worked.

"That's another thing that made him great — he pays attention to the grass roots of the party," Mr. Wilhelm says. "He cares about building a party at the grass-roots level. He devotes resources to it. I respect him for that."

Mr. Barbour also managed to keep united the disparate elements in the GOP coalition of pro and anti forces on such issues as abortion and gun control.

"They had some very difficult intraconservative challenges to deal with," Mr. Mellman says. "How do you hold the Wall Street and Christian Coalition factions together? The small number of pro-choice and the very large number of pro-lifers hold together? Haley

did a good job of keeping the lid on what is by its nature a pretty fractured coalition."

When it gradually dawned on Republicans that they had the makings of a historic rout of the opposition but not enough money to fuel it, Mr. Barbour decided to put the RNC in debt and traveled the country raising more money.

"Republicans had more competitive races than ever before and not enough money," says Mr. Wallop. "It was hard to persuade contributors to give to Republicans when the Democrats had both houses and the White House. He persuaded them it was worth the gamble."

"The RNC borrowed \$5 million from Signet bank," Mr. Barbour recalls. "I said when the dice are hot, you got to bet the ranch. Turned out we were right. You could not with a good conscience let candidates miss their opportunities because the party couldn't carry its financial share."

At the same time, Mr. Barbour propped up a weak-sister campaign committee for House candidates — the National Republican Congressional Committee. "He pulled us out of the fire when we were in trouble," NRCC Communications Director Dan Leonard recalls. "And when we got our

feet back on the ground, we worked as equal partners in the congressional elections."

"The RNC put \$5.2 million directly into House races — hard cash out the door," says RNC Executive Director Scott Reed. "It was the first time the national committee ever spent anything like that on House races."

"In the past this committee [NRCC] has gone it alone on House races," Mr. Leonard says. "We couldn't have had the year we had without a coordinated effort by the RNC and us."

But the ability to sweep the board on Nov. 8 would take more than borrowing from a bank.

"Haley recognized in June or July that we would need more money," Mr. Reed says. "He got Dole and Gingrich committed to set up a national finance committee which had the three of them flying around raising more than \$9.5 million, which allowed the RNC to supplement all its campaign operations."

The Dole-Gingrich-Barbour committee had up to 18 meetings around the country with groups of chief executive officers.

"We contributed to every one of the 73 [GOP] challenger and open-seat candidates who won," Mr. Barbour said.

TUESDAY, DECEMBER 27, 1994 The Washington Times

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Part of the problem was that, from the outset, health care reform had been the first lady's pet project, not the president's, and Hillary Rodham Clinton was determined to launch a comprehensive nationwide health reform plan covering everyone.

pooled resources for ads and coordinated activities.

One of the most aggressive critics of the Clinton plan was the Health Insurance Association of America (HIAA), whose "Harry and Louise" commercials depicted a middle-class couple discussing the horrors of a vast health bureaucracy limiting options and choices. HIAA spent about \$17 million to inspire public opposition to the Clinton plan, airing "Harry and Louise" in a dozen markets reaching 40 percent of the population.

Then President Clinton and the first lady complained about "Harry and Louise," making them a major media event. HIAA head Bill Gradison credits the Clintons with making the ads even more effective.

"Harry and Louise are still under contract and may reappear if their services are needed again," Mr. Gradison says.

The health care reform debate brought to the fore some lesser-known groups, including Citizens for a Sound Economy, Berman & Co. and the Christian Coalition, that seized the opportunity to enhance their stature as up-and-coming powers to be reckoned with.

Ambushed on the road

Citizens for a Sound Economy, or CSE, has been around for 10 years, but was only one of many think tanks until health reform came along. It invested \$5 million in a media campaign to turn public opinion against the Clinton plan, producing a steady stream of economic analyses and ideological critiques, backed by radio and print ads. "We are advocates of free enterprise and enemies of big government," says CSE's Brent Bahler.

The bus caravan that crossed the country in early summer seeking public support for the administration's plan was ambushed by CSE. "We successfully redefined the Health Security Express as the Phony Express, and shocked its sponsors, the White House and their allies by having far more opponents at their media events than they had supporters," says CSE's Carl Parks.

The government-relations firm Berman & Co. eagerly beat the drum in the hinterland among small-business people most likely to be adversely affected by health reform. Founder Rick Berman also manages the Employment Policies Institute, which contracts prominent economists and scholars to conduct research into labor issues.

The Clinton plan energized Berman & Co., which saw it as a threat to its clients. "Much of the debate

over health care reform hinged on potential loss of jobs, and that was driven by our research," Mr. Berman says. "We were the first out with solid numbers on that, and it quickly became the most easily understood downside of the Clinton plan."

In 1993, Mr. Berman already had enlisted presidents of corporations employing millions of entry-level workers to come to Washington and meet key members of the House Ways and Means and Energy and Commerce committees, along with the Senate Finance Committee. They also visited the leadership of both parties to explain the impact of employer mandates on their businesses. "When they opened their corporate books to show why the Clinton plan wouldn't work, a lot of eyes were opened," Mr. Berman says.

Deadly on Hill Democrats

If Berman & Co. made an impact disproportionate to its size, it can be attributed to the clarity of the threat to the economic interests of its clients. The same cannot be said of the Christian Coalition.

Founded by television evangelist Pat Robertson, the 1.5 million-member Christian Coalition now is completely independent, according to spokesman Mike Russell. "We take an active interest in any law or policy that would affect the family."

The coalition focused on three aspects of the Clinton plan that warranted its disapproval: tax-funded abortions, price controls and premium caps that would have led to rationing and the loss of jobs as forecast by CSE and Berman & Co.

"We spent \$1.4 million to fight President Clinton's plan," Mr. Russell says.

Like most of the players in this drama, the Christian Coalition supports reform of health care. "It was the increased government bureaucracy in the Clinton plan that we focused on mainly," Mr. Russell says. "But elements of our health care system need improving, no question about it."

In the waning days of the 103rd Congress, administration partisans tried desperately to ram through hastily designed alternatives to the Clinton plan, but to no avail. Clinton pollster Stan Greenberg found in a post-election survey that health reform loomed large in the minds of disgruntled voters. "It is impossible to overestimate the amount of damage the health care bill did in shaping the image of President Clinton as a big government proponent," says Al From, president of the Democratic Leadership Council.

"It is truly ironic," says Mr. Berman, "that in this crude effort to

impose a national health care plan on the nation, the administration brought down the Democratic majority and effectively killed any effort to expand government in our lifetime."

The irony of opposition

But what may be even more ironic is that in sacrificing the Democratic majority on the altar of health care reform, the administration has evoked a consensus for reform among the very groups that led the fight against its plan.

"The Christian Coalition supports reform of health care," says Mr. Russell. "People do not have to lose their house or car insurance because they change jobs, and they shouldn't have to lose their health insurance. Nor is it fair that people should not have access to insurance because of pre-existing conditions."

"The NFIB is not obstructionist," says Mr. Isakowitz. "To the contrary, the cost of health insurance is the No. 1 issue with our members. The problem is not going away and in fact is getting worse."

There is no question the system must be changed," says the U.S. Chamber of Commerce's Mr. Leshner. "But changes must be based upon the existing free-market system. There is a lot we can do within that context."

"A lot of learning has taken place over the last year," says NAM's Ms. Canner. "We are meeting with other business groups to discuss a pro-active agenda."

The changes most often advocated by members of the Coalition for Jobs and Health Care are insurance reforms to provide portability and coverage of people with pre-existing conditions; administrative reforms to reduce paperwork; legal reforms to reduce excessive malpractice expenses; pooling to permit small employers to obtain the same economics of scale available to large enterprises; and 100 percent deductibility of all health care and insurance expenses for the self-employed.

"These reforms would take a bite out of the apple, get the process started and help a lot," says Mr. Isakowitz.

"Health care requires action," adds HIAA's Mr. Gradison. "The Republicans would be making a big mistake if they do not act on it." Even the insurance industry supports potentially costly changes that would affect it directly, such as portability of health insurance for workers who change jobs.

"Once someone is in the system, they should be able to transfer to another plan," Mr. Gradison says. "But it must be written into law so that everyone is playing by the

same rules."

Mr. Gradison is more ambivalent about requiring insurers to accept people with pre-existing conditions. "It will raise rates," he says, "and encourage more businesses to drop out of the system. This is already happening in New York. The cost will have to be passed along to someone."

There is almost universal opposition to waivers from ERISA that would permit stepped-up activity by the states. "Multistate companies cannot deal with 50 different sets of rules and requirements," says the Business Roundtable's Ms. Schneider. "It would be a nightmare to administer."

Others in the insurance industry share the general business opposition to waivers. "Insurance companies and businesses active in many states need consistent laws and regulations to live by," says Gary Fendler, Aetna vice president for health plans. "ERISA is basic to that and must be protected."

Nemesis of the 104th

It is not clear at this juncture what effect, if any, broad Republican gains in state legislatures might have on the impetus for state activity in health care. On the one hand, Republicans tend to resist expansion of government power; on the other hand, Republican governors recently issued a challenge to Congress to cede greater autonomy and authority to the states.

Meanwhile, the Clinton administration is trying to expand state Medicaid plans to provide health insurance to the poor. "States already spend a quarter of their budgets on Medicaid," says CSE's Mr. Bahler. "They can't afford to pay more."

"There is a lot of pressure on Congress to do something," Mr. Gradison says. "We just released a poll showing the same plurality that opposed hasty action this year would be disappointed if the new Congress did not do something. In fact, that plurality put health care reform right up there with drug abuse and crime as top issues."

In a recent Kakwer Family Foundation/Harvard School of Public Health/KRC Election Night survey, voters rated health care reform as a top priority, along with crime, taxes and the deficit. They prefer health insurance run by private companies instead of the government by a margin of 55 percent to 24 percent. The voters made it clear they want modest reforms, and they want Congress, not the president, to take the lead.

The free-market reforms embraced by the Coalition for Jobs and Health Care would appear to satisfy that demand. "It may not seem very dramatic compared to what the administration had in mind," says Mr. Berman, "but by any objective standard, this consensus represents a major breakthrough that will go a long way to resolving our health care problems."

FEDERAL REPORT

Government's bad rap makes hiring good people difficult

By Ruth Larson
THE WASHINGTON TIMES

With last week's widely publicized calls for slashing the government work force, some officials fear it will be tougher to attract top-notch workers in the future.

Government is already viewed as an "employer of last resort" on college campuses, according to a recent General Accounting Office study conducted at 13 colleges.

"The public's attitude has been that government is the problem, not the solution. Why be part of the problem?" the GAO report quoted one graduate as saying.

Personnel specialists readily admit that the government has an image problem.

"The negative image of the federal government as an employer really hurts our recruiting," said John M. Palguta, deputy director of policy and evaluation at the Merit Systems Protection Board.

On Dec. 19 President Clinton announced \$24 billion in cuts to help pay for a middle-class tax cut. The cuts were aimed at the Departments of Energy, Transportation, and Housing and Urban Development, along with the Office of Personnel Management and the General Services Administration.

"Given everything the public's reading in the papers about government, it's very understandable for college graduates — or anyone — to be reluctant," Mr. Palguta said. "It doesn't sound like a place you'd want to work."

Mark Gable, spokesman for the Federal Managers Association, said, "One of the attractive features in the past was that [a government job] wasn't as lucrative as the private sector, but it was viewed as a 'safe' place to work. Now that's not the case."

"The salaries are miserably low," one recent graduate said in the report. "It makes me question the government's ability to hire qualified and bright personnel."

Len Klein, associate director for career entry at OPM, conceded the report "accurately reflects the feelings ... about federal employment" but said government service continues to attract top students.

TAKE THIS JOB AND . . .

A General Accounting Office survey of recent college graduates found that most see the federal government as an unattractive employer and believe the private sector offers better job opportunities. Results do not add up to 100 percent because non-responses were not counted.

Most important employment considerations:

Factors	Those preferring			
	Government jobs	Private jobs	Both equally	No preference
Career growth	12.8%	35.8%	27.8%	21.2%
Promotion potential	16.9	31.1	25.0	24.6
Ability to apply education and skills	12.3	22.7	39.7	23.0
Challenging assignments	11.1	31.5	30.5	24.8

Top reasons why graduates did not apply for federal jobs:

- Did not have information about federal jobs
- Unable to identify specific job openings
- Starting salary too low
- Application process too burdensome
- No federal recruiters visited my campus

The Washington Times

College placement officials said low starting salaries were the most frequently mentioned drawback of working for the government mentioned by students. The complicated and time-consuming hiring process was a close second.

Mr. Klein said, "My frustration with the report is that it buried the real story, which is, a large proportion of college graduates do apply," he said.

The survey data indicate that 20 percent of the graduates surveyed applied for a federal job, he said.

But a GAO official familiar with the study downplayed that figure, saying "applied for" could have meant anything from calling for information to actually filling out an application.

Mr. Klein said many improvements in the hiring process had been made since the study was done, such as using campus computer bulletin boards and telephone services to provide federal job information.

The government's lengthy application form, the SF-171, is being phased out and will be replaced by standard resumes.

Graduates who said they were not applying for federal employ-

ment made that decision because of limited career growth and promotion opportunities. Mr. Gable echoed those concerns, saying that targeting midlevel managers for cutbacks could well reduce opportunities for advancement.

Mr. Klein countered that there are excellent promotion opportunities, particularly up to the GS-11 pay grades. "This may be the best time to come in," he said.

New workers continue to be hired, though in much smaller numbers. In 1993, about 40,000 new full-time workers were hired; this year, 31,000 were added, Mr. Klein said. In comparison, an average of 120,000 new workers were hired annually five years ago.

Law enforcement specialists are in demand, particularly in immigration and border patrol, Mr. Klein said.

"Just because the Department of Energy is scaling back, doesn't mean they aren't still hiring in Veterans Affairs, or Justice, or even the Department of Defense," said the MSPB's Mr. Palguta.

"We need good people now more than ever, people who are adaptable, smart and can operate in the changing environment that both sides of the aisle are calling for."

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

September 26, 1994

Statement by the President on Health Care Reform

Today Senator George Mitchell reported that he sees no way to pass health care reform in this session of Congress. He and the bipartisan group of Senators have been doing their best. But he cannot find the 60 votes needed to overcome the Republican filibuster.

I am very sorry to say that this means Congress isn't going to reform health care this year. But we are not giving up on our mission to cover every American and to control health care costs.

When I addressed Congress a year ago, I said our journey to health care reform would have some rough spots in the road. Well, we've had a few. But this journey is far, far from over.

Some Republican leaders keep saying: "Let's put this off until next year." I am going to hold them to their word. We have reached out to Republicans, and we will continue to do that. But we are going to keep up the fight against the interests who spent \$300 million to stop health care reform. We will fight for campaign finance and lobby reform so these special interests do not continue to obstruct vital legislation and we will return to the fight for health care reform. There is too much at stake for all the American people and we have come too far to just walk away now.

Although we have not achieved our goal this year, Hillary and I are proud - and our allies should be proud as well - that we were able to bring this debate further than it has ever progressed before. For solid, smart and important reasons, the ordinary working families of America expect their elected leaders to pass health care reform:

*If we don't act, the deficit we have worked so hard to contain will balloon again over time

*And, most important, millions of Americans still won't be able to count on coverage when their families need it. Every month that we don't act, 100,000 more Americans will lose their coverage. They will join the five million Americans who lost theirs in the last five years.

For their sake, and for the sake of those who touched us during this great journey, we are going to keep up this fight and we will prevail.

#



★
National Health
Policy Council
★

September 23, 1994

Mrs. Hillary Rodham Clinton
First Lady of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mrs. Clinton:

During our meeting last week, we discussed the importance of creating a targeted list of key "health reform" initiatives to guide our efforts during the next twenty-four months. This list should serve as the basis for a strategic plan designed to refocus the health reform debate, re-energize our supporters within the provider community, and advance the overall health reform agenda.

NHPC will soon supply a list of initiatives in the following three categories:

- ★ Administrative or Regulatory. These are actions that can be implemented without legislation within the next two years.
- ★ Consensus Items. These are initiatives that require legislation but upon which there is enough consensus that there is a high probability of favorable Congressional action.
- ★ Critical Reform Initiatives. These are items that we expect will continue to be controversial but are essential to health reform and merit strong advocacy during the next twelve to twenty four months.

Identifying the items that fall in the first category has begun. The National Health Policy Council (NHPC) will submit its list to you within the next three weeks (a preliminary outline is enclosed.) We are prepared to work with key Administration officials and outside groups to refine and expand these proposals.

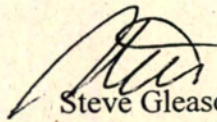
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September 23, 1994
Page Two of Two

Development of the second and third lists should be done with the assistance of our strong supporters within the provider community and key Congressional contacts. Obviously, the November elections will play a role in determining the scope of the consensus package. The interim health strategy team that we have proposed could play a key role in outlining the consensus and the critical reform packages.

I look forward to seeing you again soon.

Sincerely,

A handwritten signature in black ink, appearing to read 'Steve Gleason', with a stylized flourish extending from the end.

Steve Gleason
National Health Policy Council

Areas of Administrative and Regulatory Relief to be Reviewed:

1. Health Care Financing Administration
 - ★ Peer Review Organizations
 - ★ Medicare/Medicaid Quality Requirements
 - ★ Medicare/Medicaid Payment Requirements
 - ★ Fraud and Abuse Rules
 - ★ Medicaid Pharmaceutical Review
 - ★ Technology Medicare Approval
2. Clinical Laboratory Improvement Act
3. Occupational Health and Safety Act
4. Food and Drug Administration
5. Public Health Service and CDC Reporting
6. DOJ and FTC Antitrust Requirements

Examples of Administrative and Regulatory Relief Proposals

1. Paperwork Reduction

Health care providers are being buried in Federal, State, and local paperwork requirements. This is one of a number of areas that could be targeted for action in 1994. A modest investment in simplifying provider utilization, certification, and reimbursement forms could substantially reduce unnecessary paperwork requirements and increase the proportion of federal health care dollars spent on delivering services. The following three areas should be targeted:

- A. Standardization of Quality Measures. An interagency task force should be charged with developing common standards for utilization review. Health providers are now required to comply with as many as 50 different utilization review, certification, and quality control programs. In addition, a common federal health certification form should be developed to cover compliance with OSHA, CLIA, Medicare, and Medicaid certification requirements. The development of this form should be coordinated with JACHO and other leading certification bodies.

- B. Standardization of Claim Forms. Claim formats should be simplified and standardized. Government efforts to develop such a form need to be accelerated. A uniform one page billing form can, and should, be developed within the next twelve months.
- C. Uniform Payment Policies. Individual Medicare carriers and fiscal intermediaries have issued inconsistent payment guidelines. This is not only confusing for providers served by more than one intermediary or carrier, it also may result in excessive Medicare payments in those situations where a provider has discretion regarding selection of billing location.

2. **Regulatory Barriers to Integrated Delivery Systems**

There are a number of regulatory barriers that inhibit the development of integrated health delivery systems. Providers are encouraged to coordinate the delivery of services as a part of capitated payment systems. Yet, there is substantial uncertainty regarding whether these new arrangements present problems under the federal antitrust and fraud and abuse laws. Many of these concerns can be answered through the following actions:

- A. Anti-trust Safety Zones. The Department of Justice and the Federal Trade Commission published a preliminary list of health care "safety zones" in February. One of the areas addressed in that document was physician networks. The current definition is unduly narrow and should be broadened. In addition, a safety-zone should be established for physician-hospital organizations.
- B. Fraud and Abuse Safe Harbors. The HHS Inspector General's Office developed a list of safe harbors from the federal anti-kickback statute. A new managed care safe harbor needs to be created.
- C. Advisory Opinions. There is substantial uncertainty among providers and health care attorneys regarding what types of practices and arrangements between providers are acceptable and what practices are prohibited. This uncertainty has stifled innovation. The HHS Inspector General should initiate an advisory opinion procedure similar to the IRS. This would ensure that providers comply with the law but give the providers the necessary assurance they need to develop new systems.

NATIONAL HEALTH POLICY COUNCIL

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NHPC Founder, Chair and Expert Speaker Participant. An osteopathic physician and head of Mercy Clinic system in Des Moines, Iowa. Former Chair of the Health Professions Review Group; key Clinton supporter; senior consultant to HHS; and, member Clinton transition team.

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NHPC Board Member, Finance Chair, and Expert Speaker Participant. Member of the Health Professions Review Group; serves as the only physician member on the board of advisors of the Medical College of Wisconsin Health Policy Institute and University of Wisconsin Health Policy Institute; and is the Medical Advisor to Reps. Kleczka, Barrett, and Barca and Sens. Feingold and Kohl. Boxer is a Board member of the National Jewish Democratic Council (NJDC), and serves on the Democratic National Finance Committee.

Pat Ford-Roegner, R.N.

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NHPC Board Member and Expert Speaker Participant. Ford-Roegner is the Region IV Director for the U.S. Dept. of Health and Human Services. Former Co-Vice Chair of the Health Professions Review Group. Formerly with SEIU and ANA. SEIU and ANA were both members of the Health Care Reform Project.

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NHPC Board Member, former Vice Chair of the DNC. Currently, she the Vice President of the Kamber Group and a Fellow at Harvard's Kennedy School of Government.

These folks deliver!

Gerry Shea

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NHPC Board Member. Shea is the chief health policy person at AFL-CIO. Formerly, Special Assistant to the President at SEIU. Very active in health care reform. AFL-CIO and SEIU were both members of the Health Care Reform Project.

Ron Dozoretz (doe-zor-etz)

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NHPC Board Member. Dozoretz is the President, Chief Executive Officer and Chair of First Hospital Corp., one of the nation's largest privately-held mental health companies. Dozoretz served as a member of the Health Professions Review Group; is active in the DSCC and DNC; and, currently serves as a site selection member of the 1996 Democratic National Convention Committee.

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NHPC Board Member. Gaffney is a state organizer for the ANA. She has been organizing nurses in support of health care reform. ANA has been very active in supporting health care reform and was a member of the Health Care Reform Project.

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NHPC Board Member. Bresch is the chief lobbyist for Catholic Health Association. CHA has been very active in supporting health care reform and was a member of the Health Care Reform Project.

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NHPC Expert Speaker Participant. Anderson is an internist and Prof. of Internal Medicine at the Univ. of Texas Southwestern Medical Center in Dallas. He is the President and CEO of Parkland Memorial Hospital, a large public teaching hospital. Anderson is the Chair of the Texas Board of Health and an outspoken advocate for health reform. In 1994, he appeared on several national broadcasts: a CNN feature segment on public sector hospitals and health care reform and NBC's "To Your Health."

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NHPC Expert Speaker Participant. Baskin, a private practice internist, has been very active in health care reform efforts through the NHPC and the Society of Internal Medicine. He is the President of the NJ Society of Internal Medicine. Baskin is a big supporter of the President's health plan and was a physician reviewer for the Task Force. Baskin was a member of the 1992 electoral college.

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NHPC Expert Speaker Participant. Berenson, an internist, is currently the Medical Director of the National Capitol PPO, a local managed care organization. Berenson served as co-chair of two working groups of the President's Task Force: malpractice reform and accountable health plans. He was a health policy advisor to the Clinton/Gore campaign and served on the transition team. Berenson provides policy research to the Urban Institute, is a member of the Health Affairs editorial board, and an advisor to the Physicians Payment Review Commission (PPRC.)

NHPC Expert Speaker Participant. Bergen, an internist, is the President of the University of Medicine and Dentistry of New Jersey. It is New Jersey's second state university, with seven schools on four campuses and a statewide network of more than 100 affiliated hospitals and three community mental health centers. Prior to joining UMDNJ in 1971, Dr. Bergen was the Chief Operating Officer for New York City Health and Hospitals Corporation, which operated the city's 19 public hospitals.

NHPC Key Contact. Blumenthal is the Chief of Health Policy Research and Development Unit and Associate Physician at Massachusetts General Hospital as well as Associate Professor of Medicine and Healthcare Policy at Harvard Medical School. He was the Chief health advisor to the Dukakis campaign and a staff member on Sen. Ted Kennedy's sub-committee on health. He is a member of the editorial boards of the New England Journal of Medicine, Quality Management in Health Care, and Quality Review Bulletin and serves on advisory committees to the National Academy of Sciences, Institute of Medicine and U.S. Office of Technology.

NHPC Key Contact. Bulger is an internist and professor of medicine and public health. Currently, he is the President of the Association of Academic Health Centers in Washington, D.C.

NHPC Key Contact. Butcher is the immediate past president of the Natl Medical Assn and current President of the "Summit '93 Health Coalition," representing all aspects of the Afro-American community that have come together around health care reform.

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NHPC Key Contact. Cohen, an internist and the President of the Association of American Medical Colleges. Dr. Cohen is active in the American College of Physicians and the American Board of Internal Medicine.

NHPC Expert Speaker Participant. Cooper is a pediatrician specializing in infectious diseases. Currently, he is the Senior Attending Physician and Director of Pediatric Services at the St. Luke's-Roosevelt Hospital Center in New York City. Dr. Cooper has served as both consultant and board member to numerous committees for the city and state of New York, the Department of Health and Human Services and on several national committees. He is very active in the AAP.

NHPC Expert Speaker Participant. D'Alessandri, an internist specializing in infectious diseases, is the Vice President for Health Sciences and Dean of the School of Medicine at the Univ. of West Virginia. He served as a member of several working groups on the Task Force and helped organize a state-wide broadcast for Mrs. Clinton entitled, West Virginia Speaks. D'Alessandri works closely with Governor Caperton and Senators Byrd and Rockefeller on health care issues. In addition, he appears weekly as a medical correspondent on television news programs as well as hosting "Doctors on Call," a live public television broadcast.

NHPC Expert Speaker Participant. DeJong has been very active in the ESP and has given numerous speeches, particularly in the disability and traumatic brain injury communities. DeJong is the Director of the National Rehabilitation Hospital Research Center and is a Professor of Community and Family Medicine at Georgetown's School of Medicine. DeJong has become an expert in disability, health outcome measurement, health utilizing, and bio-medical ethics. DeJong served on the Clinton/Gore transition team's working group on long-term care policy. Recently, he testified before the House Ways and Means Cmte. on the impact of health care reform on Social Security Disability Insurance and Social Security Insurance program.

NHPC Key Contact. Delfs is a gerontologist and neurologist from Boston, where he is Chief of Geriatric Medicine at Deaconess Hospital, Assistant Professor at Harvard Medical School and Harvard School of Public Health, and directs a program of interdisciplinary care coordination for high risk older persons.

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NHPC Expert Speaker Participant. Eckstat is a family practitioner who has practiced in Des Moines, Iowa for 22 years. A member of the Health Professions Review Group briefing team.

NHPC Key Contact. Feild is a pediatrician from Little Rock.

NHPC Expert Speaker Participant and Key Contact. Fickenscher is the Senior VP and Chief Medical Officer of Aurora Health Care in Milwaukee, where he is directly responsible for all aspects of a medical care system with over 2,200 physicians. He is a national expert in rural health and systems integration and an early advocate of health care reform. He has advised national and state candidates on health issues. Fickenscher was a member of the Health Professions Review Group.

NHPC Expert Speaker Participant. Freed has practiced Emergency Room medicine for twenty years. He is the founder and director of the Emergency Medicine Program at Albany. Freed served as a physician reviewer on the Task Force. In 1992, he served as an aide to Clinton/Gore chief of staff Eli Segal and was the Deputy Director of Special Projects.

NHPC Expert Speaker Participant. Jackson, a critical care and neurology specialist, is the President and CEO of AssurQual, Inc., a long-term management consulting and quality management information systems company. He is also a clinical professor at the Department of Medicine at Ohio State University in Columbus. He previously served on two working groups of the President's Task Force, including the committees on quality and information systems.

Steven "Steve" Jonas, M.D.

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NHPC Expert Speaker Participant. Jonas is a Professor of Preventive Medicine, School of Medicine, SUNY at Stony Brook. Jonas uses his lengthy experience as a public speaker, author, educator, and his more recent experience as the host of a weekly political talk show on local Long Island radio, to promote national health care reform. Jonas has made a number of radio and television appearances before both professional and lay audiences, speaking in support of the President's health plan. He is active in New York and national politics.

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NHPC Expert Speaker Participant. Kumpuris is a cardiologist in private practice in Little Rock, where he is the Director of the Coronary Care Unit at St. Vincent Infirmiry Medical Center. He served as a working group member to the President's Task Force on health care delivery. Currently, he is Chairman of the Governor's Task Force for Health Care Reform in Arkansas.

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NHPC Key Contact. Laurence is a clinical psychologist in private practice in Knoxville. He is an Assistant Professor of Psychology at the University of Tennessee at Knoxville, a consultant to St. Mary's Medical Center, the President of Clinical Management Services and Associate Director of the Guntrip Post Graduate Training Institute in Knoxville. Laurence has been an active participant, including leadership positions, in the Tennessee Psychology Association, he also served as a member of the Health Professions Review Group as the only psychologist.

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NHPC Key Contact. Lewin is Hawaii's Director of Health. He has served as a health advisor to the White House, is the former President of ALTHO, and a Democratic candidate for Governor of Hawaii (1994.)

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NHPC Expert Speaker Participant. Loh is an internist and cardiologist in Thousand Oaks. He is an Assistant Clinical Professor of Medicine at University of California, Irvine, School of Medicine and Adjunct Assistant Professor of Medicine at Baylor. Dr. Loh served on two working groups of the Task Force.

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NHPC Expert Speaker Participant. MacLeod, a general internist and public health professional from Pittsburgh, has been a longtime advocate of national health insurance. He has promoted health care reform by working with community leaders and physicians to sponsor and develop health management organizations, by advocating freedom of choice in selecting health care providers, and by promoting community rating.

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TODAY'S NEWS

Health reform could find "natural" legislative vehicle in budget reconciliation next year, HHS Secretary Shalala says Oct. 20 **Story below**
ERISA hearing to be held Nov. 30 by Reps. Wyden, Williams; move during lame duck session indicates issue's potential importance in 1995 **Page 2**

HEALTH REFORM COULD FIND LEGISLATIVE VEHICLE IN BUDGET RECONCILIATION LEGISLATION, HHS Secretary Donna Shalala commented at an Oct. 20 breakfast with health reporters. After stating that the Clinton Administration will propose a health reform plan next year, though in a "new format" to build on the lessons of this year's debate, Shalala was asked if the Administration would include the plan as part of its budget proposal or as a separate package. "Some of it will have to be taken on through budget reconciliation simply because we're doing the budget," the secretary replied. "So [for] any changes that we want in the Medicare system or the Medicaid system or in something linked to welfare...it is a natural vehicle."

She added that the budget reconciliation approach "also gives us some discipline in terms of timeframe to think through the changes" and is "easier for the committees to handle as part of their own processes."

Budget reconciliation, which covers entitlement programs, taxes and other programs, is enacted as the counterpart to appropriations bills for discretionary spending programs. The legislation is drafted following submission of the President's budget request in February. Shalala noted that under the traditional budget-drafting schedule, the President would have to be making decisions in December on what health reform provisions to include.

Shalala commented that there "is no new analysis" and "no tricks here" to find new proposals. Instead, she characterized the upcoming decisionmaking as choosing among the range of provisions already identified and conducting more of a "strategic discussion."

"The public clearly told us...that they were very gun shy over taking on the whole [health care] system," the secretary said. "The big target creates a politics of its own," whereby many groups may each have opposed only a few elements of the plan but "cumulatively created a lot of negatives." As a result, Shalala continued, "we're going to try to be shrewder and more strategic about what things need to be done first. What that list is, we have not decided, but we clearly ought to learn from our experience of trying to take on what the public perceived as too much. Even though we argued and would continue to argue that you can't do this piece without

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this [other] piece, they clearly have sent the message that while they want health reform, they would like it to be in stages and see what the implications are of each piece as we move along."

Shalala said the President has made no decisions on how to finance health reform, including whether again to propose employer mandates. But she noted that the public made clear that it opposed a "government-run" health system and that it viewed employer mandates as a "proxy" for such a system. "Comprehensive reform can be taking on the first strong steps" in the "direction that you want to go in," she added, but the President is unlikely to drop his "overall goal" of ensuring that everyone "can get good health insurance" and that the existing health care system is "strengthened" with an "appropriate" role defined for government.

The secretary said she believes Congress would have enacted a health reform bill this year had time not run out. Noting that the numbers of the uninsured are increasing and health inflation, while slowing, is still double that of general inflation, Shalala said the problems that motivated health reform still remain, and the Administration is "still enthusiastic" to learn from this year and push on for reform. She several times predicted more bipartisanship next year because both parties "will be more responsive to the fact that we have larger numbers of working folks who just don't have any coverage and don't have any chance of getting coverage unless we do something."

Shalala was asked about the tension between using federal spending proposals for deficit reduction versus expanded health coverage. The President "clearly intends to keep his priority on deficit reduction, [but] simultaneously he wants to get going in this country in health care reform." The trade-off between these must be resolved but "one of the good things about doing all this within the context of the budget is that you have all those options laid before him as opposed to doing it in a more fragmented way."

The President also pledged during his recent campaign swing through New York "that we would look again at the Medicaid distribution formula," Shalala noted. Asked whether the Administration may examine more fundamental structural changes to Medicare, Shalala said that Health Care Financing Administration chief Bruce Vladek is analyzing a number of "strategies" and "different approaches." The examples she gave focused on avoiding institutionalized care and finding flexible ways to assist the frail elderly. Shalala herself has been averaging about two days per week on the campaign trail.

REPS. WYDEN, WILLIAMS TO CO-CHAIR ERISA HEARING NOV. 30, the congressmen announced in an Oct. 19 release. The joint hearing on the Employee Retirement Income Security Act of 1974 will be held by the House Education and Labor/Labor-Management Relations Subcommittee, chaired by Rep. Pat Williams (D-Mont.), and the Small Business/Regulation Committee, headed by Rep. Ron Wyden (D-Ore.).

Members of Congress should be in Washington, D.C. on the day of the ERISA hearing taking up trade issues in a special lame-duck session scheduled in both chambers. Representatives of states, multi-state employers, small business, organized labor and consumers are expected to testify, the release notes.

The November date and early announcement of the hearing indicate that Wyden and Williams intend to pursue ERISA reform early on in the 1995 session of Congress. During the 1994 health care reform debate, the White House allies supported the state single-payer option and across-the-board employer mandates, both of which would have required significant changes to ERISA. Those two provisions encountered stiff opposition from pro-business lobbying groups who sought to preserve the law that keeps all self-insured corporations outside the purview of state insurance regulation.

According to the announcement, the hearings will begin the process of formulating a "three-part federal framework" for modifying the "outdated provisions of ERISA." The goals are to allow generous multi-state employers to continue providing uniform employee benefits; regulate companies that ration benefits and are not subject to consumer protection laws; and allow reform-minded states to pursue cost containment, expanded coverage and insurance market reforms.

Health Care Reform

Examples of Administrative, Regulatory or Budget Actions Not Requiring Statutory Modifications

Prepared by:

**The National Health Policy Council
Dr. Steve Gleason, Chair
October 14, 1994**

Health Care Reform

Examples of Administrative, Regulatory or Budget Actions Not Requiring Statutory Modifications

- A. Reimbursement Claims Processing
 - 1. Development of Common Claim Format
 - 2. EDI Model Demonstration Projects
 - 3. Education and Publicity
 - 4. Confidentiality Legislation
 - 5. Physician Office Practices Demonstrations
- B. Coordination of Federal Health Insurance Programs
 - 1. Standardize FEHBP Claim Forms to Match Medicare/CHAMPUS
 - 2. Standardize CHAMPUS and HCFA Procedures
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 - 2. Risk Appropriate Requirements

- G. Provider Reimbursement Review Board (PRRB)
 - 1. Develop Procedures for Expedited PRRB Review
 - 2. Eliminate PRRB Backlog
 - 3. Reduce the Proportion of Discretionary Reversals by the Administrator
- H. Antitrust Enforcement Standards
 - 1. Physician Network Joint Ventures
 - 2. Advisory Opinions
- I. Managed Care Safe Harbor Regulations
 - 1. Price Reductions
 - 2. Non-medical Services
 - 3. Waiver of Coinsurance and Deductibles
 - 4. Capitation Payments
 - 5. Duration of Agreements
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- J. Fraud and Abuse Advisory Opinions
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- K. Home Health Care
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- L. Regulations Governing the Development of Pharmaceutical Products
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Health Care Reform

Examples of Administrative, Regulatory or Budget Actions Not Requiring Statutory Modifications

Introduction

This report was prepared by the National Health Policy Council ("NHPC") in order to outline examples of administrative, regulatory or budget actions that could be taken by the Executive Branch to further the goal of health care reform.

The National Health Policy Council was founded with the belief that decisions about health care and health care financing should be patient-centered. NHPC has taken a leadership role in stimulating creative, broad-based, patient centered solutions to health policy problems. During the last two years, NHPC has participated as a founding member of the Health Reform Project, served as a network clearinghouse for providers and consumers, sponsored public television broadcasts ("Minnesota Speaks" from the Mayo Clinic in Rochester, Minnesota and "New England Speaks," from Brown University in Providence, Rhode Island), sponsored Presidential candidate debates on health care; organized health policy Technical Advisory Committees; and has established and staffed an Expert Speakers Program.

There are a wide variety of actions that could be taken by federal agencies to simplify our current health care system. Providers and consumers are being buried in Federal, State, and local paperwork. A modest investment in simplifying reimbursement, utilization, and certification forms could substantially reduce unnecessary requirements and increase the proportion of federal health care dollars spent on delivering services. This report outlines examples of administrative, regulatory or budget actions that can be accomplished without new legislation.

A. Reimbursement Claims Processing

Last year, health care providers submitted over 4.8 billion claims to over two thousand different commercial health insurance firms, HMOs, PPOs and Medicaid and Medicare processors. While, progress is being made toward developing standard claim forms and electronic billing, less than twenty percent of all public and private claims in 1992 were electronically processed.

Workgroup for Electronic Data Interchange (WEDI) estimates that as much as \$42 billion by the year 2000 can be saved through the implementation of a comprehensive Electronic Data Interchange (EDI) system. The progress made by WEDI to date has not depended on federal legislation. The Federal government should fully cooperate and support this effort to the maximum extent possible. The savings from these efforts will be shared by physicians, hospitals, ancillary service providers, employers, insurers, and the government.

Recommendations:

1. Development of Common Claim Format. This is probably the most important paperwork simplification objective. Absent federal legislation requiring a common format, additional attention needs to be devoted to the efforts of WEDI and ANSI X12 Groups to produce a uniform billing format. HHS should continue to play a lead role in promoting these efforts.
2. EDI Model Demonstration Projects. The Agency For Health Care Policy Research, the National Library of Medicine, and the Health Care Financing Administration should provide support for EDI demonstration projects. Financial support for these efforts will speed the development of national standards for EDI systems. These projects can be supported under existing authority. Funds need to be allocated to these projects through the annual budget process.
3. Education and Publicity. Implementation of a common EDI system will require an extensive provider education and publicity effort. Absent federal legislation requiring use of common claim forms, the growth of EDI system will be largely dependent on provider outreach and education. Federal support for the WEDI initiatives in this area is particularly important. This project can be supported by AHCPR, HCFA, or NIH under existing authorities.
4. Confidentiality Legislation. Public/private cooperation on claim forms and electronic system technology standards could be undermined by the proliferation of conflicting state confidentiality laws. The federal government should encourage the adoption of model state laws regarding confidentiality. Ultimately, federal legislation is probably necessary.
5. Physician Office Practices Demonstrations. While nearly 70 percent of all hospital claims are submitted electronically, only about 12 percent of physicians claims are processed in this manner. WEDI estimates substantial physician office savings associated with electronic submission. However, providers are reluctant to purchase the necessary hardware and software. The Federal government should support physician office projects to demonstrate advantages and cost savings associated with physician office electronic claims processing.

B. Coordination of Federal Health Insurance Programs.

While substantial progress has been made in coordinating the paperwork necessary to file claims for the various federally sponsored health programs (Medicare, FEHBP, CHAMPUS, Medicaid). Further coordination of both paperwork and administrative procedures is necessary.

Recommendations:

1. Standardize FEHBP Claim Forms to Match Medicare/CHAMPUS. The plans participating in the Federal Employee Health Benefit Plan (FEHBP) all use different claim forms. These should be standardized, match the Medicare form, and be consistent with the WEDI recommendations.
2. Standardize CHAMPUS and HCFA Procedures. While CHAMPUS and Medicaid now use common claim forms, the procedures for filing claims and appealing adverse decisions remain distinct. CHAMPUS forms are sent to one set of contractors, Medicare forms to another. The procedures for filing claims and appealing adverse decisions should be coordinated.

C. Standardization of Federal Medicare Payment Policies.

The Medicare program is administered largely by the 21 "fiscal intermediaries" and 47 "carriers" who are responsible for processing and paying Part A and Part B claims. These contractors exercise substantial discretion subject to HCFA guidance and requirements. As a result, there is variation in the administration of the program from one region to another.

In addition, Medicare policies provide for variations in reimbursement rates depending on the location where a service is provided. In many cases, the reimbursement procedures discourage the provision of care in less costly settings.

Recommendations:

1. Reduce Inappropriate Regional Disparities in Medicare Reimbursement Policies. Variations in Medicare payment policies are particularly confusing for health care entities that provide services in more than one contractor region. Moreover, inconsistencies in payment policies between regions provide opportunities to game the federal reimbursement system.
2. Uniform Reimbursement Rate for Nursing Home Clinical Laboratory Services. The Medicare reimbursement rate for nursing home laboratory services should be standardized at the Part B payment rates in a manner that does not prejudice nursing home selection of the appropriate provider.
3. Reimburse Overhead Expenses for Physician Office Surgical Procedures. In 1980, Congress directed HCFA to develop rules regarding Medicare reimbursement of overhead expenses associated with physician office surgical procedures. HCFA's failure to promulgate such a rule during the last 14 years, has increased Medicare costs for procedures that could be more efficiently performed in the physician office

but instead must be performed at a hospital or in an ambulatory surgery center in order to get full Medicare reimbursement.

D. Coordination of Certification and Credentialing Requirements.

Health care providers are required to submit a wide variety of certification and credentialing forms to participate in federal, state, and private programs. Many of these forms are duplicative or unnecessary, particularly when the services to be rendered are delivered by an integrated health system that has previously supplied the information to the certifying agency in order to qualify for another program.

At minimum, the unnecessary paperwork associated with qualifying to participate in federal programs should be reduced. Currently, providers are required to comply with certain conditions of participation, requirements, or conditions of coverage to be paid for providing the following separate services to Medicare patients:

- Hospital (42 CFR 482)
- Skilled Nursing Facility (42 CFR 483)
- Nursing Facility - Medicaid (42 CFR 483)
- Home Health Agency (42 CFR 484)
- Outpatient Rehabilitation (42 CFR 485)
- Outpatient Physical and Speech Therapy (42 CFR 405)
- Organ Procurement Organizations (42 CFR 485)
- Rural Health Clinics (42 CFR 491)
- Federally Qualified Health Centers (42 CFR 491)
- Clinical Laboratory Services (42 CFR 493)
- Mammography Services (34 CFR 494)
- End Stage Renal Suppliers (34 CFR 405)
- Ambulatory Surgical Centers (34 CFR 416)
- Rural Primary Care Hospitals (34 CFR 485)
- HMO's (34 CFR 417)
- Hospices (34 CFR 418)
- Portable X-Ray (34 CFR 405)

Recommendations:

1. Standardize Basic Certification Information. A uniform federal health care provider certification cover sheet should be developed. This cover sheet should be used to acquire the common information needed to qualify for participation in federal Medicare and Medicaid programs.

2. Defining Quality Measures. An task force should be charged with developing common standards for utilization review. Health providers are now required to comply with dozens of different private and public quality review and credentialing standards. The federal government could play leadership role in developing common standards comparable to the role it has performed as a member of the WEDI working group.
3. Emphasize Compliance Audits and Followup Instead of Annual Inspections. The limited resources of federal and state agencies charged with ensuring compliance with conditions of participation should be focused on identified problems rather than annual survey and inspections. A substantial amount of government resources are wasted reviewing providers who are in compliance with federal requirements.

E. Clinical Laboratory Improvement Act.

The Clinical Laboratory Improvement Act of 1988 expanded the scope of federal regulation to all clinical laboratories, including physician office laboratories. The regulations implementing this new statutory authority have been criticized as excessively burdensome. While most of the proposed changes require changes to the CLIA statute, there are actions that can be taken without legislation.

CLIA '88 directed the Secretary of HHS to conduct five separate studies. These studies involved the effects of proficiency testing, personnel standards, and quality assurance on the accuracy of laboratory tests, documentation of the extent of treatment problems caused by inaccurate testing, and the affect of errors on the testing process. These studies were intended to assist the department in drafting regulations. While the regulations have been promulgated, the studies have not been finished.

Recommendations:

1. Complete CLIA Studies. Nearly 6 years have passed since Congress mandated the five CLIA studies noted above. Priorities should be placed on completing these studies within the next twelve months. The conclusions of the studies should be incorporated in a simplification of the current CLIA requirements.
2. Reduce CLIA Compliance Burden. Any revision to the current CLIA regulation should be focused on reducing the administrative burdens on providers. The current rule is complicated and difficult to implement. Compliance procedures for waived laboratories should be clearly spelled out in the regulation.
3. CLIAC Representation. Physician offices and independent laboratories claim that they are underrepresented on the Clinical Laboratory Improvement Advisory Committee.

HHS should examine the scope and type of testing regulated by CLIA and the current composition of the CLIAC board. If POLs and independent community laboratories are underrepresented when compared with the type of testing regulated by CLIA, the CLIAC should be expanded to ensure representation of these viewpoints.

F. Occupational Safety and Health Act.

Implementation of OSHA's blood borne pathogens rule imposes many new and burdensome requirements on health care providers. Some of these requirements do not appear to add appreciatively to work protection, but will increase substantially the cost of care and may make it impossible for care to be provided in certain areas.

Recommendations

1. **Recordkeeping.** The OSHA requirement to keep records for 30 years beyond the employment of a worker far exceeds any recordkeeping routinely undertaken within medical practice, even for patients. This provision is extremely burdensome on small practices. The requirement should be revised to reflect a more reasonable period for maintaining old records.
2. **Risk Appropriate Requirements.** The OSHA standards are not designed to reflect the enormous variation in risk. In low risk areas, the cost associated with compliance greatly exceeds any potential benefit. OSHA should work with provider groups to define those settings where less costly and cumbersome requirements are appropriate.

G. Provider Reimbursement Review Board (PRRB).

In 1972, Congress established the PRRB to furnish providers with an impartial forum for resolving Medicare payment disputes arising from cost reports. The Secretary of Health and Human Services may affirm, modify, or reverse a decision of the Board. This responsibility has been delegated to the Administrator of the Health Care Financing Administration (HCFA).

The PRRB's caseload has expanded from 105 in 1975 to over 2,500 in FY 1992. Yet, the PRRB continues to issue only about 100 decisions a year. It now takes over three years to get a PRRB hearing and another year to get a decision. Moreover, the HCFA Administrator has liberally exercised the Secretary's discretionary authority to reverse PRRB decisions. The Administrator has reversed the PRRB's decision in nearly 30 percent of the cases heard since 1975.

Recommendations:

1. Develop Procedures for Expedited PRRB Review. The current procedures are not working. While the PRRB has initiated double booking, constructed a second hearing room and initiated teleconferences, these measures are not adequate to respond to the current caseload. New procedures and additional resources need to be assigned to the PRRB.
2. Eliminate PRRB Backlog. A high percentage of the open PRRB appeals are more than three years old. Priority should be placed on getting these cases off the docket. This may require a special short-term resource allocation. However, if the residual backlog is not dealt with, all appeals will take three or more years, even if the PRRB has adequate resources to handle its current caseload.
3. Reduce the Proportion of Discretionary Reversals by the Administrator. The PRRB was intended to serve as an impartial body to resolve Medicare payment disputes. The high percentage of reviews by the Administrator and the fact that they are virtually all decided in favor of the Intermediary is particularly distressing. The Administrator should be more judicious in deciding when to review PRRB decisions.

H. Antitrust Enforcement Standards

The antitrust laws have inhibited the consolidation of health care delivery systems by putting into question the legality of mergers, joint ventures and other fee arrangements among hospitals, physicians and other health care providers. To address some of these problems, the Department of Justice and the Federal Trade Commission recently issued new "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust" which define antitrust safety zones where DOJ and FTC will not challenge mergers, joint ventures and other activities. While these Statements are a step forward in providing better health care to consumers while promoting competition, they could be improved in several ways.

Recommendations:

1. Physician Network Joint Ventures. The Physician Network Joint Venture Statement should be amended to permit physician networks to offer discounted fees without requiring the network to share substantial financial risks in the form of capitation or a fee withhold. Currently, providers must seek advisory opinions prior to the formation of such networks.

2. Advisory Opinions. The DOJ and FTC should provide an expedited procedure for parties seeking guidance on proposed health care joint venture and other activities. Currently, it often takes a year or more to receive such advisory opinions.

I. Managed Care Safe Harbor Regulations.

The federal Medicare/Medicaid anti-kickback statute was designed to curb abuses in a fee-for-service third party payor health care system. While the Health and Human Services Agency issued a safe harbor regulation to protect certain managed care activities from the reach of the anti-kickback law in November 1992, the narrow scope of this regulation is at odds with the movement towards managed competition. The current safe harbor regulation fails to protect many relationships which use economic incentives to encourage preventive care and control utilization. The failure to protect such relationships chills innovations in the health care industry.

The safe harbor regulation should be broadened to protect the full range of managed care programs in which Medicare and Medicaid beneficiaries are enrolled. Many managed care plans rely on non-traditional compensation and contractual arrangements, such utilization review or enrollment screening, to efficiently provide care. Such relationships should be protected and encouraged.

Recommendations:

1. Price Reductions. The "price reduction" safe harbor should encompass a broad range of non-traditional compensation methodologies, including intermediary contractual relationships, self-insured employer plans, and state or local government programs that do not charge "premiums". Further, it should be clear that the safe harbor encompasses capitation, risk sharing and other payment methodologies that may not involve any fee schedule or reductions from a usual price. Finally, "burden shifting" to other payors or individuals should not be a bar this safe harbor protection.
2. Non-medical Services. Non-medical services such as credentialing, utilization review, quality assurance and administrative tasks are an integral part of a successful managed care program. The safe harbor rules should protect agreements between managed care programs and other entities for the performance of such services.
3. Waiver of Coinsurance and Deductibles. The safe harbor regulation currently allows certain managed care plans to waive coinsurance and deductibles for some Medicare patients. All bona fide managed care plans should be permitted to offer such waivers to their Medicare beneficiaries.

4. Capitation Payments. The safe harbor regulations should explicitly allow managed care plans to pay physicians and suppliers on a capitation or other risk basis where there is no separate fee-for-service billing of Medicare copayment amounts to the plan.
5. Duration of Agreements. The ability to adjust fees based on utilization and referral patterns are an inherent part of managed care plans as is the ability to enter into patient-specific agreements with non-plan providers. Because flexibility is critical to the effectiveness of these mechanisms, the safe harbor rules should not establish minimum or maximum durations for fee schedules or other pricing arrangements.
6. Coverage. The safe harbor regulations should explicitly protect all coverage terms issued by managed care plans to Medicare and Medicaid beneficiaries, including extra-contractual inducements to enrollment.

J. Fraud and Abuse Advisory Opinions

The current fraud and abuse laws are broad and vague and carry substantial penalties for their violation. Providers should be able to seek clarification of these laws from the Inspector General prior to engaging in new or uncertain activities. Because the IG will likely be inundated with requests for advisory opinions, one of several mechanisms should be put in place to facilitate this process.

Recommendations:

1. Advisory Opinions. Preferably, the IG should be the financial and human resources needed to respond to requests for advisory opinions.
2. Targeted Advisory Opinions. If adequate resources are unavailable to permit the IG to respond to all requests, the IG should issue "no action letters" in those situations where it would not take any action under the particular circumstances. In the alternative, the IG should be given the discretion to prioritize the areas of greatest concern and respond only to letters in those areas.

K. Home Health Care

Home health agencies are currently paid on a cost reimbursement basis for the services provided to Medicare patients. Some in Congress and HCFA have advocated that home health agencies be reimbursed on a prospective payment system similar to that used for hospital reimbursements. While most agree that payments made under a prospective payment system should be on a "per episode" basis rather than a "per visit" basis, adequate data for

determining the appropriate reimbursement rates does not currently exist. Although we believe that a prospective payment system should be seriously studied, in the meantime, the following changes should be made to the current system:

Recommendations:

1. Demonstration Project. The prospective payment system demonstration project should be expanded to additional states/home health agencies. Under this project, home health agencies receive a uniform payment per episode. This process simplifies the submission of claims and provides incentives for home health agencies to improve their care. Further, physicians who participate in the management of home health cases should be reimbursed on a reasonable basis.
2. Conditions of Participation. Medicare conditions of participation (COPs) for home health agencies should be revised to provide an outcome-oriented analysis rather than a structural analysis of agency operations. First, the COPs should apply only to Medicare patients. Second, RNs should not be required to supervise home health aides. Third, the capital budget and the 60-day recertification requirements should be eliminated. Finally, surveys should be done less frequently than annually. Such revisions focus the attention on the quality of care rather than on recordkeeping.
3. Home Health Care - Outcomes Data. HCFA should implement the proposal to provide access and fast track to data outcomes for home health agencies. Demonstration projects should be implemented for those agencies that want to move forward in this area.
4. Long Term Care Waiver. The access waiver program for long term/chronic care should be expanded for home health agencies that wish to enter these fields.
5. Billing Matters. Home health agencies should be permitted to bill more than once a month. Credit balance reporting should be eliminated. Cost reports and audits should be eliminated or done on a less frequent basis.
6. Copayment. Proposals for copayment for home health services should be eliminated from budget proposals. Copayment merely increases costs for both providers and the government. For providers, the administrative costs of copayments often exceed the amounts collected. Any amounts not collected are passed through to Medicare as bad debt.

L. Regulations Governing the Development of Pharmaceutical Products.

Certain regulatory requirements and procedures established by the Food and Drug Administration (FDA) and the Drug Enforcement Administration (DEA) are unnecessary and inhibit the ability of manufacturers to develop and produce new products.

While long delays associated with FDA approval have been widely reported, less attention has been devoted to DEA procedures. The DEA regulates controlled substances. A pharmaceutical company interested in developing a new product involving controlled substances, must obtain a DEA research license. It also must obtain a manufacturing license in order to mass produce the product.

Recommendations:

1. Eliminate DEA Procedures that Permit Pharmaceutical Companies to Stifle Competition. Under current DEA procedures, any competitor can challenge a DEA application. Most of these challenges are designed to keep competitive products off the market, and are not based on any security risk associated with manufacturing procedures. DEA published proposed regulations to end this practice nearly two years ago. The final rule should be issued as soon as possible and should give DEA authority to terminate appeals that DEA are generated for competitive rather than security reasons.
2. Permit Bulk Manufacturers to Obtain Research Licenses. The current DEA policy prohibiting bulk manufacturers from obtaining research licenses stifles competition, innovation and market efficiency. As noted above the manufacturing license procedure has been abused by competitor companies. Manufacturers should be permitted to qualify for research licenses to develop products.

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General Caveats for Medicare Savings Proposals

Estimates are derived from earlier proposals, new estimates will differ for several reasons:

- certain proposals will be affected by changes in assumed starting dates
- 10 year estimates will include an additional year, 2005
- Medicare baselines will be reestimated by both CBO and OMB
- CBO will score cost-shifting impacts from Medicare price reductions, this will have the effect of raising subsidy estimates and lowering federal tax revenues
- Net Medicare savings from the Mainstream bill based on preliminary CBO estimates and differences between start and end dates of similar proposals in OBRA will affect estimates
- Part A interactions and Part B offsets are approximated

Revenue Caveats

All tax revenues are derived from previous CBO estimates--pending Treasury confirmation

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TABLE 2.
ESTIMATED CBO SCORING of MEDICARE SAVINGS PROPOSALS
 Fiscal years, dollars in billions

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1996-2000	10-yr Total 1995-2004
Extensions of OBRA 1993 Baseline Savings													
Extend OBRA93 Medicare Secondary Payer		0.0	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3	-3.0	-11.4
Part B Offset		0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Reduce Routine Cost Limits for HHAs		0.0	0.0	-0.3	-0.4	-0.5	-0.5	-0.6	-0.6	-0.6	-0.7	-1.7	-4.2
Extend OBRA93 SNF Update Freeze		0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.8	-1.8
Permanent 25% Part B Premium - Gross savings		0.0	0.0	0.0	0.0	-1.3	-3.6	-6.1	-9.2	-12.9	-16.2	-4.9	-49.3
<i>Subtotal</i>		0.0	-0.1	-0.4	-0.6	-3.1	-6.0	-8.7	-11.9	-15.9	-19.4	-10.2	-66.1
Extensions of OBRA 1993 Savings Policies													
Hospital PPS Update (MB-0.5%, 1997-2004)		0.0	0.0	0.0	-0.3	-0.8	-1.3	-1.9	-2.7	-3.6	-4.6	-2.4	-15.2
1995 Physician Update -3% (-0% primary care)	1/	-0.3	-0.4	-0.5	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-2.5	-5.6
Part B Offset		0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.6	1.4
ASC Payment Update Freeze (1996-1999)	2/	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.3	-0.8
Clinical Lab Payment Update Freeze (1996-99)	3/	0.0	0.0	-0.1	-0.2	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-0.9	-2.9
Reduce Hospital Capital (-7.31%/-10.41%)		0.0	-0.7	-0.7	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.1	-3.7	-7.8
HI Interactions		0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.7
<i>Subtotal</i>		-0.2	-1.0	-1.2	-1.6	-2.3	-2.9	-3.7	-4.7	-5.7	-6.9	-9.0	-30.2
Additional Medicare Savings and Receipt Proposals													
Extend HI Tax to All State & Local Employees		0.0	-1.6	-1.6	-1.5	-1.5	-1.4	-1.4	-1.3	-1.2	-1.1	-7.6	-12.6
Income-Related Part B Premium (\$90K/\$115K)	4/	0.0	0.0	-1.7	-1.2	-1.5	-1.8	-2.5	-3.0	-3.7	-4.5	-6.2	-19.9
Eliminate MVPS Upward Bias	1/	0.0	0.0	0.0	0.0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5	-0.8	-14.2
Part B Offset		0.0	0.0	0.0	0.0	0.1	0.2	0.4	0.7	1.0	1.4	0.2	3.6
<i>Subtotal</i>		0.0	-1.6	-3.3	-2.7	-3.2	-3.7	-5.0	-6.3	-7.8	-9.7	-14.4	-43.2
TOTAL		-0.2	-2.7	-4.9	-4.9	-8.6	-12.6	-17.3	-22.8	-29.5	-36.0	-33.6	-139.5

NOTES:

- 1/ Savings assume implementation of proposals in 1995. Savings would need to be recalculated for 1996 effective dates. FY 1995-2004 savings would be decreased.
- 2/ OBRA 1993 eliminated the update for ASC payment rates in 1994 and 1995. Proposal shown would extend freeze through 1999. OACT (9/14/94).
- 3/ OBRA 1993 eliminated the update for clinical lab payment rates in 1994 and 1995. Proposal shown would extend freeze through 1999. OACT (9/14/94).
- 4/ Proposal would establish income thresholds at \$90,000 for single filers and \$115,000 for joint filers (HSA and Senate Finance proposal).

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Potential Sources of Funding

	1996-2000		1996-2005	
	Medicare	Total	Medicare	Total
Tobacco Tax (\$0.45 per pack) <i>\$505</i>	0		0	
Tobacco + OBRA '93 - I	10		66 <i>by extending current law</i>	
Tobacco + OBRA '93-I + OBRA '93-II	20		96	
Tobacco + OBRA's + Additional Medicare Savings:	34		139	
Tobacco + OBRA's + Additional Medicare Savings + Mainstream Medicare Savings	73		256	
Tobacco + OBRA's + Additional Medicare + Net Mainstream Medicare + Change in Cafeteria Plans + Tax Cap	73		256	

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Possible Options and their Costs

Billions of Net Subsidy Dollars, 1996-2005

Subsidy Options							
	30-60	120	150	200	280	350	540-800
Welfare to Work	X						
Unemployed	X						
Kids Only	X	X	X				
Working Families					X	X	X
Broad, Low Income Voucher						X	X
State FMAP Flexibility	?	?	?	?	?	?	?

All options assume a 1/1/97 start date. The options have been estimated as if they are independent, stand alone options. For example, the cost of doing Welfare to Work, Unemployed, and a lower cost Kids Only version simultaneously could cost as much as \$160 billion.

Net Subsidy Dollars is gross subsidy dollars minus any Medicaid savings and state maintenance of effort requirements. Each column assumes a particular amount of funding available, AFTER any Other Options (detailed below) are financed.

Other Options

Total Cost			
	1996-2000		1996-2005
Self-Employed Deduction			
Long Term Care	8-10		20-50
Medicare Drug	21		100

The self-employed deduction phases from x% on 1/1/95 to y% by 1/1/01.

The long term care options range from the capped entitlement in the Mitchell bill to something smaller.

The Medicare drug benefit is the one in the Mitchell bill, . . .

Broad-Based Income Voucher

- ▶ **Who Is Eligible?** All families and individuals are eligible. Families with incomes below 200% of poverty are eligible for some federal premium assistance. A second option examined would exclude Medicaid beneficiaries.

- ▶ **What Benefits Would They Receive?** Two options were examined:

Option 1. The Blue Cross/Blue Shield standard option

Option 2. A catastrophic plan (high deductible); or alternatively a package covering ambulatory care services with 5 days of inpatient hospital care.

- ▶ **How Much Would Eligible Families Pay?** Families with adjusted gross income under 100% of poverty would not pay toward the cost of the premium. Family premium payments above poverty are based on a sliding fee scale; by 200% of poverty the family would pay the full cost of the premium; at 150% of poverty they would pay 50% of the cost of the premium.
- ▶ **How Much Would the Federal Government Pay?** The federal government would pay the full cost of eligible families living in poverty. They would also provide subsidies according to the sliding fee schedule noted above. State and local governments would make a maintenance of effort payment toward the cost of premium subsidies in options where the Medicaid population is eligible for the program.

Voucher Program for Working Families

- ▶ **Who Is Eligible?** All working families would be eligible; those with incomes below 200% of poverty would be eligible for a federal assistance. Eligibility is based on a family's work history; families that average at least 20 hours of work per week, or 480 hours in the previous 6 months would be eligible for the program. For the self-employed, eligibility is based on earning a specific level of self-employed earnings in a quarter (or in the previous two quarters). Families eligible for medical assistance under a State's Medicaid program are not eligible for subsidies under this program.

- ▶ **What Benefits Would They Receive?** Two options were considered:
 - Option 1. The Blue Cross/Blue Shield standard option.
 - Option 2. A catastrophic (high deductible plan), or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

- ▶ **How Much Would Eligible Families Pay?** Eligible families with incomes at or lower than 100% of poverty would not contribute toward the cost of their premium. Families between 100% and 200% of poverty would contribute based on a sliding fee scale (i.e. families at 150% of poverty would pay 50% of the premium).

- ▶ **How Much Would the Federal Government Pay?** The federal government would pay the entire premium for those eligible families living in poverty. Federal payments would end at 200% of poverty; subsidies between 100% and 200% of poverty are based on a sliding scale.

Extension of Medicaid Benefits When Welfare Recipients Go To Work

- ▶ **Who Is Eligible?** Families that lose AFDC benefits when working (increased earnings place them over the AFDC eligibility thresholds). Today such families can receive up to 1 year of transitional Medicaid coverage after leaving AFDC. The proposal extends this to two years of Medicaid coverage.
- ▶ **What Benefits Would They Receive?** Those eligible would receive an additional year of Medicaid benefits.
- ▶ **How Much Would Eligible Families Pay?** Like today's Medicaid program, eligible families would not pay toward the cost of coverage.
- ▶ **How Much Would The Federal Government Pay?** The program would use the existing Medicaid matching formula. On average, the federal government pays approximately 57% of program costs, with states and local governments paying 43%

Coverage for the Unemployed Uninsured

- ▶ **Who Is Eligible?** All families that have a head of household or spouse who is unemployed and receiving unemployment compensation at least one month during the year. The household is not eligible if the spouse of an unemployed person is receiving employer-sponsored insurance and the employer is contributing at least 80% toward the premium.
- ▶ **What Benefits Would They Receive?** A benefit package similar to the Blue Cross/Blue Shield standard option for up to 6 months.
- ▶ **How Much Would Eligible Families Pay?** Families with income under 100% of poverty will receive the coverage at no cost. Families between poverty and 250% of poverty will pay according to a sliding fee scale. For purposes of the program, income is defined as cash income (computed on a monthly basis) excluding unemployment compensation and other transfers.
- ▶ **How Much Would The Federal Government Pay?** The full cost for families under 100% of poverty. For those above poverty, a sliding fee scale would be used. At 250% of poverty, eligible families would be expected to pay the full cost of the policy.

Expansion of Coverage to Kids

- ▶ **Who Is Eligible?** Children under the age of 19 who were not covered by a private insurance plan during the 6 months prior to their enrollment. In addition, children whose parents have access to employer-sponsored insurance where the employer pays at least 80% of dependent coverage are not eligible.

- ▶ **What Benefits Would They Receive?** We have examined two options.
 - Option 1. Eligible children would receive the Medicaid package available in their state.

 - Option 2. Eligible children would receive a benefit package similar to the Blue Cross/Blue Shield standard option provided through the Federal Employees Health Benefit Program.

- ▶ **How Much Would Eligible Children Pay ?** Children in families with income less than 185% of poverty would receive the coverage at no cost. Households with income between 185% and 300% of poverty would pay according to a sliding fee scale (i.e. those at 240% of poverty would pay approximately 50% of the premium)

- ▶ **How Much Would the Federal Government Pay?**
 - Option 1. Under the Medicaid option, the federal government would share the costs with states and local governments using the existing federal medicaid matching formula.

 - Option 2. The federal government would pay for kids living in families under 185% of poverty and split the costs with children according to the sliding fee scale noted above.

NEC/DPC HEALTH CARE ISSUES AND OPTIONS

1. Coverage options

A wide variety of coverage options will be considered, including:

- low income families
- kids only
- welfare to work populations
- in-between job (unemployment) protections
- elderly (likely only consider if Medicare cuts high)
- combinations, different benefit package assumptions and zero option, etc.

Structure options to illustrate how much coverage you can buy for different dollar amounts.

Options considered will include an examination of feasibility, advisability and cost of different administrative options for each subsidy scheme.

2. Insurance reform options:

Benefits and risks of alternative insurance reform in a non-universal coverage market.

Graduated (from minimal to major) insurance reform options and implications and tradeoffs in each alternative.

3. State flexibility options:

Options for providing incentives or removing potential barriers to state-based reform efforts. We plan on looking at Medicaid and ERISA waiver options for group consideration.

4. Cost containment options:

Private sector options must be reviewed in detail. (Included among analysis will be medical savings accounts, cost containment, commission options, and various tax cap alternatives).

Public sector options will be reviewed. (Medicare and Medicaid savings).

5. Financing options:

Linkage to public cost containment.

Review of alternatives already proposed is underway. Revenue options will be done by Treasury.

6. Regulatory options:

Many Departments have regulatory reviews underway with expressed purpose of developing initiatives that can be helpful to health reform legislative and/or policy goals.

Previously Proposed Sources of Funding

	1996-2000		1996-2005	
	Medicare	Total	Medicare	Total
Ways and Means				
λ Tobacco Tax (\$0.45 per pack)	0	24	0	56
(w/m)				
λ Tobacco + OBRA '93-I	10	34	66	122
(w/m)				
λ Tobacco + OBRA '93-I + OBRA '93-II	20	44	96	152
(w/m)				
λ Tobacco + OBRA + Additional Medicare Savings <i>Bipartisan</i>	34	58	139	195
(w/m)				
λ Tobacco + OBRA + Additional Medicare Savings + <i>Bipartisan</i> Mainstream Medicare Savings	73	97	256	312
<i>Bipartisan</i>				
Tobacco + OBRA + Additional Medicare + <i>Bipartisan</i> Net Mainstream Medicare + Previously Bipartisan Supported	73	104-128	256	353-411
Other Revenue Options				

Medicare Savings in Previous Proposals	1995-2000	1995-2004
House Ways & Means	120	490
Health Security Act	118	376
Mitchell	103	348
Dole	43	160

THE WHITE HOUSE
WASHINGTON

MEMORANDUM

To: Hillary Rodham Clinton
From: Chris Jennings
Date: November 9, 1994
Re: Presentation to Principals
cc: Melanne Verveer

Attached is a packet of materials in preparation for tomorrow's meeting. Obviously these documents, particularly the financing documents, are extremely sensitive. The talking points include a list of political/strategic questions that hopefully will help form the policy option discussion. These questions will be read aloud by Carol, Bob, or myself, but will not be printed and distributed to the participants. The documents to follow include:

- NEC/DPC Talking Points
- **Outline of Strategic Questions**
- **Ten Year OMB & CBO Deficit Table** (which illustrates how little deficit reduction you obtain in the first 5 years if you have only Medicare "extenders" to draw from.)
- **Coverage Options and their Costs**
- **Previously Proposed Sources of Funding**

We will have clean documents for tomorrow's meeting. If you have any questions or concerns about this meeting, please do not hesitate to call me.

* Documents in bold will be distributed to meeting participants.

NEC/DPC MEETING

- The purpose of today's meeting is to begin to discuss and focus our attention on what health reform options we believe we should present to the President for his consideration. This is the first of a series of meetings with principals who will be playing the primary role in determining these options.
- We obviously must conduct our evaluation within the context of what we believe to be the realistic political, economic, and policy environment that we face following Tuesday's election results.
- Having said this, if we have any desire for any health investment or cost containment option to be included **in the budget** (or, for that matter, if we simply want to keep our options open), it is clear that our work must proceed in a timely manner in order to have a full and complete review of the options available. Today we will hopefully start the process of narrowing the infinite number of options that are possible, so that our respective staffs can better serve us and the President.
- Once again, before we start in earnest, we want to thank you for the assistance you and your staff have provided to this effort. To date, we have been quite successful in completing some preliminary staff groundwork and the information discussed and circulated has been carefully and professionally handled.
- As we proceed forward, there will be an intensified interest in our work by the media, the Congress, the outside interest groups and others. As a result, we are going to have to bend over backwards to guard against leaks. (In this regard, sometime during this meeting, we'd like to discuss and seek advice on how we -- as a group -- want to characterize our work and progress outside this room).
- Failure to protect ourselves against leaks and/or characterize meetings inappropriately or inconsistently is likely to severely hamper if not eliminate the possibility of providing the President with the best and most broadly-based policy options.
- We cannot afford to have the Congress or the outside interest groups reach the false conclusion that anything other than preliminary discussions are taking place. A belief to the contrary has every potential to be devastating to our relationships with them and our ability to produce a politically and policy-sound health reform strategy and package.
- We have asked Chris to develop a brief, first-cut health policy options presentation that we hope will help focus and give context to today's discussion.
- Prior to turning to him, however, we believe it is important that you evaluate these options within the context of the following questions regarding our health care goals, policy philosophies, and overall strategy:

- 1) **Legislative Strategy.** Should our health policy recommendations be driven by a "positioning" or an "enactment" strategy? How can we best integrate our political/budget/policy priorities with the new Republican Congressional Leadership? (Pat, et al)
- 2) **Budget Strategy.** Should we integrate our health policy inside or outside the President's budget proposal?
- 3) **Deficit Reduction.** Do we have a desire/need to dedicate any of the savings or revenues associated with health reform for deficit reduction as opposed to coverage expansions? If so, can we begin to think about parameters of the amounts and budget year timeframe (i.e., short term and/or long term deficit reduction goals) that we would like to be considered?
- 4) **Coverage Expansion.** To what extent -- if any -- do we desire or need to advocate for coverage expansions?
- 5) **Revenue Options.** In the new political environment, what -- if any -- revenues can be even contemplated for consideration for coverage expansion?
- 6) **Medicare Savings.** Within the context of deficit reduction, how many -- if any -- Medicare dollars should be on the table? Are there some categories of cuts that can/should be put on or off the table or prioritized in any way (e.g., extenders, hospitals, physicians, beneficiaries)? If we are talking about anything significant in terms of Medicare cuts, do we have to consider expansions of benefits for the Medicare population?
- 7) **Cost Containment.** Do we have public or private cost containment objections beyond medicare?
- 8) **Government Role.** Should there be a driving philosophy about the role of Government relative to any of these options? For example, can we consider public (i.e., medicaid) coverage expansions understanding, if we do not, significant Federal insurance reform will be necessary if we opt for private subsidy approaches?
- 9) **Federal/State Strategy.** Should any health care reform strategy be a substantially Federal driven/administered initiative OR should we give more latitude to the states?
- 10) **Linkage to other Administration Priority Issues.** Should we link our health policy options to other Administration policy priorities, such as welfare reform?

Obviously, the politics and numbers will significantly drive our policy decisions. As such, it is extremely helpful to us (and to Chris, as well as all principals' staff) to get a sense of where we are headed on the above mentioned issues. Please keep them in mind as you evaluate the policy options that Chris will now present.

Start Presentation by Chris....

HEALTH CARE STRATEGIC QUESTIONS

- 1) Legislative Strategy
- 2) Budget Strategy
- 3) Deficit Reduction
- 4) Coverage Expansion
- 5) Revenue Options
- 6) Medicare Savings
- 7) Cost Containment
- 8) Government Role
- 9) Federal/State Considerations
- 10) Linkage to other Administration Priority Issues

BUDGET DEFICITS AND ESTIMATED CBO SCORING OF PREVIOUSLY PROPOSED MEDICARE SAVINGS

Fiscal Years, Dollars in Billions
1995-2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995- 1999	1995- 2004
DEFICIT (Administration Midsession Estimates)	-167.1	-179.2	-190.0	-191.8	-207.4	N/A	N/A	N/A	N/A	N/A		
DEFICIT (CBO Midsession Estimates)	-162	-176	-193	-197	-231	-257	-287	-319	-355	-397		
<u>Medicare Savings Options:</u>												
Extensions of OBRA 1993 Baseline Savings	0.0	0.1	0.4	0.6	3.1	6.0	8.7	11.9	15.9	19.4	10.2	66.1
Extensions of OBRA 1993 Savings Policies	0.2	1.0	1.2	1.6	2.3	2.9	3.7	4.7	5.7	6.9	9.0	30.2
Extensions Subtotal	0.2	1.1	1.6	2.2	5.4	8.9	12.4	16.6	21.6	26.3	19.2	96.3
Additional Bipartisan Medicare Savings and Receipt Proposals	0.0	1.6	3.3	2.7	3.2	3.7	5.0	6.3	7.8	9.7	14.4	43.2
TOTAL OBRA + ADDITIONAL BIPARTISAN MEDICARE SAVINGS	0.2	2.7	4.9	4.9	8.6	12.6	17.3	22.8	29.5	36.0	33.6	139.5
MITCHELL III MEDICARE SAVINGS	2.5	8.1	13.9	17.5	25.1	33.6	42.2	53.2	66.2	80.1	67.1	342.3

Coverage Possible Options and their Costs

Coverage

Subsidy Options	Billions of Net Subsidy Dollars, 1996-2005						550-815
	30-60	120	150	200	310	410	
Welfare to Work	X						
Unemployed	X						
Kids Only	X	X	X				
Working Families					X	X	X
Broad, Low Income Voucher						X	X
State FMAP Flexibility	??	??	??	??	??	??	??

All options assume a 1/1/97 start date. The options have been estimated as if they are independent, stand alone options. For example, if Welfare to Work, Unemployed, and Kids Only programs were to be implemented simultaneously, the total cost would substantially exceed \$60 billion but would not reach \$180 billion because the programs are somewhat overlapping.

Net Subsidy Dollars represents gross subsidy cost minus any Medicaid savings and state maintenance of effort requirements.

Each column shows the amount of funding required for different coverage proposals, and does NOT include the cost of any Other Options (detailed below).

Other Options

	Total Cost	
	1996-2000	1996-2005
Self-Employed Deduction	4-15	9-36
Long Term Care	10-12	20-75
Medicare Drug	21	100

Scheduled to expire

The self-employed deduction options range from extending the current 25% deduction from 1/1/94 to one that also increasing the deduction to 100% on 1/1/95.

The high end of is and the range includes the long term care options range from the capped entitlement in the Mitchell bill to something smaller, and also include other related policies.

The Medicare drug benefit is the one in the Mitchell bill. Beginning 1/1/99, beneficiaries pay a deductible and 20% copayment up to a \$1275 yearly out-of-pocket limit. This program is 25% financed by an increase in the Part B premium.

Twenty-five percent of

United States Senate

WASHINGTON, DC 20510-3803

December 21, 1994

Dear Colleague,

As our Senate office closes down and the moving van takes our health care and other files home to Bryn Mawr, I want to thank all those with whom I've worked to reform the health care system. And I want to assure you that I look forward to continuing work with you to achieve the goal of affordable health care choices for all: choices as good as Congress has arranged for itself.

With the new leadership of the Senate and House, we cannot expect -- in the next two years, at least -- anything like the comprehensive reform I had hoped for. But the common ground, first-step, children-first proposals I made to Senators Dole and Mitchell last summer may be possible. Senator Dole has said that if the new Congress doesn't pass some significant health care reform within a year, it should be "whacked."

Some of us will be available to do the "whacking," if necessary, but let's hope that before the 1996 election season reaches its full partisan fury, some constructive first steps can be taken.

Congress cannot avoid the issue for long because any successful welfare reform must deal with the problem of assuring women with dependent children that when they leave welfare to take a job, they won't lose the health care they now get through Medicaid. If the Republicans are serious about their wish to reduce government, they should be open to an arrangement for vouchers through which those who leave welfare get private health insurance choices with their new jobs. That was one of our proposals last year that got little recognition in the onslaught against "government takeover" of medicine. This would get government out of the business of paying directly for medical services for the poor.

Then there is the central budgetary problem of how to reduce the rate-of-increase in the costs of both Medicare and Medicaid without shifting those costs onto the private sector or undermining the care given by hospitals and doctors. This challenge, perhaps more than any other, will bring Congress back to need for health reform.

Meanwhile, Congress' failure to act has shifted the challenge back to state governments, local communities, the medical professionals and the health care

industry. The attached December 18, 1994 *New York Times* article describes the extraordinary change underway in that industry. For those of us who want more consumer choice -- not less choice -- of doctors and health insurance plans, the increasing limitations on such choice in the private sector is disturbing.

Most stimulating to me is the enclosed article by James Fallows in the January 1995 *The Atlantic Monthly*. It says much of what I've wanted to see in the media, but sorely missed during the months we lost the debate. The Clinton bill was too long, too regulatory, and too bureaucratic. Our Labor and Human Resources Committee recognized that and made major changes at the mark-up. But the misinformation and distortion was greater than I have ever experienced on any other public issue.

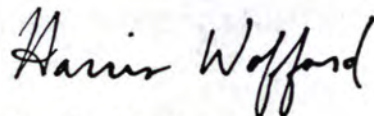
I hope you'll read the article. If you have thoughts on what went wrong, or, more importantly, on where we should go from here, I hope you'll get in touch with me (407 Old Gulph Road, Bryn Mawr, Pennsylvania, 19010). I'm starting to do some writing and talking on that subject, and I want to be part of shaping a new strategy as the country goes back to the drawing board on health reform. I would benefit by your reflections and counsel.

Aside from the health care debate, there was also, of course, the election I lost this Fall. I lost it in part because the health care debate was lost. In 1991, the need for health reform was the symbol of why voters in Pennsylvania wanted Washington to act on our economic and social problems. In 1994, the distorted version of Democratic health care proposals became a symbol of "Big Government," and the failure to get agreement was an example of failure by the Administration.

Other factors -- gun control and the NRA, abortion, Clinton, my opponent's direct mail campaign, and lost opportunities by our own campaign -- were each enough to make the difference of about 85,000 votes out of more than three and a half million cast.

I'm looking back only in order to figure out how to move forward. Most of all, I'm deeply grateful, this holiday season, for the extraordinary opportunity I've had, during the three and a half most challenging years of my life -- so far. For this, I thank you and all the people of Pennsylvania.

With warm good wishes,

A handwritten signature in cursive script that reads "Harris Wofford". The ink is dark and the signature is fluid, with a large, stylized 'H' and 'W'.

Harris Wofford

United States Senate

WASHINGTON, DC 20510-3803

September 26, 1994

The Honorable George Mitchell
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Robert Dole
Minority Leader
United States Senate
Washington, D.C. 20510

Dear Senators Mitchell and Dole,

Even though there is broad agreement on many elements of health reform, it now appears that Congress may recess without passing any health reform legislation. To adjourn without enacting those measures upon which we agree would be a scandal. It is hard for me -- and more importantly hard for the American people -- to understand why we would leave so many significant agreements on the table.

We have seen how baseball owners and players, by emphasizing their disagreements, ruined a wonderful season for everyone. Let's choose the opposite course. Let's emphasize our common ground, and act on it. That would be a victory for everyone, most significantly for the American people who would find health insurance more accessible and more secure.

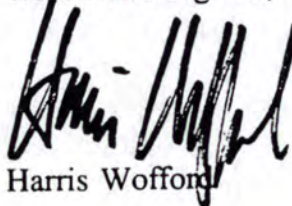
As you, Senator Dole, have suggested on numerous occasions, there are clear areas of agreement on health reform that can still pass with overwhelming support in the Senate and the House of Representatives. Specifically, I propose a bill that includes the following provisions, which you and many Republicans and Democrats have supported. (I have noted how each item has already been included in existing proposals.)

1. **Insurance market reforms.** Strengthen private health insurance by eliminating pre-existing condition exclusions and enacting other widely agreed upon changes in insurance industry practices. (Mitchell, Dole, Labor Committee, Finance Committee, Mainstream Group)
2. **Federal Employees Health Benefits Program (FEHBP).** Open to individuals and small businesses the program that we and millions of Americans use to get health insurance. (Mitchell, Dole, Labor Committee, Finance Committee, Mainstream Group)

3. **Expanded coverage for children.** Provide subsidies for low and moderate income children. Virtually all health reform proposals include subsidies for individuals and families with low and moderate income. This approach would focus subsidies on expanding coverage for children. (Mitchell, Dole, Labor Committee, Finance Committee, Mainstream Group)
4. **Long-term home and community-based care.** Make a start on long-term care by creating a capped state grant program to provide assistance to the elderly and disabled for the cost of home and community-based care. (Mitchell, Labor Committee, Finance Committee, Mainstream Group)
5. **Deductibility for the self-employed.** Permit farmers, sole proprietors, and other self-employed persons to deduct 100 percent of their health care costs. Virtually all health reform proposals include an expansion of the deductibility for the self-employed. (Mitchell, Dole, Labor Committee, Finance Committee, Mainstream Group)
6. **Administrative simplification.** Reduce the cost and frustration caused by the mass of paperwork that plagues the current health care system by moving to a uniform electronic system for medical records and claims, building on private sector, not government initiatives. (Mitchell, Dole, Labor Committee, Finance Committee, Mainstream Group)
7. **Anti-fraud and abuse.** Enhanced investigation and enforcement of fraud and abuse laws. (Mitchell, Dole, Labor Committee, Finance Committee, Mainstream Group)

This "Seven-Point Common Ground Plan" is made up entirely of provisions that we have all supported. I believe the American people would understand and support such a bill if we could agree to move it through Congress. To be sure, such a bill would not include many reforms that I support, as well as provisions that others favor. But I suggest that we leave those disagreements for another day. Now is the time for us to come together to work for what we agree is the common good.

With warm regards,

A handwritten signature in black ink, appearing to read "Harris Wofford", written in a cursive style.

Harris Wofford



Peter Diana/Post-Gazette

A meteoric career through the Senate

Wofford exit graceful amid post-mortems

Unseated senator calls half-term his 'high point'

By Pat Griffith

Post-Gazette Washington Bureau

WASHINGTON — Three years ago, he was the toast of the national Democratic Party and the talk of Washington, the man who beat a Pennsylvania political powerhouse named Richard Thornburgh to gain a Senate seat and media acclaim as Mr. Health Care Reform.

Last week, seated in a stripped-down office lined with stacks of boxes bearing labels such as "coffee table books" and "honorary degrees" and "glassware," Harris Wofford was amidst a transition back home to the Philadelphia suburb of Bryn Mawr.

Wofford's meteoric Senate career had run about 3½ years, hardly more than a blip in a ponderous institution that prides itself on tradition, respects seniority and, above all, venerates longevity.

In the same week that Sen. Strom Thur-

mond of South Carolina, the Republicans' newly chosen president pro tem, turned 92, two-thirds of the way through his seventh term in office, Wofford was making as graceful and gracious an exit from his eventful half-term as the prickly post-mortems of political reporters would permit.

"I liked these years more than any in my life," he said with obvious enthusiasm. "It was maximum challenge. I just loved it."

Then with a broad, almost mischievous grin, he added: "It's the high point, I would say, so far."

Wofford, 68, insists that he doesn't know precisely what "perch" he'll occupy next. The former college president and state official said he is looking at the full range of possibilities — public or private, corporate or non-profit foundation, education or health care — just about anything except becoming a paid Washington

lobbyist.

Asked if he might run for office again, he beams enigmatically.

"I wouldn't rule anything out. I notice [Senate Republican leader Bob] Dole is running for president at age 72, so that gives me four years to run for president — which I'm not going to do."

A harsh assessment of Wofford's quick spin through the Senate would assert that after building up Pennsylvania voters' hopes for a major overhaul of the health care system, he didn't produce — and so was defeated.

Some would contend that he was hurt by his identification as a supporter and admirer of President Clinton. Another line of political punditry dismisses him as an out-of-step liberal swept away in a floodtide of conserva-

SEE **WOFFORD**, PAGE A-10

DECEMBER 11, 1994

Pittsburgh Post-Gazette

Wofford exit graceful amid post-mortems

WOFFORD FROM PAGE A-1

tism and anger at Washington.

But Wofford refuses to feel rejected or dejected. If there is one group of voters he wishes he had worked harder to reach, he says, it would be hunters who believed the National Rifle Association's harsh rhetoric that his support of an assault-weapons ban was a step toward taking away hunting rifles. Wofford vehemently denies that he would ever advocate government interference with hunting.

"Ironically, because the economy was better and people weren't as concerned about losing their jobs, some of the special-interest issues became more important," he said. "The gun issue alone more than made up the spread in the votes."

Wofford said he doesn't view the election result as a personal rejection because half the state's 3½ million voters, "minus 87,000 people," voted for him. He said that instead he's "full of gratitude" to those who wanted him to return for a full six-year term. In his mind, the closeness of the Pennsylvania contest refutes the widespread portrayal of the midterm elections as an overwhelming political mandate for Republicans.

Wofford barely admits to personal disappointment that his Senate tenure ended so abruptly. He said he has explained to "dispirited younger friends" that the three significant losses in his life were the deaths of John and Robert Kennedy and Martin Luther King Jr.

"When you think of losses like that, a little election defeat is very small," he said quietly.

He last spoke to Sen-elect Rick

Santorum on Election Night. While no meeting with his successor is scheduled, he said he expects to have one, "and I look forward to it."

Wofford does acknowledge that in hindsight he wishes he and other Democratic senators had moved sooner and more forcefully to simplify Clinton's original health care proposal to win support from moderate Republicans and the public.

At the same time, he says he's unsure that even if Democrats had signaled willingness to compromise early last year, instead of waiting until September to attempt a bipartisan bill, that Republicans would have let a bill pass the Senate in an election year.

"But we put the issue on the map in an indelible way," he says confidently. "And even Dole said recently that if Congress has not passed a health care reform bill within a year, it should be 'whacked.' It won't happen in the first 100 days, but I expect it to come."

Wofford predicts that Congress will eventually pass a measure somewhat similar to the one he suggested, opening the federal employees' health insurance program to individuals and small businesses and assuring all Americans of a choice of benefit plans comparable to what members of Congress have.

Against the failure to enact health care reform during his tenure, Wofford stacks the bills he sponsored and helped push to passage: the Martin Luther King holiday bill; the Civilian Conservation Corps and National Service programs; the school-to-work bill, which incorporated lessons from Pennsylvania's youth apprenticeship programs that Wofford had

*"All this suggests
that you may see
more of me."*

helped develop; and an overhaul of the student loan program that lets payments be adjusted to graduates' earnings and extend them for longer periods.

As a going-away present, his Senate staff gave him framed copies of those bills and the pens the president used to sign them.

"I'm grateful to [Gov.] Bob Casey for appointing me ... and [for] being elected. It's been a wonderful 3½ years. I'm not leaving with any sense other than an appreciation for the opportunity I had."

Wofford said he finds much he agrees with in incoming House Speaker Newt Gingrich's "inaugural speech" to Republicans last week, especially Gingrich's professed admiration for Franklin D. Roosevelt as a great statesman who took a "trial-and-error" approach to

government reform.

But he leaves with one great worry: "that we might go back to tax breaks for the rich that aren't paid for and do defense spending that isn't paid for," with a resulting increase in the deficit.

More by accident than design, Wofford was the last senator to speak on the Senate floor in the 103rd Congress.

In a brief valedictory Dec. 1 that closed the special session, Wofford recalled that he had begun his active involvement in public policy as an 11-year-old in New York, when he wrote his two senators, Robert Wagner and Royal Copeland, to protest Roosevelt's attempt to pack the Supreme Court.

"So, if past is prologue," he said in parting, "all this suggests that you may see more of me — not as a senator, but once again as a citizen who will do his best to help the Senate do its duty."

Earlier that week, honoring Senate tradition, Wofford lifted the lid on his desk to carve his name for posterity. To his surprise and delight, he found the names of Wagner and Copeland there ahead of him.

New York Times

NEW YORK, SUNDAY, DECEMBER 18, 1994

While Congress Remains Silent, Health Care Transforms Itself

By ERIK ECKHOLM

In the two years that Congress wrangled over health care before quashing proposals for fundamental change, private market forces were acting on their own to transform the country's medical system dramatically.

Indeed, cost cutting, intensive competition and the growing role of large, profit-seeking corporations in health care escalated some of the very trends that many members of Congress said they most opposed, like limitations on the choice of doctors. Among the milestones American health care reached without fanfare during 1993 and 1994 were these:

¶A majority of privately insured Americans were enrolled in managed-care plans that limit choice of doctors and treatments. Sixty-five percent of workers at medium and large companies were in such plans by 1994.

¶For-profit health maintenance organizations grew so fast that they overtook nonprofit H.M.O.'s as the dominant force in managed care. Today the majority of all people enrolled in H.M.O.'s, the most common and stringent form of managed care, are in plans run by for-profit companies.

¶At least three-fourths of all doctors signed contracts, covering at least some of their patients, to cut their fees and accept oversight of their medical decisions. Among doctors who work in group practices, the share of such managed-care contracts was 89 percent by 1993, up sharply from 56 percent the year before.

Healing Process

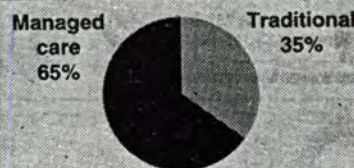
A special report.

This year, reflecting dramatic change, almost two-thirds of people insured through employers will receive their care from some kind of managed care arrangement, involving a limited choice of doctors and tighter cost controls. Figures are for companies with 200 or more employees.

1991



1994



Source: KPMG Peat Marwick

The New York Times

Run for decades more like a collection of cottage industries than a system that now accounts for one-seventh of the economy, medical care is increasingly the domain of big business, offering a rich new playing field for Wall Street. Mergers and acquisitions of hospitals; clinics; doctor groups with their patient lists; medical laboratories, and other patient-care services, have totaled \$20 billion this year, up from just \$6 billion in 1992. Combined with the \$22 billion in pharmaceutical deals, health care mergers surpassed in value those of any other industry for 1994, according to the Securities Data Company, a research firm in Newark.

But this restructuring has done nothing to ease the plight of the uninsured, whose numbers keep climbing, and it is also raising profound new questions about how quality care and medical ethics can be guarded.

"There's never been a time in the history of American medicine when the independence and autonomy of medical practitioners was as uncertain as it is now," said Dr. Arnold S.

Continued on Page 34, Column 1

Relman, editor emeritus of the New England Journal of Medicine. "I think that in this process businessmen and their agents will begin to exercise unprecedented control over the allocation of medical resources."

But proponents of H.M.O.'s say that their brand of medical care, prevention-oriented and centered on a family doctor, is generally better as well as more economical. They say consumers have little to fear.

"It's the corporatization of health care," said Kenneth S. Abramowitz, a market analyst with Sanford C. Bernstein & Company in New York, who advises health investors. "And what's wrong with that?"

"Corporations produce hotel rooms and toothpaste and automobiles, and the country does fine. You still have to produce a service and monitor and improve it, for a finite price."

The rapid changes have been driven, above all, by the desire of those who pay most health bills — employers and the government — to reign in costs. In response, insurers and H.M.O.'s are offering to care for people at reduced, all-inclusive prices, confident that they can suppress spending enough to offer good care and still make a profit. And in turn, investors and speculators are attracted to companies that hold the promise of delivering the health care "product" for less.

The national debate over how to revamp health care only speeded up the changes in the marketplace, many experts think, as doctors, hospitals and investors realized that one way or another, managed care was likely to reign supreme.

H.M.O.'s seek to cut costs by curbing tests, surgery, referrals to specialists and

hospital stays they consider unnecessary, as well as by paying lower fees, pushing prevention and seeking out efficiencies wherever they can. In regions where H.M.O.'s have begun to compete with each other for business, there is, in fact, evidence that they can hold down overall medical spending.

In California, a bellwether in the transition to managed care, three-fourths of all privately insured patients are now in H.M.O.'s, and even one in four elderly Medicare patients have joined them, said Albert Lowey-Ball, a consultant in Sacramento. In the most recent sign of savings, larger employers in the state, in negotiations with fiercely competing H.M.O.'s, have obtained rollbacks in health premiums for next year of up to 10 percent.

Nationwide, health spending slowed considerably over the last two years, though it was still double the general inflation rate.

Whether recent reductions in H.M.O. premiums can be maintained for long is disputed. And over time, many experts believe, health spending will still grow faster than the economy as a whole because of new technologies and the aging of the population.

Whatever it may do to cut spending, market competition has not halted the rise in the number of uninsured, which is linked to broader economic trends. According to Federal surveys, the number of Americans living without health insurance climbed to 39 million in 1993, from 37 million in 1992, and further increases are expected this year.

While President Clinton's ill-fated health care plan sought to encourage the trend toward market competition, it also proposed numerous new regulations and agencies intended to keep the system fair and cap future spending. These regulatory measures were seen as potentially suffocating by many in the health industry, who turned against the plan.

Market competition portends drastic change for many doctors and hospitals. The scale of the possible dislocations is suggested by a single example. In southern California now, the going rate paid by H.M.O.'s for heart-bypass surgery is \$15,000, including all doctor, hospital and other fees. In contrast, total fees for bypass surgery under traditional insurance in much of the country can easily be \$45,000 or more. There is no evidence of any differences in medical outcomes.

Already in California, "the incomes of specialists are dropping like stones," said David Langness of the Hospital Council of Southern California. Hospitals throughout southern California are now only 48 percent full on average; 40 have closed in the last five years and many of the remaining 279 are in financial straits.

Doctors who are not well ensconced in H.M.O.'s are in a state of near-panic, said Dr. Gary Krieger, a pediatrician in San Pedro, Calif. "They're joining physician groups, signing any contracts put in front of them and losing control of their patients."

The Changes

A New Breed Of H.M.O.'s

In the vanguard of change is a new breed of for-profit H.M.O.'s, aggressively competing for contracts to provide care for a preset monthly fee and exercising strong controls over the decisions of their doctors and hospitals.

Some of these H.M.O.'s are run by the large insurance firms, like Prudential and Aetna, while others are newer, independent companies like U.S. Healthcare, based in Pennsylvania or FHP Inc., based in California. Together, they have eclipsed the older nonprofit groups like the Kaiser Foundation of California that pioneered in the creation of H.M.O.'s, underpricing them and often providing extra services like longer office hours.

As they take over a larger share of insured patients, the for-profit H.M.O.'s are forcing the rest of the system to emulate their practices, with private doctors and nonprofit hospitals joining new groups searching for ways to market their services and cut costs.

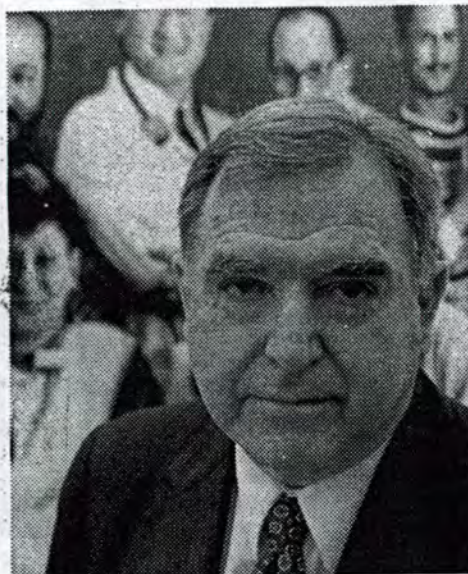
From 1992 to 1994, nine million people joined H.M.O.'s, bringing the total of participants to more than 50 million, a fifth of the country's population. This was more than double the growth of four million in the previous two-year period, and it largely occurred among for-profit companies. In some cases, the H.M.O.'s allow patients to use outside doctors if they pay extra fees.

Tens of millions more people are in looser forms of managed care like "preferred provider" networks that require use of doctors who have agreed to work for a discount, but that do not oversee daily medical decisions as closely as the H.M.O.'s do.

In parts of the West, Minnesota and recently Massachusetts, more than one-third of all residents, including most privately insured patients, are already in H.M.O.'s. The numbers are climbing fast everywhere except in sparsely populated regions, where H.M.O.'s are less practical. In New York City, long a holdout, enrollment in H.M.O.'s jumped by 20 percent in the year ending in April, and now includes 18 percent of the total population.

As H.M.O.'s and medical groups swallow each other, fewer, larger systems are taking over the market. Over the last two years in southern California, seven large medical systems have gained control over 75 percent of the private insurance market of some 7.2 million people, said Dr. Jacques J. Sokolov, a physician and chief of Advanced Health Systems, a consulting firm in Los Angeles. The largest one is the nonprofit Kaiser group, but all the others are for-profit H.M.O.'s and medical groups.

Even where H.M.O.'s are not yet dominant, their looming presence is prompting a frantic burst of acquisitions and speculation more typical of the airline or telecommunications industries than the formerly staid world of medicine.



Evan Richman for The New York Times

Dr. Arnold S. Relman

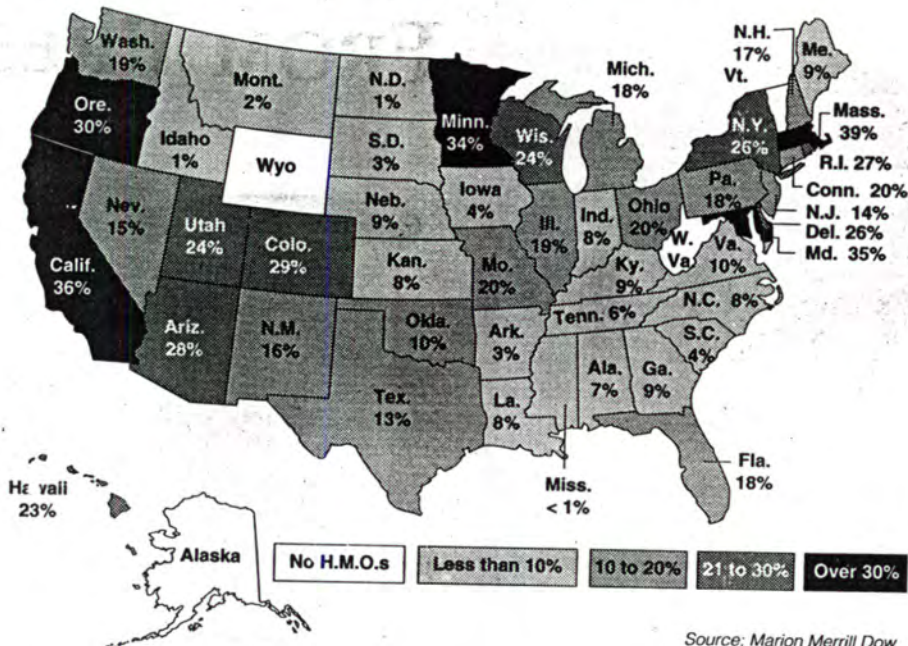
Editor, New England Journal of Medicine

"There's never been a time in the history of American medicine when the independence and autonomy of medical practitioners was as uncertain as it is now."

Health Care in Transition

MANAGED CARE HAS ADVANCED FASTEST IN THE WEST

The percentage of the population in each state covered by an H.M.O. on Dec. 31, 1993.



Source: Marion Merrill Dow

FOR-PROFIT H.M.O.s HAVE GROWN THE FASTEST OVER THE LAST TWO YEARS, AS WASHINGTON DESIGNED MAJOR HEALTH CARE LEGISLATION

The ten largest H.M.O. chains.

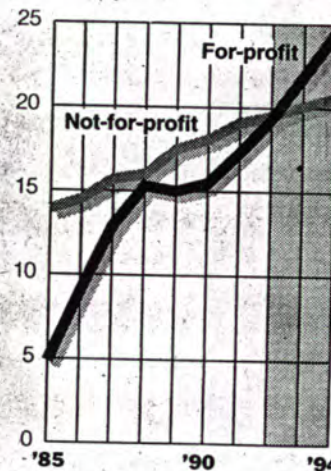
■ For-profit ■ Not-for-profit

Chain	1994 Enrollment*	% growth since '92
Kaiser Foundation	6,597,667	0%
Prudential Health Care	3,811,408	37
CIGNA HealthCare	3,237,123	42
United HealthCare	3,159,100	87
Aetna Health Plans	2,858,000	92
U.S. Healthcare	1,737,000	24
FHP Inc.	1,712,000	139
Health Systems Int'l	1,439,013	23
Humana	1,431,000	15
PacificCare	1,358,219	42

*Includes plans that allow use of outside doctors for a fee; enrollments are given as of various points in mid- to late 1994.

Source: Group Health Association of America

The number of patients, in millions, covered by H.M.O.s of each type.



Source: Interstudy

Insurers, hospitals, doctor groups and new kinds of hybrid health care companies are buying each other out, forging strategic alliances and sometimes engaging in cut-throat price wars as they seek to position themselves for the coming competition.

The object is to gain the best position for signing up insured patients — “money-generating biological structures,” as Uwe Reinhardt, an economist at Princeton University, says they might be defined today.

No one is chasing after the uninsured, whose plight may actually be worsening as financially strapped hospitals cut back on charity care, said Glenn A. Melnick, a researcher with the Rand Corporation in Santa Monica, Calif.

The Competition

Seeking to Control The Market

Even as insurers, doctors and hospitals begin to link up, the three groups are jostling to see who can dominate. So far, the insurers and H.M.O. companies generally have the upper hand, but in the last two years doctors and hospitals have begun to regroup, trying to build large organizations of their own to salvage some autonomy and bargaining power. In the most dramatic example, in just two years one private hospital company, Columbia/HCA Healthcare, has grown from a small regional chain into the owner, when recent deals are completed, of 311 hospitals — half of all the for-profit hospital capacity in the country.

This chain and others are now starting to buy up nonprofit hospitals as well. At the same time, larger nonprofits are buying up small hospitals and doctor groups in hopes of securing their own share of the market.

The nonprofit hospitals were often formed with a charitable purpose and are exempt

from many taxes. In the new competitive climate, many are behaving more and more like the investor-owned chains, which seek a profit for shareholders, leading some to ask whether the distinction is meaningful. But leaders of the nonprofits say they retain a deeper commitment to serving their communities.

Doctors are often forming associations for negotiating purposes and in one case, in Florida, a group of private surgeons have tried joining a union to bolster their bargaining power over fees.

Meanwhile, Federal antitrust enforcers are struggling to define when consolidation by hospitals or doctors amounts to the illegal infringement of competition.

“It’s a free-for-all, with different groups vying for control,” said Dr. Peter Kongstvedt, a partner of Ernst & Young in Washington and, like Dr. Sokolov, one of a growing number of physicians working full-time as business consultants.

Huge sums are required to create giant, low-cost health plans to pay for everything from the computer systems used to monitor doctors’ decisions, to mass advertising.

With their broader ability to raise funds from investors, the for-profit companies should have an edge over nonprofit H.M.O.’s and hospitals, said Dr. Sokolov. “The future of the nonprofits is in jeopardy,” he said.

Competition for patients in southern California has become so intense that, in the view of many industry analysts, some of the H.M.O.’s and medical groups may be losing money in that region this year, covering the losses with profits made elsewhere. Desperate to keep a flow of patients, hospitals are agreeing to fees that are below their true costs.

And now, with the pie shrinking, conflict over the division of revenues is building among the insurers, doctors and hospitals.

“The H.M.O.’s are taking extraordinary profits,” said John C. McDonald, chief executive of the Mullikin Medical Centers, a for-profit group of 400 doctors based in Long Beach, Calif., that subcontracts with H.M.O.’s to provide patient care at a set price. “They’re taking one-third off the top and using that money to expand in other parts of the country.”

Doctor and consumer groups have at-

tacked the H.M.O.’s for spending from 15 percent to 30 percent of their revenues on marketing, administration and profits. But defenders say this is not out of line with other industries, and that it takes extra oversight to rechannel medical practices.

“I would not characterize this as money being diverted from health care,” said Alan Hoops, chief executive of Pacificare Health Systems Inc., an investor-owned H.M.O. based in Orange County that has expanded into five other states. “It’s no different from any other business. Management is part of health care.”

In the fierce competition for contracts, Dr. Sokolov said, “There has been less focus on quality measures, report cards and the like and an extreme focus on price.”

Over time, as all groups offer care at similar rock-bottom prices, he said, customer service should become a more important arena for competition. Larger employers, many working together in the Bay Area Business Group on Health in San Francisco, have already begun demanding that health plans produce data for public release on medical performance and patient satisfaction.

“But on the downside,” Dr. Sokolov said, “there may be no money left in those systems to invest in quality studies.”

The Care

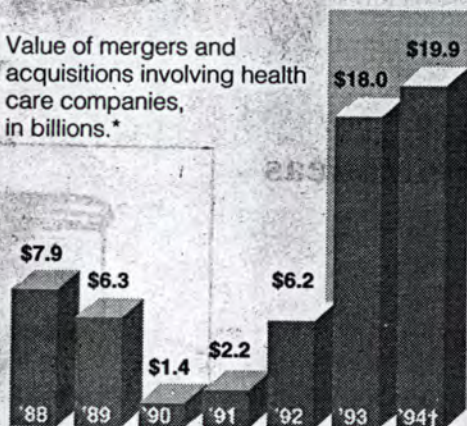
Is Quality Sacrificed?

At the heart of the transition occurring in American health care is a basic switch in the way medical services are paid for, from one in which fees are paid for each service provided, to one in which health plans receive a preset fee to meet all medical needs.

In the traditional system, doctors and hospitals made money by doing more, creating an unhealthy incentive to perform marginal tests and surgery. In the new system of prepaid care, the H.M.O. receives the same fee no matter what; an extra sonogram comes out of its profits. And increasingly, the H.M.O. pays physicians and hospi-

HEALTH CARE IS INCREASINGLY THE DOMAIN OF BIG BUSINESS

Value of mergers and acquisitions involving health care companies, in billions.*

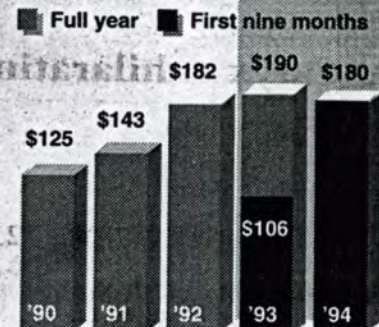


*Domestic companies only, by date deals were announced. Excludes pharmaceutical companies.

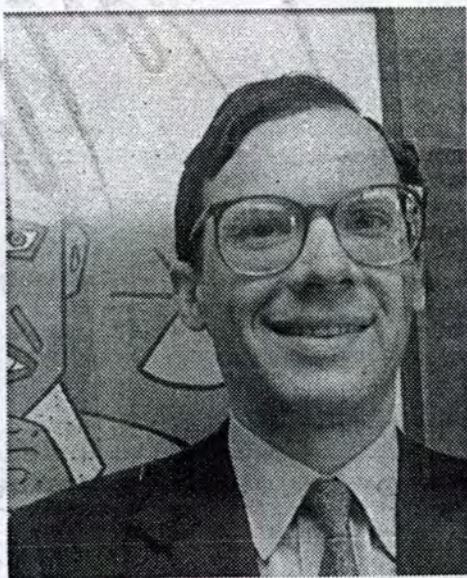
†Through December.

Source: Securities Data Company

Advertising expenditures by health and dental insurers, in millions.



Source: Competitive Media Reporting



Susan Harris for The New York Times

Kenneth S. Abramowitz

Market analyst

“It’s the corporatization of health care, and what’s wrong with that?”

tals on a similar basis, known as capitation, giving these groups a direct incentive to hold down expenses.

Dr. William S. Andereck, an internist at California Pacific Medical Center in San Francisco, said he resigned from an H.M.O. after 10 years because he felt the incentives were unethical. "You get the same amount whether you see the patient or not," he said.

"For the black and white stuff they still make the same calls," he said. "But most of medicine isn't black and white. It's judgment calls, and that's where the incentive system has its impact."

If a woman has a lump in her breast, the doctor can wait three weeks or send her to the surgeon down the hall for an immediate biopsy, he noted. "Probably the outcome will be the same," he said. "But over that three weeks, what if it was your wife?"

The H.M.O.'s argue, though, that since they take financial responsibility for a patient's care over time, they actually have an economic imperative to perform useful tests and surgery.

"The lesson we've learned, and it cost us quite a bit to learn it, is that you do well only by keeping patients well," said Mr. McDonald of the Mullikin group. He noted that poor management of hypertension, diabetes or congestive heart failure can lead to catastrophic expenses.

"Those delayed procedures this year will cost you far more next year," Mr. McDonald said.

In some cases, the detailed scrutiny of medical decisions by H.M.O.'s can mean better care for less. The Kaiser plan in southern California, for example, found that by offering Pap smears to women on a scientifically based schedule, in most cases every three years, they could perform fewer total tests on more women. They spent less money, but detected more cases of early cervical cancer.

Well aware that their future hinges on public perceptions of the quality of care, H.M.O.'s now stress that commitment whenever they can. Most have physician medical directors who work closely with the doctors, monitoring patterns of care and outcomes, seeking consensus on the most cost-effective treatments. Some have panels including outside doctors or consumers that help rule when a patient appeals an H.M.O. decision to deny a service.

The plans say they reward doctors not only for holding down referrals and tests, but also for improving the rate at which children are immunized and for their scores in privately conducted surveys of consumer satisfaction. They also foster the use of scientific guidelines for care and peer review of doctors' decisions.

"The many non-financial influences balance out the financial incentives," said Dr. Alan L. Hillman, director of the Center for Health Policy of the University of Pennsylvania.

"The part of the system that has the best quality, the part of the system that is most accountable, the part that is best able to present information to the public is the managed-care part of the business," said William Roper, former head of the Federal Medicare and Medicaid programs who is now chief medical officer of Prudential Health Care.

The Decisions

'Who Are The Managers?'

But questions of what gets covered and who decides are certain to crop up again and again. The mantra of managed care is "high quality and cost-effective," but there is no objective way to say how much extra benefit an expensive antibiotic, for example, has to bring in order to justify substituting it for a cheaper one. And when is heart surgery that can make a patient more comfortable, but is unlikely to extend life, a cost-effective choice?

"I'm all in favor of managed care," said Dr. Melvin H. Kirschner, a family practice physician in Van Nuys, Calif. "But who are the managers and why do they manage?"

Critics worry, above all, that in the emerging system, those in charge of care, from corporate overseers answerable to stockholders down to individual doctors worried about their own income, will have too much incentive to shortchange patients.

"The doctor can make more money if he doesn't prescribe the test or the X-ray, if he doesn't send you to the hospital, or if he discharges you as quickly as possible," Dr. Relman said.

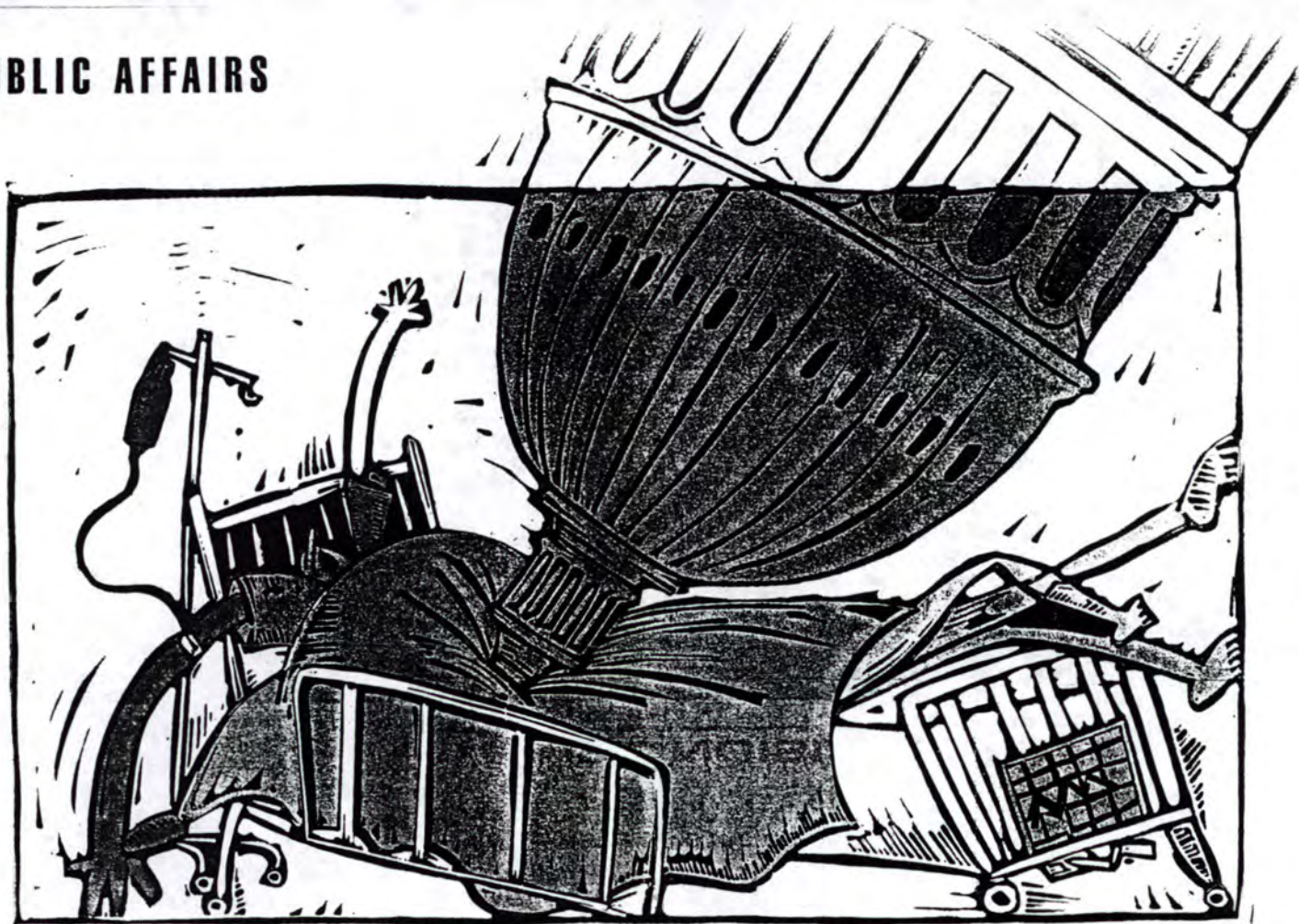
"I don't think the patient can feel comfortable," he said. "Whose interest is the doctor serving — his own, the company's or the patient's?"

Geraldine Dallek, director of the Center for Health Care Rights in Los Angeles, a patient-advocacy group, has fought against H.M.O.'s scrimping on needed care, like physical therapy for elderly patients.

One recent client was a man who needed unusual throat surgery. His H.M.O. said he had to use its surgeons, who had never performed this particular procedure. The man balked, arguing that the H.M.O. should pay for an experienced specialist elsewhere. Only after persistent calls from the advocacy group did the health plan relent.

"I'm not against managed care, but more needs to be done to protect people against under-service," she said, calling for broader Federal and state regulations. Consumers should be able to know, for example, what financial incentives their doctors are working under, yet many insurers will not disclose their financial arrangements.

"Just because we did a lousy job in fee-for-service is not an excuse to do a lousy job with H.M.O.'s," Ms. Dallek said. "At least in fee-for-service if you didn't like a doctor's decision you could go somewhere else. If you're in an H.M.O., you're really stuck."



A Triumph of Misinformation

Most of what everyone "knows" about the demise of health-care reform is probably wrong—and, more important, so are the vague impressions people have of what was really in the Clinton plan

BY the time the Clinton health-care-reform plan was abandoned, in September, everyone knew how terrible it was. It had been hatched in secret by an egghead team that knew a lot about policy details but had no grasp of political reality. The Administration had wasted time and missed deadline after deadline for presenting the plan to Congress, causing the plan to miss its best opportunity for passage—during the President's brief honeymoon period, in

by James Fallows

1993. The scheme was fatally overcomplicated. The proposed legislation, 1,342 pages long, was hard for congressmen to read and impossible for anyone except the plan's creators, Hillary Rodham Clinton and Ira C. Magaziner, to understand.

The Clinton plan would have imposed sweeping changes on one seventh of the national economy, with consequences far greater than Congress could possibly consider before casting a rushed vote. It represented a regulation-

minded, top-down, centralized approach at a time when the world was moving toward decentralization and flexibility—and when the supposed health crisis was solving itself anyway. The more people learned about this plan, the less they liked it, and it finally died a natural and well-deserved death.

Or so goes the conventional wisdom, as relayed in countless newspaper and magazine postmortems of the health-care struggle. The critiques were usually accompanied by veiled jabs at Hillary Clinton—what will she do with her time now that health care's gone?—and outright ridicule of Magaziner, who was portrayed as the smartest person with the dumbest plan since Robert McNamara and the Vietnam War.

But suppose that what everyone knows is wrong. This happens all the time in politics. Barely a year ago, for example, everyone in Washington knew that Congress was absolutely certain to pass a health-care program by now. The leaders of the Administration's health-care-reform effort, Hillary Clinton and Magaziner, believe that everyone is wrong again now. I heard them elaborate this view in September and October, during a series of

"No one understood this, but the average American patient would have had more choice under the Clinton plan than they now will."

long background conversations. "Background" means that I agreed to check with them on any material I wanted to quote directly. The gist of their views, however, was on the record. It is no surprise that they view the reform plan as something other than an overcomplicated bureaucratic nightmare. The surprise is how much more convincing their version of reality is than the prevailing one.

These conversations began at Magaziner's suggestion. He and I were friends in graduate school, more than twenty years ago, and he was obviously betting that I'd listen to him more sympathetically than other reporters would. I am biased, in that I like and respect Magaziner. But until these meetings I had had no contact with him during his time as health czar, and I have not always agreed with his ideas. (His worst achievement: helping bring a no-requirements curriculum to Brown University, when he was the student-body president in 1969.) In this case the facts seem to be on his side.

Let's consider each count in the conventional bill of indictment against the Clinton-Magaziner plan.

FIRST count: *The plan was hatched in secret.* During the 1992 presidential campaign Bill Clinton talked frequently about his interest in health-care reform and gave a signal about the reform approach he preferred. In a speech in September he recommended "competition within a budget." To the health-care cognoscenti this indicated an approach different from the main Republican and Democratic proposals of the time.

The most familiar Democratic approaches were "single-payer" and "play-or-pay." Single-payer, which was endorsed during the 1992 Democratic primaries by Senator Robert Kerrey, of

Nebraska, meant a Canadian-style or Medicare-style system. Private doctors and hospitals would provide care, but the government would take over all medical payments, financing them with a big new medical tax. All Americans would be covered. Play-or-pay, supported by many Democrats, required companies either to buy health insurance for their workers or to pay into a public fund, which would insure workers not covered by their companies. People who were not working would not be insured. An approach popular among Republicans relied on new tax breaks to encourage people to buy health insurance on their own. Some politicians from both parties endorsed a "managed competition" scheme, separate from all these.

Clinton's reference to "competition within a budget" fit a proposal laid out in the fall of 1992 by Paul Starr, a Princeton professor, in a short book called *The Logic of Health Care Reform*. This book came closer than any other document to anticipating the ultimate shape of the Clinton-Magaziner bill.

In Starr's plan, which was a variation on a managed-competition scheme, all Americans would be covered—even if they were out of work, even if they had "pre-existing conditions." The cost of coverage would be paid mainly by companies, which would contribute to the insurance premiums for each of their workers. The government would subsidize coverage for those who were unemployed or worked for small firms. Private insurance companies would offer coverage, as they do now, but the government would "manage" the way they competed for business. Each company would come up with a list of standard benefits, which it would have to offer at the same price to all customers. That is, the insurers could not turn down people who were already sick, or charge fifty-five-year-old applicants more than thirty-year-olds. Each year people could compare the offers and choose the plan they liked best—including a fee-for-service plan that let them go to their family doctor. From the customer's point of view, the system would work like the "open enrollment" policy at many corporations, in which employees can choose a new health plan each year. The government would set an overall limit on the amount of money that could be spent on medical care each year, while giving insurance companies and health plans latitude to spend the mon-

ey as they thought best. This limit was the "budget" in Clinton's reference to "competition within a budget."

With numerous changes of detail and emphasis, the plan that Starr explained in his book and that Clinton alluded to in his campaign became the plan the Clinton-Magaziner task force unveiled in 1993. The most important difference lay in what was meant by "within a budget": the bill that Clinton presented would have limited total spending not directly, by fiat, but indirectly, by limiting the amount that insurance premiums could rise each year. The process of working out these details and emphases kept Magaziner and some 500 task-force members busy round the clock during the Administration's first few months.

ACCORDING to today's conventional wisdom, these meetings doomed the reform effort before it really began, for it was here that Magaziner and his fellow nerds cooked up their unrealistic schemes. But did the process seem weird, secretive, and isolated at the time? Yes, but in only one limited and revealing way.

On matters of substance, the task force went out of its way to hear a variety of views. Most members of the task force were policy or budget officials borrowed from other parts of the government, but the group also included outside scholars and experts, plus several doctors and nurses. There were no representatives of organized outside interests—no delegate from the American Medical Association, no one from the Pharmaceutical Manufacturers of America—but the task force met frequently with outside groups and above all with senators, representatives, and their staffs. By early May, *Congressional Quarterly* reported, the task force had met with 572 separate organizations. "We had a couple of hundred meetings with the congressional leadership and individual members," Magaziner says now. "People were saying that it was the biggest outreach effort ever in laying the groundwork for a bill."

Indeed they were saying so. A *Congressional Quarterly* headline on May 22 read, "CLINTON TASK FORCE ALL EARS ON THE SUBJECT OF OVERHAUL." The article said,

Most members of Congress give the president high marks for laying the political groundwork necessary for his proposal to get the careful considera-

tion of both parties. . . . Clinton has been playing the health-care issue with an eye to keeping everyone at the table, at least at the outset.

In late September of 1993, when Hillary Clinton appeared before five congressional committees in three days to explain the rationale behind the bill, not a single legislator complained about "closed" or "secretive" deliberations: not Robert Dole, not Robert Packwood, not John Danforth—Republican senators who all later came out against the bill. Senator John Breaux, of Louisiana, a conservative Democrat who supported a competing reform plan, praised Hillary Clinton for the "truly remarkable" consultations the task force had carried out.

So when did the task force become "secretive"? Complaints inevitably arose when Magaziner and his assistants stopped soliciting outside advice and started announcing decisions. Those who disagreed felt that they hadn't been listened to. "Some people say they were excluded because in this case we didn't agree with them," Hillary Clinton told me. "But I think that a fair assessment is that we listened to everybody—and then made recommendations based on what we thought made the most sense."

The larger problem was with the one group that truly was excluded from the deliberations—the Washington press and, by extension, the public in whose interest it is supposed to act. During the brusque early weeks of the Clinton Administration, when George Stephanopoulos was walling reporters out of the White House press office and the Administration thought it could use talk shows to take its message directly to the public, over the heads of the daily press, Magaziner was told by the White House communications office that he and his associates should not talk to reporters about what ideas they were considering for the new bill. Instead they were supposed to refer all queries to the communications office. This didn't stop leaks, of course, but it gave Magaziner a

lasting reputation among reporters as a man who liked to operate in the dark. Hillary Clinton is known within the Administration for a combative attitude toward the press. But she now says that the news blackout on emerging details of the health bill was a major mistake.

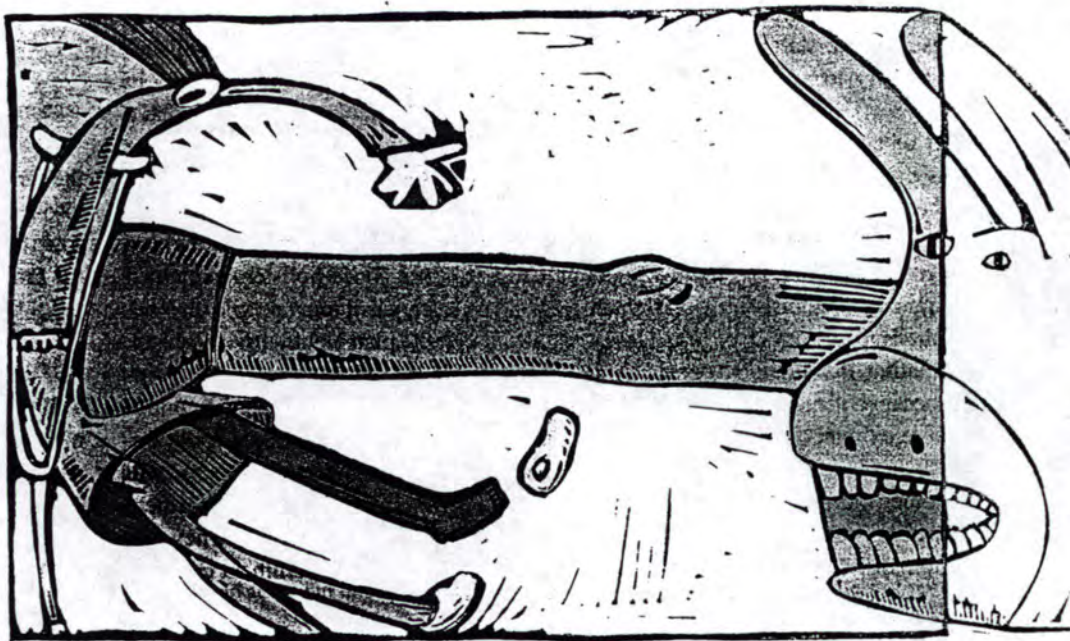
"Even though we had a process unlike any other that has drafted a bill," she told me, "—more open, more inclusive—we got labeled as being secretive because of . . . our failure to understand that we should be more available to the press along the way. That was something we didn't do well. . . . We were not aware of how significant it is to [shape] the inside story in Washington, in order to make the case . . . for whatever your policy is."

Secrecy toward reporters was stupid. But reporters are now acting as if it were something worse: closed-mindedness about ideas.

SECOND count: *The plan was politically naive.* Everyone now knows that the health-care reformers drew up their master plan without taking the slightest interest in what most Americans thought or felt. In reality, though, the plan suffered because the Administration was

publican arguments and how to rebut them, about the connection between a health-care bill and a re-election campaign in 1996. Week in and week out his memos to Bill and Hillary Clinton contained head counts of likely Senate and House votes—who was leaning, who could be pressured and pushed. In his conversations with me Magaziner seemed to spend half his time sizing up the legislators he had had to deal with: Senator X was in thrall to Bob Dole because of personal problems, Congressman Y had to start out opposing the bill because of donations from Interest Group Z.

Two fundamental decisions about the plan had much less to do with policy than with judgments of political reality. One involved handling the single-payer challenge. A Canadian-style single-payer system has two big virtues. It is simple to administer, since doctors, hospitals, and patients no longer have to worry about dozens of insurance companies with scores of different payment plans. The single-payer approach also guarantees that everyone in the country has medical coverage. But Clinton was dead set against a single-payer plan, arguing that it would require sweeping new taxes and would,



too attentive to shifting political moods. Even before Inauguration Day, Magaziner was churning out memos about the right way to pitch the plan to editorialists and interest groups, about the likely Re-

in effect, abolish the entire medical-insurance industry. This left the political problem of how to deal with the hundred or so members of the House who supported some kind of single-payer plan.

Without them, no health bill of Clinton's could possibly pass.

Congress also contained a large number of supporters of market-reform and managed-competition plans. The main advantage of such plans is that they change the incentives of medical practice so that doctors, patients, and hospitals are more conscious of costs when making medical decisions. To get a plan passed, Clinton had to show that it would reform the medical market.

"We had to try to bridge the chasm" between these groups in drawing up the plan, Magaziner told me. "If we were serious about universal coverage, we felt, then the single-payer people would buy off even if they didn't like managed competition. We felt we were doing enough of the market reforms that the reform people would buy off too. And, by the way, we also thought that that was the best policy."

But by June of 1993 one of the main market-reform legislators, Representative Jim Cooper, of Tennessee, made clear that he wouldn't buy off. He recommended seeing to insurance reforms first and getting around to universal coverage in a few years. The single-payer group, of course, was not going to agree to that. "At that point," Magaziner said, "we knew that the only way we could try to bridge the chasm was to start a little bit left of center and try to negotiate toward the center."

"Left of center" meant proposing a benefits package a little more generous than what the Administration really wanted, setting the employer's share of total costs a little bit higher, making the limits on insurance premiums a little bit tighter. When the Republican Party lost interest in negotiating, this strategy became a liability, because it made the Clinton plan look more extreme than it was meant to be.

The other purely political calculation concerned sales strategy. Throughout his campaign Bill Clinton had emphasized the overall cost of medical care as a central evil of the U.S. system. Americans spend about twice as much money per capita on medical care as people in other developed nations, with results that are not twice as good. Whenever he was asked about cutting the budget deficit or taming the entitlements monster, Clinton said that the first and most important step

was to control health-care costs. This approach won the support of business, since health-insurance costs had for years been rising faster than any other business expense. (From 1948 to 1990, Paul Starr points out, business spending on health coverage rose by an average of 15.6 percent a year.) Through most of 1993, while the plan was being developed and unveiled, major business groups like the U.S. Chamber of Commerce and the National Association of Manufacturers supported its general outlines and accepted even its "employer mandates," which would require companies to pay most of the cost of coverage for their employees. But by the summer of 1994 the Administration was selling the plan mainly as a matter of fairness and security. Its slogan was "Health Care That's Always There."

In theory the Administration could have kept stressing both aspects of its plan—that it would make individuals more secure while reducing the strain on business. The peculiar logic of health-care economics, as revealed in most other developed countries and in American group-care systems, is that when everyone is covered, it becomes easier to control overall costs.

The Administration's political experts, however, recommended a more streamlined sales approach. Clinton's pollster, Stanley Greenberg, produced results in 1993 showing that no one believed that a government health-care plan could ever save money. Although opinion polls taken through the end of 1993 showed that most people supported the idea behind Clinton's plan (once pollsters explained what the idea was), most people also believed that the plan would drive costs up, not down. Therefore the more the Administration emphasized its cost-control themes, the less believable it would become. "The polls showed that people will trust the government to guarantee them security," Magaziner told me. "They will not believe that the government can control costs."

As Republican opposition to the bill increased in 1994, Democratic strategists decided that "security" would be a more effective, partisan rallying theme. "You have to mobilize people, and it's hard to mobilize people around words like 'cost containment' or 'universal coverage,'" Hillary Clinton told me. "So if we didn't

convince the middle class that universal coverage meant *them*, we wouldn't get the political support. . . . If you talked about how they could lose their job, how they are one divorce or one pre-existing condition away from losing coverage, then perhaps they would get engaged." By the end of the struggle this sales approach made the Administration even more vulnerable to Republican charges that it was putting out a bighearted, soft-headed, typically liberal plan.

One other enormously important, and almost purely political, decision sealed the fate of the bill. Magaziner and Hillary Clinton had hoped to present the bill to Congress a few months after the Inauguration, in the spring of 1993. Thanksgiving had nearly come before they were actually ready to present a finished bill. That delay had little or nothing to do with

*Hillary Clinton now
says that the news
blackout on emerging
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care-reform bill was a
major mistake.*

the nuances of policy. It had everything to do with political necessity—and of a sort that everyone knew was sensible at the time.

THIRD count: "The First Lady's whiz-kids wasted precious months." This was how *The Economist* stated the next objection. Rather than getting busy and presenting the plan when the Administration still had a dewy glow, the health team sat around until it was too late.

The Administration's original strategy was to rush the health plan through as part of its first budget-reconciliation bill. That would have meant having detailed health proposals ready by April at the latest, and the task force had been geared toward meeting that deadline. The genius of this approach, little noticed by the public, is that it would have allowed the health plan to pass with a simple majority vote.

Congressional politics has quietly moved into the "supermajority" system that Lani Guinier was widely denounced for seeming to recommend. In theory it takes fifty-one votes to get a bill through the Senate. In reality it takes sixty votes to end a filibuster, so Bill Clinton knew that the Senate's forty-plus Republicans could stop nearly any legislation they chose.

They could not stop budget bills. These come to the floor under rules that limit debate, and with only a fifty-one-vote majority required for passage. So if the health-care plan could be made part of the budget bill, the Administration could get it acted on quickly, with enough of its own party's votes to see it through.

The Senate's majority leader, George Mitchell, endorsed this strategy, but its de facto parliamentarian, Robert Byrd, objected, scuttling the plan. The Administration then decided that it would introduce the health-care plan as soon as the budget bill passed. But passage was the rub. The budget bill, with its big deficit-reduction package, was seen by everyone in Washington as a major early test of the Administration's strength. (The struggle over the bill is the subject of Bob Woodward's book *The Agenda*.)

The budget fight dragged on much longer than Bill Clinton had hoped or planned. As it became obvious that the final budget vote would be very close (on August 6 it finally passed the Senate 51-50, with Vice President Al Gore casting the deciding vote), the Administration wanted to avoid any extraneous controversy that might affect it. Clinton had been scheduled to make the final decisions about the health-care plan in late May. Because of fears that leaks about his choices would complicate the budget vote, the decisions were put off—a delay that had ripple effects lasting the rest of the year. Without Clinton's decisions, the task force could not prepare detailed legislation; without legislation, it could not start negotiations with congressmen and their staffs. Without final choices on what would be in the package, it could not prepare budget estimates; without those estimates, the Treasury and the Congressional Budget Office could not vet the plan.

By the fall the budget fight was over—but then NAFTA became the issue of the moment. Clinton had been scheduled to spend most of the month of October traveling and speaking about the health-care

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plan. As he was flying to his first event, a labor convention in California, news came that U.S. soldiers had been killed in Somalia. Clinton flew back to Washington after his speech and spent most of the month dealing with Somalia and NAFTA; he canceled all the other health-care events.

Despite the delays and missteps, when the President finally unveiled the plan, in September of 1993, it seemed to have a good chance. "The reviews are in and the box office is terrific," the political analyst William Schneider wrote just after it was presented. "President Clinton's health care reform plan is a hit. . . . The more people read and hear about the plan, the more they seem to like it."

Six weeks after the Inauguration, Magaziner had written a memo to Bill and Hillary Clinton saying that if health-care-reform legislation was not presented and passed immediately, it probably could not be passed during "your first term." With Republican midterm gains in Congress, it now appears that this prediction will be borne out. But the delay was neither negligent nor intentional. It is a reminder of how quickly events spin out of a President's control, and how rare it is for him to be able to advance his own agenda rather than respond to someone else's emergency.

FOURTH count: *The plan had delusions of grandeur.* Now we move to the substance of the plan, which has been described as a regulatory rat's nest, a nightmare of overambitious social engineering, and a sweeping solution where modest reforms would do.

The reality is that very little in this plan was new or unprecedented, and that it was barely more complex or comprehensive than most other plans.

According to the peculiar logic of health-care economics, when everyone is covered, it becomes easier to control overall costs:

When people complained that the plan was grandiose, they had three features in mind: universal coverage (everyone would be insured, whether working or not), community rating (everyone in a given region would pay the same premium for coverage, regardless of age or pre-existing conditions), and employer mandates (forcing businesses to cover much of the insurance cost).

All these ideas have been part of the health-care-reform debate for years. Universal coverage and community rating sound like bleeding-heart concepts, but they are based on tough economic reasoning. The idea behind both is that piecemeal reform of a health-care system can be worse than no reform at all.

The fairness argument for universal coverage is obvious. Even people who are poor deserve care when they are sick or hurt. This is why every developed nation except the United States offers universal care. The economic argument has become almost as familiar. Even people without health insurance ultimately receive treatment, when they show up in emergency wards; hospitals cover the cost by padding charges for everyone else. This backhanded form of coverage is neither economically efficient nor humane. As recently as the fall of 1993 Bob Dole was saying that universal coverage was a "non-negotiable goal of reform."

Community rating is a closely related idea. Every health-care-reform scheme in America is concerned with holding down costs. In most businesses market competition does the job, but competition in the health-insurance area often works in a perverse way. Insurance companies have tended to compete not by improving the incentives, habits, and nature of medical treatment—which in the long run is the only way to limit expenses—but by becoming choosier about whom they will insure. If they can limit their coverage to young, healthy people and rule out those who are already sick, then they can offer coverage at a lower price, without having done anything to improve the efficiency of care.

This is what has happened to the health-insurance business in the past generation. In the old days Blue Cross offered coverage to everyone in the same geographic area at the same price. Now younger, healthier people can get cheaper coverage—which many of them skip anyway,

figuring they don't need it—while prices rise for those most likely to need care. Fewer of them can afford to buy it, more must take advantage of the cruel and inefficient fallback of emergency-room coverage, and overall costs keep going up. The young, healthy people eventually become old and sick, and are caught too.

This cycle is known as adverse selection, and it has been talked about in the health-care-reform business for years. Community rating is the main response. It is designed to average each person's medical costs over the course of his or her whole life and to make sure that people have coverage at the times of their lives when it's most necessary. In proposing community rating the Clinton team was hardly making waves.

Even the part of the plan that sounded strangest and most radical, its "mandatory alliances," is already familiar to millions of Americans under a different name. Anyone who works for a big company or a state or federal agency knows about the open-enrollment system for selecting health insurance. The company or agency negotiates with HMOs, insurance companies, and local medical networks that want to offer coverage to its employees. Once a year employees choose which plan they want. The employer then deducts money from their paychecks, adds its own share, and passes the money on to the medical providers.

This, with small variations, is also how the task force's mandatory alliances would have worked. They would have taken bids from insurance companies, HMOs, and other health providers and then let each household choose the plan it liked best. Each provider would have been required to set a price for a standard benefits plan, so that customers could make easy price comparisons among the offerings. The alliances would not, as has often been assumed, have tried to provide medical care themselves, through big new government clinics.

The most ominous-sounding aspect of the new alliance system was its "mandatory" nature. Everyone would have been obliged to choose and buy a standard benefits plan from an alliance. (Contrary to repeated claims by opponents of the bill, people would have been free to buy any extra coverage they wanted, or get any additional treatment from any doctor they chose, as long as they did it with their own

money. Employers would also have been free to offer additional coverage.) The health-care task force argued that the alliances had to be mandatory in order to create the community-rating effect. Otherwise, young, healthy people would stay out of the system, and the pernicious cycle of adverse selection would begin. An exception was made for employees of very large companies, who would still have been able to buy through their own firms' open-enrollment plans. The reasoning was that a General Motors or an AT&T had a work force large and diverse enough to constitute a community-rating pool all by itself. Everyone would have been forced into a pool one way or another.

Some health-care-reform plans have no mandatory component. Several versions of managed competition, for instance, would set up alliances like those in the Clinton bill but not require anyone to buy from them. It is virtually impossible, though, to achieve universal coverage without some element of compulsion. (Medicare offers universal coverage for those over sixty-five, but everyone who works is compelled to pay a Medicare tax.) Moreover, Magaziner argued, for most people the mandatory system would in practice mean more choice and freedom than they now enjoy.

When he ran a small business in Rhode Island, Magaziner said, he covered all health-insurance costs for his employees but could give them only two plans to choose from. Handling the bidding and paperwork for a broad range of plans would have been impossible. "If there had been an alliance, I could have paid my dues to the alliance and let people choose among all the plans." The alliances in the Clinton bill would have been required to offer customers a choice among all plans that met basic certification requirements. In big cities a dozen or more plans might be available. The minimum offering would be three kinds of coverage, including at



least one fee-for-service plan that would permit a family to stay with the independent doctor it had been using.

After the plan was withdrawn, Uwe Reinhardt, an economist at Princeton University, told *The New York Times*, "No one understood this, but the average American patient would have had more choice under the Clinton plan than they now will. If you work for a particular company, your choice of HMOs is whatever that company offers you." Some critics argued that the Clinton plan would destroy the market for coverage beyond the plan's basic benefits, and that as a result people would find it difficult to buy as much coverage as they might like. But that is different from the widespread belief that extra coverage would be against the law—and for most people the range of choice would probably be broader under Clinton's plan.

Far from concocting a system that would look and feel radically different from what Americans were accustomed

to, the task force believed that it was changing the surface of health care as little as possible while altering its underlying economic structure. The alliance system, despite its strange name, was meant to look familiar to people who already had coverage. The employer-mandate system of finance, in which companies would bear most of the health-insurance costs, reflected the fact that 90 percent of the people who now have insurance (excluding those on Medicare) get it through their employer. The employer mandate is a de facto tax but a well-established one, and a familiar concept in health-policy circles. Many Republicans, including Robert Packwood and Richard Nixon (!), have over the years endorsed employer-mandate plans.

Indeed, none of the individual elements of the Clinton plan was a shocking new entrant into the health-care debate. The plan's system for controlling expendi-

tures, through premium caps that limited how fast the cost of basic coverage could rise, departed from Paul Starr's recommendations. But it closely resembled a plan offered by a group of congressional moderates that included the Republican senators John Danforth and Nancy Kassebaum.

To say that the resulting package of proposals was "too complex" is like saying that an airplane's blueprint is too complicated. The Medicare system is complex. So is every competing health-care-reform plan. Most of the 1,342 pages of Clinton's Health Security Act (which I have read) are either pure legal boilerplate or amendments to existing law. Conventional wisdom now holds that the sheer bulk of the bill guaranteed its failure. The NAFTA bill was just as long, and so was the crime bill that passed last summer. If the health bill had been shorter and had not passed, everyone would know that any proposal so sketchy and incomplete never had a chance.

FIFTH count: *It was a coercive approach to one seventh of the economy—and to a problem that was solving itself.*

Much of the problem for the plan seemed, at least in Washington, to come not even from mandatory alliances but from an article by Elizabeth McCaughey, then of the Manhattan Institute, published in *The New Republic* last February. The article's working premise was that McCaughey, with no ax to grind and no preconceptions about health care, sat down for a careful reading of the whole Clinton bill. Appalled at the hidden provisions she found, she felt it her duty to warn people about what the bill might mean. The title of her article was "No Exit," and the message was that Bill and Hillary Clinton had proposed a system that would lock people in to government-run

less impressed with her scholarly precision after I compared her article with the text of the Clinton bill. Her shocked claim that coverage would be available only for "necessary" and "appropriate" treatment suggested that she had not looked at any of today's insurance policies. In claiming that the bill would make it impossible to go outside the health plan or pay doctors on one's own, she had apparently skipped past practically the first provision of the bill (Sec. 1003), which said,

Nothing in this Act shall be construed as prohibiting the following:

(1) An individual from purchasing any health care services.

It didn't matter. The White House issued a point-by-point rebuttal, which *The New Republic* did not run. Instead it published a long piece by McCaughey attacking the White House statement. The idea of health policemen stuck.

So did the idea that one seventh of the national economy would be transformed overnight. Of the vast American commerce in health care, more than 40 percent is already paid for by the federal government, mainly through Medicare. Under the Clinton plan the rest of the money would still go through most of the insurance companies, HMOs, doctors, hospitals, and laboratories that are receiving it now.

THE final element in the conventional wisdom is that this cumbersome, flawed plan was in any case unnecessary, because the health-care problem was going away. Medical costs rose by "only" 5.9 percent in 1993—yet that was more than twice as fast as wage growth and almost twice as fast as the overall inflation rate. Over the past several decades medical costs have risen about three percent faster than the overall inflation rate; in 1993 the gap was 2.9 percent.

"There is no persuasive evidence that we are in either a stabilized or an improving health-care-financing environment," Hillary Clinton told me. "In fact, many of the problems will only continue to get worse. The problems that middle-class Americans care the most about—like what doctor they can see—will likely become appreciably worse, because many will be forced into managed care over which they have no say. Employers will

make those decisions. They will pay more for fewer benefits. How deeply this sinks in and how much it motivates political action, I don't know."

IF this plan did not perish because it had been designed in intolerable secrecy, or because its designers knew nothing about politics, or because it was full of unacceptable new ideas, or because it was so much more complex than any predecessors, then what happened to it?

The Administration's view, for which, again, there is ample evidence, is that it went down because of two zero-sum games, one political and one economic. Health-care reform became a battle in which some would win and others would lose—and Clinton lost.

Through most of 1993 the Republicans believed that a health-reform bill was inevitable, and they wanted to be on the winning side. Bob Dole said he was eager to work with the Administration and appeared at events side by side with Hillary Clinton to endorse universal coverage. Twenty-three Republicans said that universal coverage was a given in a new bill.

In 1994 the Republicans became convinced that the President and his bill could be defeated. Their strategist, William Kristol, wrote a memo recommending a vote against any Administration health plan, "sight unseen." Three committees in the House and two in the Senate began considering the bill in earnest early in the year. Republicans on several committees had indicated that they would collaborate with Democrats on a bill; as the year wore on, Republicans dropped their support, one by one, for any health bill at all. Robert Packwood, who had supported employer mandates for twenty years, discovered that he opposed them in 1994. "[He] has assumed a prominent role in the campaign against a Democratic alternative that looks almost exactly like his own earlier policy prescriptions," the *National Journal* wrote. Early last summer conservative Democrats and moderate Republicans tried to put together a "mainstream coalition" supporting a plan without universal coverage, without employer mandates, and without other features that Republicans had opposed. In August, George Mitchell, the Democratic Party's Senate majority leader, announced a plan that was almost pure symbolism—no

To say that the resulting package of proposals was "too complex" is like saying that an airplane's blueprint is too complicated.

care. "The law will prevent you from going outside the system to buy basic health coverage you think is better," McCaughey wrote in the first paragraph. "The doctor can be paid only by the plan, not by you."

George Will immediately picked up this warning, writing in *Newsweek* that "it would be illegal for doctors to accept money directly from patients, and there would be 15-year jail terms for people driven to bribery for care they feel they need but the government does not deem 'necessary.'" The "doctors in jail" concept soon turned up on talk shows and was echoed for the rest of the year.

These claims, McCaughey's and Will's, were simply false. McCaughey's pose of impartiality was undermined by her campaign as the Republican nominee for lieutenant governor of New York soon after her article was published. I was

employer mandates, very little content except a long-term goal of universal coverage. Led by Bob Dole and Newt Gingrich, Republicans by September were opposing any plan. "Every time we moved toward them, they would move away," Hillary Clinton says.

"We always knew that in the end people's trust of the President and First Lady would be crucial," Ira Magaziner says. "The debate was going to be complicated, and that trust factor was very important." Whitewater eroded the trust factor. The President looked beatable, and he lost.

Economic factors counted too. Doctors had fought bitterly against Medicare in the early 1960s, but for the most part they sat this battle out. If they weren't controlled by the government, they would be controlled by insurance companies, which in some ways were worse. But other interest groups had more to lose. Health-insurance agents would be put out of business. Health-insurance companies could have their premiums capped. For-profit hospitals thought they would lose money. Manufacturers of medical equipment thought that market growth might slow. Large businesses that did not already offer health care for workers knew the employer mandate would cost them money. (These were mainly corporations like PepsiCo and General Mills, which own restaurant chains whose part-time workers are uninsured.)

During the 1992 campaign the Clinton war room excelled at answering negative charges immediately, before damaging impressions could set in. But even flatly untrue attacks on the health plan went unanswered—direct-mail campaigns saying that everyone would have to go to a government clinic, daily doses of misinformation from Rush Limbaugh, TV advertisements fanning McCaughey-style fears of jail terms for people who wanted to stick with their family doctor. Last March *The Wall Street Journal* found that a panel of citizens preferred the provisions of the Clinton plan to the main alternatives—when each plan was described by its contents alone. But when pollsters explained that the preferred group of provisions was in fact "the Clinton plan," most members of the panel changed their minds and opposed it. They knew, after all, that Clinton's plan could never work. ☛

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THE HEALTH REFORM PROCESS

One of the first actions of the President when he took office was to establish a Cabinet-level task force to assist him in developing health reform legislation. The 12-member task force, chaired by the First Lady, had a mission to devise a workable health reform plan in 100 days based on the framework laid out by the President during the campaign -- to guarantee private insurance to all Americans and bring spiralling health care costs under control.

To meet an aggressive timetable, we established a process for making policy that was unconventional for Washington, borrowed from private sector models for conducting big projects in a short time frame. Coming up with a credible health care bill means addressing dozens of specific issues. We brought together a working group of experts and practitioners in areas ranging from long-term care to mental health, and malpractice to insurance reform to prepare a wide breadth of policy options for consideration by the task force and the President.

The working group, which disbanded on May 31, 1993, developed preliminary policy options which were presented to the cabinet-level Task Force for its consideration and subsequent recommendations to the President. The ultimate decisions on the administration's health care proposal were made by the President, advised by the Task Force.

OPENNESS OF THE PROCESS

The process was one of the most open and inclusive policy-making processes, incorporating opinions from practitioners, experts and consumers from a broad range of disciplines and from all across the country.

The Center for Public Integrity, a Washington non-profit ethics watchdog said:

"Based on meetings and accessibility, it is difficult to imagine a more open, inclusive, decision-making process for a major public policy issue in Washington." ("Well-Healed: Inside Lobbying for Health Care Reform", 1994, p. 26)

We cast a wide net for participants. The working group brought together the opinions and expertise of people with different points of view -- some supported a Canadian-like single payer system; others supported a more market-oriented approach. Some members brought expertise in designing insurance and market reforms; others were knowledgeable in how to improve health care quality and information flow, designing benefits packages, developing long term care home- and community-based programs; still others brought their knowledge of antitrust, malpractice and ways to control health care costs.

September 6, 1994

We held daily meetings with members of Congress and involved more than 120 Congressional staffers on the working group. Outside experts were consulted, and regularly presented their views to the working group. The First Lady also held public hearings and town meetings across the country.

In addition, we sought outside opinions to challenge the assumptions and the workability of the options proposed by the working group:

- 14 panels of consumers came in to share their concerns and insights and ask questions of the working group members.
- A health professional review group and outreach groups of doctors, nurses, public health officials, hospital administrators, pharmacists and others reviewed and commented on policy options developed by the working group.
- Audit teams critiqued and questioned assumptions and options, including a group of actuaries who reviewed the validity and assumptions behind the numbers, a group of administrators and health plan executives who critiqued the practicality of the recommendations, a group of attorneys who reviewed the legal ramifications, a group who reviewed the impact on minority populations.

September 6, 1994

THE HEALTH REFORM PROCESS MISCONCEPTIONS IN THE CONVENTIONAL WISDOM

PRESIDENT'S PLAN WAS POLITICALLY NAIVE, GRANDIOSE, OVERREACHING, BIG GOVERNMENT

Q: The President's plan -- its premium caps, employer mandates, mandatory alliances -- was a social engineer's dream and had no chance for passing. Why did you propose such radical surgery instead of just fixing what was wrong with the current system?

A: The President's plan built on the framework he had proposed during the campaign. The American people in poll after poll support major change and support by overwhelming majorities the ideas the President proposed, including universal coverage, employer mandates, cost containment, tobacco tax, etc.

You forget that these ideas -- employer mandates, premium caps, mandatory alliances -- came from mainstream proposals. There are only 3 ways to get to universal coverage -- raising broad based taxes, mandating individual families to purchase insurance, or requiring employers and individuals to purchase insurance. We chose the employer mandate -- expanding the system that 90% of people with private insurance have today; the same approach President Nixon proposed two decades ago; the same approach supported at the time by groups like the AMA, the Chamber of Commerce, the Association of Corporate Benefits Managers, the American Hospital Association and many other groups.

To control costs, we chose market reforms to stimulate competition, with premium caps as a backup in case competition didn't work to control costs. We rejected price controls as too regulatory and instead took the idea for premium caps straight from a bill proposed by Senators Danforth and Kassebaum and Representatives McCurdy and Glickman. Premium caps were supported by many mainstream groups, including the American College of Physicians, the Catholic Health Association and the League of Women Voters.

To enhance consumer choice and provide community rating, we proposed mandatory alliances, which came from the 1992 bill sponsored by Representatives Cooper and Andrews and Senators Boren and Breaux.

In many cases, these proposals already had been tested successfully at the state level. Employer mandates are working effectively in Hawaii, Washington and Oregon; premium caps in Washington and Minnesota.

September 6, 1994

COMPLEXITY KILLED IT

Q: Why did you send up such a complicated bill? As the Los Angeles Times pointed out recently, some legislators on the Hill said that "it would have been far better to...spell out broad goals, and let Congress figure out how to get there."

A: The President has consistently focused on the goals of health reform -- universal coverage, controlling costs, etc. From the beginning, he has been open to better ideas and new suggestions. Detailed legislation would give the American people a realistic description of how the proposed changes would work and would serve as a starting point for discussions.

Most Congressional leaders asked us to send up a detailed bill to get the process rolling. Then, the normal legislative process would work through the details. In fact, two House committees and one Senate committee wrote their own bills which were similar to the President's.

Q: Wouldn't you have been better off with a skeleton bill -- one that wasn't so detailed?

A: The President was committed to sending up a bill that worked. By laying out the details for everyone to see, people would get a clear idea of how the proposed changes would affect them. As the Director of the Congressional Budget Office stated at the time: "the Health Security Act is unique among proposals to restructure the health care system both because of its scope and its attention to detail. Some critics of the proposal maintain that it is too complex. A major reason for the complexity, however, is that the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administration's on the implementation requirements."

If you look at the health reform legislation on the Hill today, you'll see that it ranges from 650 to 1,400 pages. And, that's not unique to other major pieces of legislation that have passed this year -- the Crime bill, budget reconciliation, NAFTA -- all were at least that long.

POLITICAL NAIVETE

Q: Wasn't your bill dead on arrival because it was politically naive, put together by policy wonks with tin political ears?

A: When released, the President's plan was declared "alive on arrival" by the New York Times. It was favored by the American people by a wide margin in polls and got positive reviews from moderate Republicans such as Senator Chafee who said it was a good starting point.

Only after special interests spent tens of millions of dollars to mislead the public about its contents did "the Clinton plan" lose popularity. But even now, when the elements of the plan are described without the label, the Clinton plan is widely supported and is preferred by wide margins over other proposals.

Anyone who pretends that there's an easy way to gain widespread political support for a health reform plan that achieves universal coverage is not being honest. There are no silver bullets in this debate. If there were, this would have been accomplished decades ago.

PROCESS WAS UNWIELDY, CHAOTIC

Q: Even the Administration has admitted that the working group was an "anonymous horde" and its recommendations weren't really used. Wouldn't it have made more sense to have had 20 experts consult with outside people to develop the legislation?

A: To meet an aggressive timetable, we established a process for making policy borrowed from private sector models for conducting big projects in a short time frame. The framework for reform was clearly laid out by the President during the campaign -- the charge was to develop a workable policy around that framework within 100 days. Because health care is so complex an issue, experts in one area are different from those in others. For example, mental health experts are different from antitrust experts and they are still different from experts in insurance reform. Leaders of the different issue areas acted as those "20 experts", directing the work of their teams, defining cross-cutting issues and synthesizing options.

The working group process was very fluid -- initially conceived to include about 100 representatives from within and outside the government. The working group grew over time as departments added additional staff, as gaps in expertise were filled, and as members of Congress sent over their staffs to participate.

September 6, 1994

POLICY WONKS, NO PRACTITIONERS

Q: You'd have been better off if you had involved doctors and nurses instead of lawyers and academics in crafting the proposal.

A: In fact, front-line practitioners were extensively involved in shaping and critiquing the Administration's policy. From the 68 doctors on the working group to the dozens of doctors, nurses, social workers and other practitioners on the Health Professionals Review Groups, front-line medical practitioners played a large role in preparing and analyzing the working group's policy options.

In addition, members of the task force and working groups met with the organized medical profession several times during the spring of 1993. We consulted with the American Medical Association, the American College of Physicians, the American Academy of Pediatricians, the American Academy of Family Physicians and many other physician groups and medical societies.

"Contrary to recent press reports, the American Medical Association is pleased to have received several opportunities for input on the health system reform plan being developed by the White House Task Force." (Letter from the AMA to Hillary Rodham Clinton, March 30, 1993)

DOMINATED BY SPECIAL INTERESTS

Q: The American Association of Physicians and Surgeons claims that the working group was dominated by managed care interests, specifically representatives of the Robert Wood Johnson and the Kaiser Foundation. What's your response?

A: First of all, to claim that the working group or any of its recommendations showed a leaning toward managed care interests is absurd. The membership of the working group incorporated views as diverse as single payer to those that called for a completely market-oriented system and everything in between. We explicitly excluded special interests from being members of the working group, although we conducted extensive outreach. During the time, we heard the views of over 1,100 different groups.

The President has always been committed to preserving and increasing families' choice of health plans and doctors -- that's why the Health Security Act included a requirement that everyone had to have the choice of enrolling in a fee-for-service plan. And why every plan had to offer a point-of-service option which enabled consumers to see doctors outside of the network. A group dominated by managed care interests would not have come up with these kinds of proposals.

September 6, 1994

Q: What about the Robert Woods Johnson Foundation fellows – they clearly represent special interests, yet you classified them as government employees?

A: That's absurd. The charge that having a handful of RWJ fellows on a working group of over 500 people somehow opened the floodgates to special interests is ridiculous. It is true that we called them government employees because they follow the same rules as government employees. The RWJ fellows on the working group were employed by Members of Congress. As such, they are bound by the Senate Code of Official Conduct and are treated as employees of the U.S. Senate.

MISSED DEADLINE

Q: The President promised to deliver his plan to the American people within 100 days of his Inauguration, yet we had to wait until October before the President actually submitted his legislation. Why was the task force five months late getting it done?

A: We were ready to move forward at the end of May of 1993, just as the President had pledged we would do. During April and May of last year, the task force met 21 times to finalize decisions, a number of times with the President. But after the defeat of the economic stimulus package, it became clear to everyone that the introduction of health care reform should be delayed until passage of the economic package was assured. For example, when word leaked out about a Treasury Department analysis of health care financing that included a tax on wine and beer, the California delegation immediately sent a letter of complaint to the White House and some members privately threatened to withhold support for the economic package.

With the economic package stalled, the introduction of health care was delayed from early June, to late June, to mid July, to late July, and finally to late September. The legislation finally was submitted in late October instead of in late May.

Health Care Qs and As - October 20, 1994

Q. Is the new health care process a recognition that the Task Force was a failure?

A. We are simply moving health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts. We are just beginning this process and it will be a while before decisions are reached.

Q. Secretary Shalala said yesterday that you will be presenting recommendations to Congress on health care reform and that these recommendations will be part of your budget. Are you going to submit a new plan and, if yes, have you given thought to what these recommendations will include?

A. I have not had a chance to think exactly about where we will go or even in what form any such proposal would be presented. Could recommendations be submitted as part of the budget? Yes, but it is also possible it won't.

Q. So, Secretary Shalala misspoke yesterday?

A. Secretary Shalala was speculating on possible options. Again, no decisions have been reached. In fact, I have not even discussed options yet. Secretary Shalala herself said that decisions have not been made.

Q. Secretary Shalala also said that obvious revenue sources will be cuts in Medicare and a tobacco tax. Are these your options that you are considering given that they were in your original plan?

A. Let me first say that this Administration will not slash Medicare. In my original proposal, we took the Medicare savings and used them to provide benefits to older Americans. We - like every bill that came out of Committee - had a tobacco tax. Again, however, no decisions on any financing options for any proposal has even been discussed let alone decided.

Q. Secretary Shalala indicated that you would be producing a scaled back health care plan. Does this mean that you will give up on your goal of universal coverage?

A. Throughout this debate on health care reform, I have repeatedly stated that covering every American and controlling escalating health care costs should be our goals. My commitment to this mission has not changed. I still believe that every American deserves health care coverage. Every month that we don't act to reform our system, 100,000 more Americans will lose their insurance. And, if we want to ensure that the deficit that we have worked so hard to contain does not balloon again over time, we need to address rising health care costs. Americans will spend \$982 billion on health care services in 1994 - nearly 14 percent of our gross domestic product. If this trend continues, we will spend \$2.1 trillion on health care in 2001 - 20% of our GDP.

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that memo.

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you a
copy...

There are obviously decisions that need to be made on how to proceed on health care reform. The one thing that is sure is that we are serious about continuing our fight for reform.

Q. Will you veto a bill that does not achieve universal coverage?

A. I still believe that every American deserves health care coverage. Our goal is universal coverage. And we're going to do everything possible to assure that Americans have health care coverage when they need it. And we're going to do everything possible to control escalating health care costs.

The American people still overwhelmingly support universal coverage. The latest NYT/CBS News poll (September 8-11) stated that nearly 70% of the public believes that every American deserves health care coverage. We must continue to work toward achieving what the American people want and deserve.

Q. Secretary Shalala said that you have not decided if you will call for an employer mandate next year. You have repeatedly stated that an employer mandate is the best way to provide coverage for every American. Are you backing away from requiring employers to share in their employees health care costs?

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A. We are simply moving health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts. We are just beginning this process and it will be a while before decisions are reached.

MEMORANDUM

To: Hillary Rodham Clinton

From: Chris Jennings

Date: October 20, 1994

Re: Update on Health Care Working Group

cc: Melanne Verveer

First of all, I want to thank you for all of the support that you have given me since I have been here. I particularly appreciate your recent support of me when the subject of a coordinator for Bob and Carol came up. There is no question that the new roll will be a tremendous challenge. As of today, however, I am pleased to report that it seems to be working quite well.

I intend to keep you up-to-date, giving you periodic reports on our progress in producing policy options. Also, I will keep you apprised of success or lack thereof in keeping all parties feeling and being integrally involved in the development of the options, as well as the degree to which they are feeling positive about our process.

Yesterday, we had a very constructive meeting with the NEC/DPC health policy working group. I prepared the attached talking points for Bob's and Carol's use, and I made the presentation of the specific issues the group will be initially focusing on for the purposes of the policy choice discussions we will have after the elections.

We will be preparing background information for you and the rest of the NEC/DPC group on each of the issues outlined in section IV of the attached. With only minor modifications, the working group has approved of the six issues. I am quite happy to go into more detail with you regarding the six core issues. As information is produced, I will forward it on to you and Melanne.

If you have any questions, please do not hesitate to call me. If you and Melanne would like to schedule periodic meetings with Carol, Bob, and/or myself at any time, I would be most happy to arrange them.

p.s. Melanne asked that the attached transcripts from Donna Shalala's interview and today's AP story on it be forwarded over to you. I am also enclosing the Q&A's that Laurie and I worked on for prep before the President's press conference.

AGENDA AND TALKING POINTS FOR 11/19 NEC/DPC MEETING

- I. Welcome, Update on Process, Appreciation for Assistance**
- II. Definition of Structure of Roles and Responsibilities for Staff**
- III. Outline Tight Timeframe**
- IV. Discussion of Specific Issues Within Workplan -- Turn to Chris**
 - (1) Coverage options**
 - (2) Insurance reform options**
 - (3) State flexibility options**
 - (4) Cost containment options**
 - (5) Financing options**
 - (6) Regulatory options**
 - * Second tier non-core issues**
- V. (RETURN TO CAROL AND/OR BOB) Outline Need for Intense and Quiet Staff Work on Background Information, Policy Options, and Quantitative (numbers-run) Analysis**
- VI. Reiterate Sensitivity of Any Leaks About this Work Getting Out**
- VII. Will Keep In Touch, Thank You, Closure of Meeting**

AGENDA AND TALKING POINTS FOR 11/19 NEC/DPC MEETING

I. Welcome, Update on Process, Appreciation for Assistance

- Will be a very open process where all views/approaches/alternatives are aired
- Pleased with early cooperation, assistance, and advice. We feel it has been and will continue to be constructive. (Cite, for example, Alice's memo and perhaps Donna's further elaboration of President's, HRC's, Leon's, and your feeling that proposals be viewed in context of laying foundation for achieving President's eventual goal.)
- Appreciation of principals' dedication of senior staff resources to help with this effort. Their and your (the principals') involvement has already been immeasurably helpful (in terms of helping structure issues and background information that should receive priority consideration.). Such help will be requested and needed throughout the process. (Detailed discussion re this to follow).
- Assuming approval of an "issues to be analyzed" workplan, which Chris will outline in a moment, we should be getting first-cut information on some of these issues beginning as early as next Monday.

II. Definition of Structure of Roles and Responsibilities for Staff

- Role of Chris as defined and implemented with regard to Bob and Carol, and discussion of how you want him to interact with the Departments, as well as OMB, CEA, etc.
- Role of Jennifer Klein -- analogous to Sylvia and Jeremy, i.e., is empowered to facilitate and direct policy work in a manner consistent with desires and discussions of you, the principals', and Chris. Further clarification of anyone else's role that you (Carol or Bob) feels is necessary/advisable.

- As we've stated previously, Bill and Gene will play an integral roll in helping Chris and us focus on health policy issues within the context of the budget and other domestic policy priorities. They will also participate in and contribute to all discussions regarding health care policy options -- both in terms of the substance and the process of developing these options. We and or Chris will keep you apprised of other staff roles on this subject.

III. Outline Tight Timeframe

- Very little time left before significant policy/political meetings take place immediately after the election. (Perhaps outline other high priority scheduling/policy conflicts?)
- Hope to have package options outlined for first perusal for this group, with input and political/strategic direction from Pat, George and others on or about November 10th. (Obviously, no final decisions or recommendations will be made at this time, but will help set the stage on what and how recommendations are made/presented.)
- As a result, we may want to have further discussions to determine how we want some of these options layed out before such a meeting takes place. If we think this is advisable, we think that we should tentatively target November 7th for such a discussion to take place. Because of the sensitivity to the political timeframe, we do not plan on circulating paper at this time. However, it does seem advisable to get direction, particularly with regard to presentation of options, from this group before the larger group meets.
- In any event, after the November 10th meeting, we will need to move quickly in a tight calendar before and immediately after Thanksgiving to make any policy option presentations that, in particular, have any impact with regard to ongoing budget priority discussions.

IV. Discussion of Specific Issues Within Workplan -- Turn to Chris

- Keep in mind that all options, ranging from staking out no position to strongly advocating the same or another comprehensive reform approach, are still on the table. The discussion that follows assumes this fact, but concentrates on the interim steps that we were asked to pay particular attention to at this time.

The issues that we have selected for your consideration have been chosen because they can be, if done properly, used to create a solid foundation on which to move towards the President's goal of universal coverage and cost containment. Obviously, the final choice that we make in regard to what if any issue we choose to pursue will depend heavily on the President's eventual choices on his budget and policy priorities after the election. The six issues that seem to best capture what principals' senior staff believe are important for consideration by you are:

- coverage
 - insurance reform
 - state flexibility
 - cost containment
 - financing
 - regulatory options
-
- Obviously, there are many other high priority issues that all the departments would like to explore. By not listing them here, we are in no way suggesting that other issues should not be considered, but we do believe they should be considered outside the context of these core issues. (For example, we are aware that HHS has a Medicare reform initiative now being reviewed).
 - Without going into great detail, I'd like to discuss what type of issues we would consider under each of these six issue headings and how we are now thinking about structuring them. Jen and I, speaking for Bob and Carol, would like to invite you to add, subtract, modify, or clarify this list. (Ask to not be interrupted until end.)

(1) Coverage options

- A wide variety of coverage options should be considered, including:
 - low income families
 - kids only
 - welfare to work populations
 - in-between job (unemployment) protections
 - elderly (likely only consider if Medicare cuts high)
 - combinations, different benefit package assumptions and zero option, etc.
- To make it user friendly to the numbers-driven world we work in, structure options to illustrate how much coverage you can buy for different dollar amounts.
- Options considered will include an examination of feasibility, advisability and cost of different administrative options for each subsidy scheme. As such, the relationship between coverage and the appropriate Medicaid role will be carefully explored.
- In order to get these options scored, we must immediately move to get them modeled and sent through OMB, HHS and their actuaries, and others to get the type of cost estimated package options that you will want to have. We are planning to have a staff meeting for a first cut review on these models tomorrow. All models would be subject to sign-off by the principals.

(2) Insurance reform options:

- Benefits and risks of alternative insurance reform in a non-universal coverage market.
- Graduated (from minimal to major) insurance reform options and implications and tradeoffs in each alternative. (For example, the more subsidies you provide from above options may require much more significant insurance reform to guard against adverse selection.) Background information on this issue is being prepared for your staff to review on Friday.

(3) State flexibility options:

- Options for providing incentives or removing potential barriers to state-based reform efforts. We plan on looking at Medicaid and ERISA waiver options for group consideration.

- Obviously because of strong opinions on these issues, particularly with regard to ERISA, this needs to be done in context of both policy and political (competing priorities of business, labor and states) feasibility, as well as it must be understood that any such option enhances, rather than detracts from, the likelihood of national comprehensive reforms.
- All three Departments have an essential role to play on this issue and Jen and I, along with Kathy Way of Carol's staff, will watch this very closely.

(4) Cost containment options:

- Private sector options must reviewed in detail. (CJ will discuss orally all issues, including market reforms that could also involve an analysis of medical savings accounts, commission options, and various tax cap alternatives).
- Public sector options will be reviewed. (Medicare and Medicaid savings, as well as any savings emerging from proposals from HHS dealing with standardization of forms and fraud and abuse).

(5) Financing options:

- Linkage to public cost containment is very closely associated with financing.
- Review of alternatives already proposed is underway. Revenue options will, of course, be done by Treasury.

(6) Regulatory options:

- Many Departments have regulatory reviews underway with expressed purpose of developing initiatives that can be helpful to health reform legislative and/or policy goals. I am advised that the Departments of Labor and HHS have these reviews well underway. Options need to be reviewed.

There are also important second tier non-core issues. Many of these issues are being represented by departments in this room and elsewhere. The fact that these issues are not listed in no way connotes that they are unimportant, but the NEC/DPC working group concluded that we should try to limit our current analysis to a number of structural core reform options.

Lastly, in an attempt to provide a sense of where Congress ended up on the many health reform bills, we are in the process of developing a side-by-side to compare notable health care reform initiatives by both Republicans and Democrats. We hope that this will be useful.

V. (RETURN TO CAROL AND/OR BOB) Outline Need for Intense and Quiet Staff Work on Background Information, Policy Options, and Quantitative (numbers-run) Analysis

- In order for us to get this information prepared and circulated amongst ourselves for consideration and discussion in a timely manner, the staff work will need to get it done quickly and quietly. This is particularly the case with regard to any options relating to numbers/cost-revenue issues.
- Chris will be consulting you throughout this process to make certain that you are comfortable with how this is being done and who is doing it. But it must get done soon.
- On some fronts we can move quickly and build on the information base we have either through our own work or those of the alternatives that have been outlined in the Congress. However, there most definitely will be exceptions to this that will entail new and detailed work, analysis and consideration. The targeting and administration of subsidies and the advisability and feasibility of providing for state flexibility in a non-universal coverage proposal serve as two particularly good examples.

VI. Reiterate Sensitivity of Any Leaks About this Work Getting Out

- At the risk of beating a dead horse, we must continue to reiterate the importance of holding this information close. If any of these options get out into press or onto the Hill prior to early consultation, we have major problems that could undermine the whole process -- even if a leak occurs after the election.

VII. Will Keep In Touch, Thank You, Closure of Meeting

- As new information on substance or scheduling becomes available, we will be in touch. Thank you all again for all your help and cooperation. I think we are off to a great start.

Health Care Qs and As - October 20, 1994

Q. Is the new health care process a recognition that the Task Force was a failure?

A. We are simply moving health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts. We are just beginning this process and it will be a while before decisions are reached.

Q. Secretary Shalala said yesterday that you will be presenting recommendations to Congress on health care reform and that these recommendations will be part of your budget. Are you going to submit a new plan and, if yes, have you given thought to what these recommendations will include?

A. I have not had a chance to think exactly about where we will go or even in what form any such proposal would be presented. Could recommendations be submitted as part of the budget? Yes, but it is also possible it won't.

Q. So, Secretary Shalala misspoke yesterday?

A. Secretary Shalala was speculating on possible options. Again, no decisions have been reached. In fact, I have not even discussed options yet. Secretary Shalala herself said that decisions have not been made.

Q. Secretary Shalala also said that obvious revenue sources will be cuts in Medicare and a tobacco tax. Are these your options that you are considering given that they were in your original plan?

A. Let me first say that this Administration will not slash Medicare. In my original proposal, we took the Medicare savings and used them to provide benefits to older Americans. We - like every bill that came out of Committee - had a tobacco tax. Again, however, no decisions on any financing options for any proposal has even been discussed let alone decided.

Q. Secretary Shalala indicated that you would be producing a scaled back health care plan. Does this mean that you will give up on your goal of universal coverage?

A. Throughout this debate on health care reform, I have repeatedly stated that covering every American and controlling escalating health care costs should be our goals. My commitment to this mission has not changed. I still believe that every American deserves health care coverage. Every month that we don't act to reform our system, 100,000 more Americans will lose their insurance. And, if we want to ensure that the deficit that we have worked so hard to contain does not balloon again over time, we need to address rising health care costs. Americans will spend \$982 billion on health care services in 1994 - nearly 14 percent of our gross domestic product. If this trend continues, we will spend \$2.1 trillion on health care in 2001 - 20% of our GDP.

There are obviously decisions that need to be made on how to proceed on health care reform. The one thing that is sure is that we are serious about continuing our fight for reform.

Q. Will you veto a bill that does not achieve universal coverage?

A. I still believe that every American deserves health care coverage. Our goal is universal coverage. And we're going to do everything possible to assure that Americans have health care coverage when they need it. And we're going to do everything possible to control escalating health care costs.

The American people still overwhelmingly support universal coverage. The latest NYT/CBS News poll (September 8-11) stated that nearly 70% of the public believes that every American deserves health care coverage. We must continue to work toward achieving what the American people want and deserve.

Q. Secretary Shalala said that you have not decided if you will call for an employer mandate next year. You have repeatedly stated that an employer mandate is the best way to provide coverage for every American. Are you backing away from requiring employers to share in their employees health care costs?

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TO: Hillary Rodham Clinton
FROM: Chris Jennings
Jennifer Klein
DATE: 2/17/95
RE: Regulatory Review Update

Attached please find the most recent draft of the Regulatory Review Initiative Presentation (both HCFA and FDA). We are scheduled to meet with the Vice President on Tuesday, February 21 and will begin with the discussion of the FDA proposals. We have told the Reinventing Government team (including Sally Katzen) that the HCFA presentation describes regulatory changes that will be implemented as part of health care reform. They have noted that the Vice President's highest priorities are FDA, EPA and OSHA. (Therefore, we don't anticipate that he will see this as a conflict.)

We have had discussions with HCFA and with Public Liaison about scheduling an event to highlight our regulatory relief efforts. Melanne also filled us in on your conversation with Steve Gleason. Since most of the proposals in the HCFA presentation can be implemented by regulation, we could announce them as a package. The most visually powerful would be the elimination of the physician attestation requirement. Against a backdrop of thousands of these attestation forms, a hospital administrator could explain the process they have been forced to follow for every discharge of a Medicare patient.

We would recommend an event at a hospital in one of the key states. Approximately 100 supportive physicians and hospital groups would be invited for the unveiling of our regulatory relief initiative. You would lead a panel of hospital administrators, physicians, one or two HHS representatives (maybe Secretary Shalala and Bruce Vladeck), consumers, an insurer, an employer and a non-government expert.

Public Liaison and HCFA are ready to go. We can discuss this further when we meet with you on Tuesday.

cc: Melanne Verveer

HEALTH INDUSTRY WORKING GROUP
RECOMMENDATIONS

I. PHYSICIAN ATTESTATION

PROBLEM: Currently, a physician must sign an "attestation form" for each Medicare patient discharged from a hospital. The form is used to certify the accuracy of all diagnoses and procedures; without an attestation form, the hospital cannot bill Medicare. Obtaining the physician's signature is burdensome for hospitals and physicians, and resulting billing delays hurt hospital cash flow.

REGULATORY APPROACH: Streamline paperwork.

PROPOSED SOLUTION: Eliminate the requirement for the form entirely and instead hold hospitals responsible for accuracy of the diagnoses and procedures. Hospitals are better equipped to combat fraud and abuse given improvements in record keeping and coding capabilities. (This change can be implemented by regulation.)

PROS:

- Reduces paperwork burden and "hassle" on physicians and hospitals.
- Can be implemented quickly, with an immediate impact on providers.
- Implements recommendation by the Medicare Technical Advisory Group which is comprised of hospitals, intermediaries and trade associations.
- Decreases administrative costs for hospitals.
- The attestation requirement appears unnecessary. There has never been a prosecution in the 11 years of operation of the prospective payment system for hospitals.

CONS:

- Although the hospital will be responsible for accuracy of the diagnoses and procedures, this may create the impression that the Health Care Financing Administration (HCFA) is relaxing its controls on fraud.
- Despite coding/DRG complexities, physicians are viewed as most knowledgeable on care given to hospitalized patients. This may create the impression that administrators rather than doctors control patient care.

REGULATORY IMPACT: 11 million forms will be eliminated; almost 200,000 hours of physician time will be saved; hospitals will have improved cash flow and reduced labor costs.

II. HEALTH AND SAFETY STANDARDS FOR MEDICARE PROVIDERS

PROBLEM:

- Hospitals, Home Health Agencies (HHAs), hospices, and End-Stage Renal Disease (ESRD) facilities must meet health and safety requirements to participate in the Medicare program. These requirements measure "process" (i.e., procedural and administrative requirements as proxies for quality health care) rather than "outcome" (i.e., evaluations of actual patient care) and continuous quality improvement.
- Regulatory requirements vary by type of facility and provider even when the services provided in each facility are the same, creating inequities and inappropriate incentives.
- Very little information is available for consumers on the quality of care at a given facility. Information about quality can help consumers make health care choices.
- By law, HHAs must be surveyed yearly -- even though historical data show that this frequency is excessive for many HHAs and does not improve care.

REGULATORY APPROACH: Performance standards; tailor oversight and survey frequency to performance.

PROPOSED SOLUTIONS:

A. Conditions of Participation: Eliminate unnecessary process requirements and instead:

- develop outcome-based performance standards;
- collect and analyze patient care data needed for continuous quality improvement and performance evaluation;
- increase consistency of requirements across providers; and,
- ask the customer to provide input on what the outcome measures should be, and to evaluate the services they received.

(These changes can be implemented by regulation.)

PROS:

- Eliminating unnecessary process requirements will reduce compliance and survey burdens and make it possible to focus on actual patient care.
- Educating the consumer will produce a strong, non-regulatory force to improve quality of care.
- Powerful data will be available to regulators and providers.

CONS:

- Eliminating unnecessary process requirements may be viewed by patient advocates as an elimination of patient safeguards.
- Developing patient care data requirements could be viewed as an additional burden for some providers because they do not currently report this data to HCFA.

REGULATORY IMPACT:

- Produces savings because providers are free to achieve high quality outcomes in the most cost-effective manner. (Note: Outcome measures focus on results whereas process regulations require providers to follow certain procedures. To the extent we can evaluate quality by looking at results, we can discontinue the use of required procedures).

B. Home Health Agencies: Seek an amendment to Section 1891(c)(2)(A) of the Social Security Act to allow flexible survey schedule for HHAs.

PROS:

- Reduces burden on good providers (on-site inspections involve extensive provider staff participation).
- Enables survey agencies to target scarce on-site survey resources to problem providers.
- Reviews problem providers more thoroughly, which will improve care or get them out of the program.
- Provides a positive incentive to furnish good care continuously.

CONS:

Some out-of-compliance HHAs may fall through the cracks under a flexible system.

REGULATORY IMPACT: Approximately \$8.8 million in savings to the Federal Government.

ALTERNATIVES NOT RECOMMENDED:

- (1) Seek flexible survey cycle for nursing homes.
- (2) Eliminate surveys altogether for providers with good records.

WHY NOT RECOMMENDED:

- (1) Current nursing home survey cycle allows some discretion (i.e., allows a maximum of 15 months between surveys for a given home while requiring a 12 month average for each State). Greater flexibility would be inappropriate due to the vulnerability of the nursing home population, generally low level of professional supervision, and historical problems with the quality of nursing home care.
- (2) Quality of care at an institution can go from good to bad virtually overnight as a result of change of ownership, high turnover of non-professional staff, loss of key professional staff, reduction in census/client base, changes in patient mix (e.g., influx of patients who need hi-tech care), etc. Flexibility in surveying all providers reduces costs while keeping all providers alert to the possibility of inspection.

III. CLIA

The Clinical Laboratories Improvement Amendments (CLIA) of 1988 established baseline quality standards that ensure the accuracy, reliability and timeliness of laboratory testing. These requirements are based on the complexity of the test performed in the laboratory, rather than where the test is performed. Compliance with the standards is determined through on-site inspection.

PROBLEM: CLIA is unnecessarily burdensome (especially for small and physician office laboratories), and laboratories fear sanctions for failure of proficiency testing.

REGULATORY APPROACH:

- Reduce oversight for certain test systems.
- Establish performance standards.
- Use information and education as a substitute for sanctions.

PROPOSED SOLUTIONS:

- A. Waive the routine 2-year survey of users of "black box" technology, conducting surveys only if there are indications of problems or complaints, and to validate a 5% sample. Develop and implement criteria for accurate and precise "black box" technology that will be followed to determine if the technology qualifies for waiver of the routine 2-year survey. Black box technology refers to simple and easy to use test systems that have demonstrated accuracy and precision through scientific studies. (These changes can be implemented by regulation.)

PROS:

- Creates incentives for manufacturers to develop more reliable testing equipment by stimulating demand for accurate and precise technological testing systems.
- Reduces paperwork and costs for providers, especially for physician office laboratories, as well as costs of program management.

CONS:

- Less oversight and monitoring of quality in physician office laboratories.

REGULATORY IMPACT: The dollar magnitude of savings cannot be predicted.

ALTERNATIVES NOT RECOMMENDED:

- (1) Do not create new testing category to recognize "black box" technology.
- (2) Seek legislation to waive all requirements for "black box" technology.

WHY NOT RECOMMENDED:

- (1) Limits incentives to develop new technology and does nothing to reduce burden.
- (2) Our approach achieves a similar end administratively without requiring a statutory change.

- B. Clarify and expand the waiver criteria and streamline the waiver process so that more tests can be waived from CLIA requirements. In addition, waive all tests approved by FDA for home use (i.e., tests that do not require trained personnel). (These changes can be implemented by regulation).

PROS:

- Decreases burden, especially for physician office laboratories because of less regulatory oversight.
- Increases access to greater variety of tests. Physician office laboratories may expand the range of tests they perform without an increase in costs/burden.
- Creates incentives for manufacturers to develop more test systems that meet the clarified waiver criteria and criteria for approval for home use.

CONS:

- Removes quality protections for a greater number of tests.
- Major groups of laboratory professional scientists such as the American Society of Clinical Laboratory Scientists and the College of American Pathology may protest this reduction in requirements.

REGULATORY IMPACT:

- Eliminates inspection fees for many of the 60,000 physician office and other small laboratories that perform only tests from the expanded waiver category.
- Many additional laboratories will face lower inspection fees because, while they will continue to perform non-waived tests, many more tests will fall into the expanded waiver category.
- Minimizes regulatory requirements.

ALTERNATIVES NOT RECOMMENDED:

- (1) Exempt all tests performed in physician office laboratories from CLIA requirements.
- (2) Amend statutory "risk" language to allow consideration of net benefits and costs.
- (3) Repeal CLIA.

WHY NOT RECOMMENDED:

- (1) Complex tests, if incorrectly performed, can cause irreparable harm to a patient. Data from inspections indicate that a significant percentage of tests critical to the diagnosis and treatment of patients are not accurately performed.
- (2) A proposed waiver rule has already been developed that delineates a set of criteria to objectively define what constitutes a test that will have negligible risk of an erroneous result, thus allowing for waiver from CLIA standards. Once these criteria are finalized and disseminated, manufacturers and others will have a clear understanding of negligible risk. Manufacturers will have incentive to produce high quality tests that are accurate and precise and have only a negligible risk of error.
- (3) Due to serious problems (e.g., incorrectly read Pap smears), public concern has demanded oversight of laboratory testing in the U.S. HCFA inspections have since confirmed the existence of quality problems.

- C. Use performance standards and require less frequent on-site inspections (surveys) of excellent performers. Approve private accrediting organizations for deemed status when their accreditation standards are as stringent as CLIA. Exempt labs from CLIA requirements when the State where they are located has requirements equal to or more stringent than CLIA's. (These changes can be implemented by regulation.)

PROS:

- Reduces inspection burdens.
- Rewards good performers with fewer inspections. This is a positive incentive to improve performance.
- Educational emphasis on the inspection process has generated a positive response from the laboratory community.
- Approving organizations for deemed status offers laboratories oversight by peers.
- Approving States for CLIA exemption allows expanded role for States with strong licensure programs.

CONS:

- Without frequent inspections of all laboratories quality may decline.

REGULATORY IMPACT:

- Less oversight.
- Lower burden for laboratories.
- Lower user fees needed to offset the costs of the inspections.
- Deemed status allows for privatization; State exempt status allows for State role.

ALTERNATIVES NOT RECOMMENDED:

- (1) Repeal quality control, quality assurance, personnel requirements (except in cytology laboratories), while relying on proficiency testing and outcomes as the basis for quality control.

- (2) Amend the statute to allow for waiver of quality control, quality assurance and personnel qualification requirements to allow HCFA to waive such requirements for high performing laboratories.

WHY NOT RECOMMENDED:

- (1) Elimination of quality and personnel requirements will have an adverse impact on the accuracy of laboratory tests and their use for patient diagnosis and treatment. It is important to note that:
 - Inspection data indicate that significant numbers of laboratory tests are not accurately performed; good quality control and quality assurance practices are not being followed by many laboratories.
 - Proficiency testing results reveal that the failure rates for previously unregulated labs are double that of previously regulated labs.
 - Deficiency rates in physician office laboratories are two to three times that of previously regulated labs.
- (2) Adherence to quality and personnel requirements is what defines sound laboratory practices in high performing laboratories. If these requirements are waived there would be no standards available to evaluate the laboratory in the event their performance deteriorated. Further, proficiency testing alone is unreliable as the sole indicator of laboratory performance.

D. Use proficiency testing (PT) "failures" for education and as an outcome indicator in laboratory quality. (PT is testing samples of known values to assess the accuracy of a laboratory's results). Sanctions (i.e., loss of Medicare payment or loss of approval to do testing) are imposed only in cases of immediate jeopardy or when the laboratory has refused to correct the problem or has had repeated failures on proficiency testing. (This change can be implemented by regulation.)

PROS:

- Less intrusive than traditional regulation and oversight.
- Reduces anxiety in the physician office laboratory community while maintaining opportunity for self-assessment and improving performance.
- Allows use of proficiency testing as an outcome measure to monitor laboratory performance and provide laboratories with feedback on test quality.

CONS:

- Difficult to prevent egregious disregard for quality testing.
- Physicians do not think that this action by itself reduces burden sufficiently.

REGULATORY IMPACT: Minimizes the fear of sanctions in 60,000 non-waived labs.

ALTERNATIVES NOT RECOMMENDED: No longer require proficiency testing.

WHY NOT RECOMMENDED: Proficiency testing is a valuable outcome indicator and educational tool.

OTHER ALTERNATIVES FOR REGULATORY REFORM

1. **Paperwork Reduction in Federal Programs.** Although many Federal programs require the use of the HCFA 1500, use of the form is not required by the Federal Employees Health Benefit Plan (FEHBP). In addition, instructions for the form vary across programs.

Alternative: Ask the Office of Personnel Management (OPM) to require participating carriers to announce to providers that they accept the HCFA 1500 for claims filed under FEHBP. Ask HCFA, the Department of Defense, the Department of Veterans Affairs and FEHBP to develop a single set of instructions for filling out the HCFA 1500 in order to streamline further the claim filing process.

Concerns: This will reduce paperwork for providers and consumers, but may be an added burden on insurers who do not yet use the form. OPM is concerned that insurance carriers, particularly HMOs or fee-for-service plans with preferred provider arrangements, have established data systems suited to their individual informational needs. These carriers would be required to create new data systems to process FEHBP claims (although most of these carriers already serve Medicare patients and therefore already process the HCFA 1500).

2. **Competition in Medicare.** The Administration is considering proposals (as part of health reform discussions) that would offer beneficiaries greater choice among managed care plans. Competition among organized delivery systems has the potential to promote greater efficiency and increase consumer choice.

As we broaden managed care options for Medicare beneficiaries, we must:

- Be aware of the practical limitations of a rapid expansion of managed care; the movement to managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with the expensive and special health needs of the Medicare program.
- Improve payment methods to managed care plans. Currently, Medicare pays 5.7 percent more for every enrollee in managed care rather than fee-for-service. Efforts are underway to improve the current payment methodology by adding health status adjusters.
- Continue to assure quality and preserve beneficiary choice. Increasing managed care options for Medicare beneficiaries will succeed only if beneficiaries recognize the benefit of the coordination of care and case management that high quality managed care plans can provide.

Alternative: Proposals are being discussed to create a voucher system under which private insurers bid for Medicare patients. The Administration has opposed these voucher proposals.

Concerns: Any discussion of voucher proposals should be informed by some facts about Medicare beneficiaries.

- Currently, the major areas of growth for the Medicare population are older seniors age 85 and older, women, and persons with disabilities.
- Second, there is an inverse relationship between income and health status and per capita Medicare expenditures.
- Third, per capita health care spending for aged beneficiaries is four times the average for the under 65 population.

Because problems of risk selection and premium and marketing discrimination in the private insurance market have not been addressed adequately, a voucher system could put the most vulnerable beneficiaries at risk, and could effectively eliminate real plan choice for many older persons. Any broad structural changes to Medicare will be seen by beneficiaries, providers and advocates as an attempt to cut, or even destroy, the program.

3. **Physician Review Organizations.** Physician Review Organizations (PROs) work with local communities and hospitals to assess variations in processes, quality and outcomes of care. Because there is a substantial emerging market in private utilization review, continuing government intervention may be unnecessary.

Alternatives: (1) Set Medicare standards for hospital quality and utilization review and allow hospitals to contract for review either through PROs or other third parties; or (2) eliminate the PRO program entirely.

Concerns: Medicare has a responsibility to ensure that its beneficiaries receive high quality care. The newly structured PRO program has the potential to improve quality, and hospitals and physicians support the new program.

4. **Ownership and Referral.** Current law prohibits physicians from referring patients to health care facilities in which they have an ownership interest. The prohibition is intended to address over-utilization rather than self-referral; therefore, restrictions and penalties should be structured to address excessive referral more directly. In addition, the current prohibition is arbitrary because it does not apply to vertically integrated facilities (e.g., labs or x-ray facilities that are part of a clinic).

Alternative: (1) Replace the ban on self-referral with restrictions on over-utilization (i.e., referring patients too often to any facility); and (2) impose heavy penalties on physicians who refer patients excessively to facilities in which they have an ownership interest.

Concerns: Studies by the Government Accounting Office, the Office of the Inspector General and non-government groups have concluded that physicians who have financial relationships with health facilities tend to refer their patients to those entities more frequently than other physicians. These studies suggest that self-referral is an effective proxy for the over-utilization of services. It may be difficult to measure and prove over-utilization in the absence of the ban on self-referral.

4. **Reimbursement Mechanisms.** Reimbursement and coverage rules under Medicare are often arbitrary and inefficient. For example, some services may be reimbursed if performed in one type of facility but not in another. In other cases, a provider may be forced to give higher cost care because a lower cost alternative is not reimbursable, or may be unable to use a new treatment or technology because it is not yet covered by Medicare.

Some examples are: (1) Medicare requires a 3-day hospitalization before it will reimburse for care in a skilled nursing facility; (2) telemedicine is reimbursed at the same rate as a face-to-face encounter, even though telemedicine is a less intensive interaction that can produce savings; and (3) reimbursement rates vary for identical care performed in inpatient and outpatient facilities.

Alternatives: (1) Identify inappropriate constraints and reform Medicare coverage and payment rules that prevent physicians and hospitals from providing lower cost care; and (2) reimburse for experimental drugs and devices administered in clinical trials for diseases for which there are no adequate proven therapies.

Concerns: The Health Care Financing Administration (HCFA) is conducting demonstration projects to explore alternatives to current reimbursement programs, including reimbursement for telemedicine and prospective payment for outpatient care, skilled nursing and home care. However, constraints on reimbursement and coverage control utilization and costs. Expanding reimbursement and coverage will increase the volume of services provided and may therefore increase total costs for both beneficiaries and the Federal government.

FOOD AND DRUG ADMINISTRATION

(Reforms in Regulation of Drugs and Devices)

The Food and Drug Administration is the component of the Department of Health and Human Services charged with ensuring that foods are safe and wholesome; human and veterinary drugs, vaccines, and medical devices are safe and effective; cosmetics and electronic products that emit radiation are safe; and that regulated products are accurately labeled. In carrying out those responsibilities, FDA regulates over \$1 trillion worth of products, which account for 25 cents of every dollar spent annually by American consumers.

Drugs must be approved by FDA prior to marketing. New chemical discoveries ("new drugs") are subjected to animal, then human testing, and the resulting data submitted to FDA scientists for review via a New Drug Application. The total time for industry testing and FDA review takes 7-10 years. Changes in a drug, such as substituting a different ingredient, are also approved by FDA via a "supplement" to the original application for approval. A similar process is followed for "biologics"--which include vaccines and drugs made from biotechnology. Generic versions of brand name drugs can be approved by FDA after the brand name drug's patent has expired, although the generic drug manufacturer must "reverse engineer" the drug by analyzing the brand name's content and making a reasonably accurate "guess" as to its formula--which FDA approves via an Abbreviated New Drug Application.

Medical devices are approved for marketing in two ways, as required by legislation enacted in 1976. Totally new devices must be subjected to testing to demonstrate safety and effectiveness, with the resulting data submitted to FDA via a Premarket Approval Application. Devices "substantially equivalent" to ones already marketed are reviewed by FDA via a Premarket Notification, in which the manufacturer informs the FDA of changes it has made in the device and why those changes can be safely made--such as changing an implanted heart valve from metal to plastic.

In considering candidates for regulatory reform, FDA has considered the concerns expressed by the drug and device industries, which are focused on expediting product reviews and eliminating unnecessary requirements. While these reforms would eliminate a number of burdensome direct cost elements, the major savings to these industries would result from the economic value of the time saved in bringing new products to market. Overall, the drug/biotech industry could realize almost \$400 million a year and the medical device industry about \$100 million a year in such time-cost savings. Savings to the FDA would be around 50 FTEs after the first year, and perhaps in the hundreds by the year 2000.

DRUGS

The Problem: FDA's longstanding regulations governing the marketing of new drugs place burdens on the industry that are unnecessary to protection of the public health. For biological drugs, originally produced from living organisms, the requirements have been especially strict and biotechnology products fall under these requirements. Specifically:

- 1) All manufacturing changes in biologic (biotech) products need FDA preapproval, even if they are relatively minor;
- 2) Manufacturers of biotech drugs must often build a production facility long before marketing approval;
- 3) Biotech drug manufacturers are inhibited from using subcontractors by requirements limiting manufacturer name on the drug; and
- 4) FDA issues "monographs" dealing with production and testing of antibiotics and insulin.

New Regulatory Approach: Streamline/reduce burden, tailor requirements to the risk involved.

Proposed Solution: Expedite market access for new drugs by fitting requirements to risk. As technology has advanced, extremely tight regulatory controls over drug manufacturing have become unnecessary. Products can now be safely made with reduced regulation, i.e.,

- 1) Waive premarket approval for all manufacturing changes in new drugs that introduce no or negligible risk;
- 2) Permit manufacturers to demonstrate capability to properly make biotech drugs without building a new plant (i.e., but establishing a small "pilot" production line);
- 3) Permit biotech drug companies to subcontract product production by allowing them to place their name on the drug produced by the subcontractor; and
- 4) Eliminate special requirements for insulin and antibiotics and allow an existing private standard setting body to establish testing and quality standards.

Pros and Cons:

- Pro:**
- Relieves industry resources;
 - Saves government resources; and
 - Provides public faster access to products.
- Con:**
- Slight risk that supposedly "minor" change could turn out to be important.

Alternatives Not Recommended (and Why):

- 1) Waive FDA preapproval of all manufacturing changes (Many manufacturing changes affect a product's active ingredients and can be significant to health).
- 2) Waive entirely the requirement to demonstrate capability to manufacture a new drug before FDA approval (Experience has demonstrated that some firms cannot properly manufacture a new drug at the beginning and need some initial FDA oversight).
- 3) Eliminate quality and testing standards entirely for insulin and antibiotics (Antibiotics and insulin can pose significant health risks if improperly produced).

Regulatory Impact:

- 1) Amendments to requirements for manufacturing changes would reduce by 50% instances whereby manufacturers of biotech drugs must wait for FDA approval, and by 10% instances whereby other drug manufacturers must wait. Will reduce FDA workload by 12-1400 applications as well as staff years assigned to those functions. Average processing times would be reduced from an average of 6-12 months to an overall time of 0-30 days;
- 2) Eliminating need for early construction of new manufacturing facility could result in savings of up to 250 million dollars to the biotechnology drug industry according to our private sector study; and
- 3) Amending antibiotic and insulin requirements would eliminate 700 pages of the Code of Federal Regulations; certification and other fees of approximately \$2 million per year by industry would be removed; FDA would save up to 3 FTEs.

GENERIC DRUGS

(Exemption of Generic Drugs from Premarket Approval Requirements)

The Problem: Generic drugs manufacturers must apply to FDA for permission to market generic versions of brand name drugs (once the patent has expired). Because data on the makeup of the brand name drug is unavailable to the generic drug manufacturer, that company must purchase the brand name drug, analyze it, determine how to make it, and submit an application to the FDA demonstrating that it has "guessed right" in how to make the generic version. Thus, generic manufacturers each year must go through that process almost 4,000 times, even though the resulting drug is merely a close copy of the brand name version.

New Regulatory Approach: Exemption from current application process; privatization of standard setting process.

Proposed Solution: Change the requirements for FDA preapproval of generic drug applications. Publicly release information about the manufacturing of brand name drugs at the time the patent expires. The application submitted to FDA would be far simpler, thus alleviating the need for the generic company, through reverse engineering, to attempt to determine how the brand name drug was made.

Pros and Cons:

Pro:

- Greatly streamlines generic drug marketing process, without compromising safety;
- Generic drugs produced under this system will have less variability, thus improving patient care; and
- Generic drug industry likely to support such a change.

Con:

- Brand name drug industry likely to oppose, based on resistance to FDA releasing drug content data.

Alternatives Not Recommended (and Why):

- 1) Review generic drugs more rapidly, thus speeding their marketing approval (insufficient FDA resources, does not address question of variability between generic and brand name drugs--e.g., a generic drug may dissolve differently than the brand name drug or otherwise be slightly "different," because the generic drug

manufacturer must "guess" how the brand name drug is made.)

- 2) Have a two-prong approach, maintaining the current 1st approved generic, while ultimately making the patent available for more exact copies.

Regulatory Impact:

- Eliminates some Federal preapproval;
- Speeds market access for generic drugs;
- Enhances consistency among generics when appropriate;
- Saves government FTEs;
- Saves industry resources;

MEDICAL DEVICES

The Problem: The medical device industry claims that the Food and Drug Administration's (FDA's) regulatory actions for medical devices have delayed the introduction of devices into the marketplace and have negatively impacted the U.S. device industry's international competitiveness. Industry concerns about FDA's device responsibilities include: (1) FDA reviews of premarket approval applications (PMA's) and premarket notification actions (requests to market a device on the ground that it is substantially equivalent to another device that is already on the market) under section 510(k) of the Federal Food, Drug, and Cosmetic Act take too much time and delay a device's entry into the marketplace; (2) FDA approval of requests to export unapproved devices is unnecessary and delays exports; (3) the device classification process is unduly burdensome because it requires classification procedures even for low risk devices; and (4) FDA has a list of firms that fail to observe good manufacturing practice (GMP) requirements when manufacturing their devices and firms are unable to determine whether they are on the list or precisely what corrective actions they should take in order to regain FDA approval to manufacture devices.

New Regulatory Approach: Performance standards; privatization; streamlining/reducing regulatory burden by tailoring regulation to risk; place greater reliance on industry certifications for exports; exempt certain low risk devices from premarket approval.

Proposed Solution: Expedite market access and export of devices by fitting requirements to risk and working with the industry by:

1. Initiating a pilot study for 3rd party review of certain device applications by private organizations;
2. Waiving FDA review of export requests for devices that are approved for investigational use in the United States;
3. Exempting over 140 device categories from premarket review;
4. Processing a manufacturer's pending applications that are unrelated to the manufacturer's GMP problems while making the GMP failure list available to industry; and
5. Requesting authorization for device user fees; these fees would be dedicated to increasing FDA resources for reviewing device applications and premarket notifications [This proposal is in the President's 1996 budget].

Pros and Cons:

- Pro:**
- Addresses major concerns of the device industry;
 - Increases the Agency's efficiency in regulating devices;
 - Once the review process is streamlined, user fees will ensure adequate resources for efficient review; and
 - Provides therapies to patients more quickly both in the United States and abroad.
 - Provides industry more information to determine what corrective actions are necessary to comply with GMP's;
 - Pilot study of external review would provide important information on whether third party review should be adopted for certain devices;
 - U.S. industries could compete more effectively in foreign markets;
- Cons:**
- User fees for review would add FTEs (albeit paid by industry);
 - Previous industry support for user fees shifting toward privatization;
 - Slight risk that exported devices and exempted devices may cause harm or present more risk than anticipated;
 - Recognition of potential problems may be delayed in exempted devices.

Alternatives Not Recommended (And Why):

1. Relying on private organizations, certified by FDA, for review of device applications (could result in marketing of unsafe devices and reduce public confidence in device products) [Pilot program will address this alternative.];
2. Phase-in third party private sector review bodies to conduct premarket approvals and inspections starting with lower risk devices. (Need experience with pilot program to determine appropriateness of expanded third party review);

3. Permitting self-certification of exports to countries where the exported product is already approved. Could also increase penalties for export of unsafe devices to address concerns of "dumping"; and
4. Exempting more device categories (many devices require some agency review to determine what controls are appropriate for the use of the device).

Regulatory Impact:

- Approval times for new devices cut from 27 months to 6 months for 1st decision, 12 months of Agency time for final approval;
- Changes in existing devices cut from 7 months to 3 months;

CROSS-CUTTING

(Categorical Exemptions from Requirements of National Environmental Policy Act)

The Problem: The National Environmental Policy Act (NEPA) requires all Federal agencies to assess the environmental impact of their actions. Before a drug, biologic, food additive, or animal drug is approved for marketing, FDA currently requires the company manufacturing the product to conduct an environmental assessment (EA). Hundreds of EAs are done each year, at a cost of \$40,000-150,000 per EA. FDA almost always finds no significant impact; thus the EAs are not believed necessary in the context of these product approvals.

Regulatory Approach: Administratively exclude product approvals from EA requirements; reduce burden.

Proposed Solution: In consultation with the Council on Environmental Quality, the FDA would reclassify product approvals with de minimis environmental effects as actions that normally are not subject to environmental review requirements. For example, it is known that human excretion of a drug's residues into the environment through public sewers poses no environmental impact.

Pros and Cons:

- Pro:** - Eliminates requirements that have little real impact on the environment; and
- Saves resources to focus on those actions that do have environmental impacts.
- Con:** - None apparent.

Alternatives Not Recommended (and Why): Have FDA staff do the EIAs, thus relieving the burden on regulated industry (insufficient resources, inadequate data to conduct assessments).

Regulatory Impact:

- Reduces burden on industry by saving \$10+ million in annual costs to carry out EAs;
- Saves government resources expended on reviewing these EAs.

CROSS-CUTTING

(FDA Submission, Tracking, and Communication of Information)

The Problem: FDA receives hundreds of applications for approvals of new products each year, particularly from drug and biologics firms. Those applications frequently comprise thousands of pages of detailed scientific information. The enormous documents require substantial space for storage, pose difficulty in retrieving information, and waste valuable time in forcing FDA medical staff to carry out analyses of findings in the data. There is a need to permit companies to submit applications electronically and to communicate questions and answers with FDA electronically; and for FDA to utilize electronic tracking and analysis in reviewing the data.

New Regulatory Approach: Modernize, utilize latest technology

Proposed Solution: Embark on a program to expand and standardize the use of information systems in support of the product review process. This would include developing a system for the electronic receipt, processing, tracking and archiving of all documents; provide the capability to analyze and sort complex data rapidly; and enhance communications between industry and FDA. System would begin with drug regulation, expand later to medical devices, food additive, and other products.

Pros and Cons:

- Pro:** - Prepares FDA-industry relations for 21st century.
- Con:** - Some, although modest, initial costs for transition.

Alternatives Not Recommended (and Why):

- 1) Retain current system (outmoded, inefficient)
- 2) Allow computerization to occur at its own pace (substantial inertia, need for leadership)
- 3) Impose a strict FDA requirement to use computerized applications in a specified manner (could be viewed as burdensome)

Regulatory Impact: It is estimated that increased use of information technology can reduce drug development time considerably. Annual savings to the industry could be approximately \$50 million.

CROSS-CUTTING

(Harmonization of Standards)

The Problem: Various countries have differing requirements for approval of new drugs, biologics, medical devices, food additives, and animal drugs. This results in multiple tests on animals and drugs and different applications for marketing approval. There is a substantial need to harmonize standards wherever possible while retaining basic safety protections.

New Regulatory Approach: Common international standards

Proposed Solution: Work jointly with other countries, particularly NAFTA partners, the European Community, and Japan to harmonize testing and product development standards with those of the U.S. Work has already begun on drug development and should be continued in that area and expanded to other areas of FDA regulation.

Pros and Cons:

- Pro:** - Improves U.S. position internationally; and
 - Encourages trade among nations.
- Con:** - Some initial FDA costs to seek/reach agreements with foreign governments.

Alternatives Not Recommended (and Why):

- 1) Adopt certain foreign standards already in place such as the CE mark accepted by the European Community or standards in countries that have comparable levels of health and safety standards.
- 2) Establish reciprocity of product approvals with certain foreign countries (many countries have insufficient protections, U.S. citizens would oppose accepting decisions made by some, if not all, foreign nations)

Regulatory Impact:

- Improved quality/safety of imported goods;
- Enhanced exports of U.S. goods;
- Burden reduction for industry; and Savings to FDA in regulatory costs.

OTHER PROPOSALS FOR REFORMING FDA

DRUGS & BIOLOGICS

The following options can all be considered for certain subcategories of drug approval applications:

FDA contracting out to private organizations the review of new drug applications.

Allow drug manufacturers to gain premarket approval through "certification" that their drugs are safe and effective from a third-party standards setting organization; manufacturer pays for the certification.

Allow drug manufacturers to "self-certify" that their drugs are safe and effective, market the drugs without FDA approval, then rely on FDA to find unsafe drugs and remove them from the market.

Relaxing the "efficacy standard" for drug approval, i.e., requiring less evidence of a drug's effectiveness than currently.

-Unrestricted access to experimental drugs, via a dual system. Drug company could 1) go through the current FDA approval process to test drugs in humans, or 2) allow use of experimental drugs with a warning to physicians and patients that the drugs have not yet been approved by FDA when the risks are either low or the potential benefits outweigh the risks.

Reduce regulation of "off-label" uses for drugs; FDA would approve a drug for its first indication, additional indications could be promoted by manufacturers in advance of FDA approval. Manufacturers would still be subject to the requirements that the labeling cannot be false or misleading, thus the full disclosure that the indication is not approved would be required.

Revoke the biologics portion of the Public Health Service Act, thereby regulating biotech drugs and vaccines as traditional drugs, and eliminating requirement for establishment licensing.

MEDICAL DEVICES

Exempt more devices from FDA review, based on assumption that they are low-risk

Adopt the European system for reviewing changes in devices already marketed, i.e., allow companies to get "certification" from a private organization that their devices' modifications are safe, then present those certifications to the FDA as proof of safety (without any FDA review). FDA would then monitor the devices on the market for safety.

Contract out reviews of new medical devices with private organizations.

Legislation protecting biomaterial suppliers to medical manufacturers with liability protection if the device harms a patient.

Accept European CE mark in lieu of FDA approval.

Post market reporting and surveillance should be streamlined to focus on devices posing significant harm.

CROSSCUTTING

Reciprocity of approvals of drugs, biologics, devices and food additives with foreign countries, i.e., when another industrialized country with review programs and comparable rigor approves a product, approval would be automatic in this country.

Unrestricted export of unapproved drugs, biologicals, and devices to countries that have already given the products their approval.

Creating one government-wide "inspection service" under which most government inspections would be carried out (e.g., a firm would get a visit from one inspector, who would inspect for food/drug, environmental, worker safety, and other violations).

Ideas for Regulatory Relief Events

1. Simplify Billing and Payment for Providers and Consumers

- ✓ Eliminate Physician Attestation Requirement. (No action taken yet by HCFA.)
- Provide Uniform Identification Numbers to all providers in Federal health programs. (HCFA has begun work. No public statement yet.)
- Simplify the "Important Message from Medicare" -- simplify the content and way it is distributed. (Work has begun. No public statement yet.)
- Improve and simplify communications with beneficiaries -- create one, easy to understand, monthly statement. (Work has begun. No public statement yet.)
- Implement the Medicare Transaction System -- uniform, national system for processing Medicare claims to replace the 14 different claims processing systems operated by 79 insurance companies at 62 sites. (GTE was awarded design contract in January 1994; implementation will begin in 1997.)

2. Eliminate Burdensome Process Requirements for providers

- ✓ Change conditions of participation to make them more outcomes-based, less process-oriented. (These are being developed for hospitals and ESRDs. HCFA is prepared to begin developing similar standards for home health agencies. No public statement yet.)

Other possibilities:

1. ✓ CLIA -- more controversy because of conflicting provider, consumer and Hill concerns
2. Physician Review Organizations (PROs) -- HHS unwilling to go as far as many providers would like (i.e., eliminate completely). We will work with Gleason on this.
3. Fraud and Abuse activities

Change in Federal Payments to States Under Medicaid Capped Payments
Capped Payments at 5%: 1996 - 2002
(Dollars in millions, fiscal years)

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Range: Reductions (-) or Increases (+) in Federal Grant

	State Baseline Growth National Rates *	State Baseline Growth at State Projected Rates (93-96)*
US	(192,580)	(192,580)
Alabama	(2,293)	(768)
Alaska	(375)	187
Arizona	(2,164)	(3,012)
Arkansas	(1,449)	(241)
California	(21,646)	(6,915)
Colorado	(1,841)	609
Connecticut	(3,258)	(4,182)
Delaware	(414)	(710)
District of Columbia	(1,037)	(794)
Florida	(8,008)	(14,572)
Georgia	(4,482)	(6,142)
Hawaii	(651)	(1,002)
Idaho	(445)	(401)
Illinois	(7,339)	(4,490)
Indiana	(3,674)	1,516
Iowa	(1,496)	(1,176)
Kansas	(1,208)	952
Kentucky	(2,468)	(163)
Louisiana	(5,117)	(124)
Maine	(1,208)	(374)
Maryland	(3,315)	(5,746)
Massachusetts	(5,881)	(3,531)
Michigan	(6,554)	(5,304)
Minnesota	(3,425)	(4,528)
Mississippi	(1,800)	(1,404)
Missouri	(3,373)	(1,913)
Montana	(446)	(170)
Nebraska	(851)	(1,011)
Nevada	(529)	78
New Hampshire	(856)	(1,072)
New Jersey	(6,130)	1,700
New Mexico	(913)	(1,524)
New York	(31,123)	(77,036)
North Carolina	(4,602)	(8,129)
North Dakota	(352)	(7)
Ohio	(7,659)	(7,403)
Oklahoma	(1,364)	103
Oregon	(1,648)	(4,444)
Pennsylvania	(9,230)	709
Rhode Island	(1,027)	468
South Carolina	(2,658)	19
South Dakota	(408)	(485)
Tennessee	(4,413)	(2,495)
Texas	(11,394)	(19,398)
Utah	(717)	(726)
Vermont	(378)	(196)
Virginia	(2,605)	(1,528)
Washington	(3,626)	(4,092)
West Virginia	(1,552)	(348)
Wisconsin	(2,964)	(1,127)
Wyoming	(214)	(236)

Base year: State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996

*Baseline expenditures are adjusted to sum to CBO total reductions.

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Footnotes for Package One - Phased-in Tobacco Tax

All estimates are preliminary. Totals may not add due to rounding.

While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays.

Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

Administrative costs have not been estimated.

- 1/ Increases by \$0.49 per pack from today's \$0.24 level. Specifically, on 1/1/97 increased to \$0.60 and to \$0.73 on 1/1/2003. Estimate from Treasury.
- 2/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Includes effects on Part B takeup and utilization of services. Estimates from HCFA/OACT and Treasury.
- 3/ Indirect effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury.
- 4/ Estimates from HCFA/OACT.
- 5/ Includes 25% behavioral offset. Estimate from HCFA/OACT.
- 6/ Medicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.
- 7/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

- 8/ Also assumes that kids and families with access to employer contributions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.
- 9/ Assumes that unemployed compensation is included in income determinations for unemployed program. Eligibility for kids' subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.
- 10/ Subsidies to unemployed individuals will have an indirect effect on the unemployment insurance (UI) program. Such an indirect effect is estimated to increase the cost of the UI program by approximately \$2 billion over five years and \$3 billion over ten years (net of offsetting UI receipts).
- 11/ Estimate from HHS/PHS.
- 12/ Estimate from HCFA/OACT.
- 13/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.
- 14/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.
- 15/ Five and ten year totals include \$0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%. Phase-in: 25% in 1994/95; 50% in 1996; 75% in 1997; and 100% in 1998 and thereafter.
- 16/ Five and ten year totals include \$0.5 billion cost for self-employed tax deduction in FY 1995.

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Possible Sources and Uses of Funds - Package Three (No Tobacco Tax)

Fiscal Years, Billions of Dollars

													5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Medicare Receipt Proposals	1/	0.0	1.4	2.7	2.6	2.6	2.9	3.2	3.5	3.8	4.2	4.6	12.3	31.4
Indirect Effects on Receipts	2/	0.0	0.0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.7	1.9
Medicare Savings	3/	0.0	0.8	4.0	5.4	7.3	9.7	12.5	14.8	17.5	20.3	23.5	27.1	115.9
Medicaid DSH Freeze	4/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Medicaid Offset	5/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.8	7.9	9.9	12.5	15.9	19.8	23.2	27.0	31.0	35.4	49.0	185.6
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	6,7,8,/	0.0	0.0	6.8	9.4	10.0	10.6	11.3	12.0	12.8	13.6	14.5	36.7	100.8
Subsidies for Kids (net of kids in TU Program)		0.0	0.0	3.8	5.2	5.3	5.5	5.7	5.9	6.1	6.5	6.8	19.8	50.7
Subsidies for Temporarily Unemployed Families 9/		0.0	0.0	3.0	4.2	4.6	5.1	5.6	6.1	6.6	7.1	7.7	16.9	50.1
Public Health Service/FQHC Expansion	10/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
FQHC Expansion Effect on Medicare/Medicaid	11/	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.5	1.5
Long-term Care Program	12/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	13/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Self-employed Tax Deduction Phased to 100%	14/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Total Uses of Funds:	15/	0.5	0.9	10.0	13.2	14.6	15.6	16.7	17.9	19.2	20.5	22.0	54.9	151.2
Impact on Deficit:	15/	0.5	-1.9	2.0	3.3	2.1	-0.3	-3.1	-5.3	-7.8	-10.5	-13.5	5.8	-34.4

DRAFT

Footnotes for Package Three - No Tobacco Tax

All estimates are preliminary. Totals may not add due to rounding.

While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays.

Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

Administrative costs have not been estimated.

- 1/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Includes effects on Part B takeup and utilization of services. Estimates from HCFA/OACT and Treasury.
- 2/ Indirect effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury.
- 3/ Estimates from HCFA/OACT.
- 4/ Includes 25% behavioral offset. Estimate from HCFA/OACT.
- 5/ Medicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.
- 6/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.
- 7/ Also assumes that kids and families with access to employer contributions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.

- 8/ Assumes that unemployed compensation is included in income determinations for the unemployed program. Eligibility for kids' subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.
- 9/ Subsidies to unemployed individuals will have an indirect effect on the unemployment insurance (UI) program. Such an indirect effect is estimated to increase the cost of the UI program by approximately \$2 billion over five years and \$3 billion over ten years (net of offsetting UI receipts).
- 10/ Estimate from HHS/PHS.
- 11/ Estimate from HCFA/OACT.
- 12/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.
- 13/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.
- 14/ Five and ten year totals include \$0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%. Phase-in: 25% in 1994/95; 50% in 1996; 75% in 1997; and 100% in 1998 and thereafter.
- 15/ Five and ten year totals include \$0.5 billion cost for self-employed tax deduction in FY 1995.



The Administrator
Washington, D.C. 20201

FEB 21 1995

NOTE TO HILLARY RODHAM CLINTON

FROM: Bruce Vladeck
Administrator

SUBJECT: HCFA's Actions to Combat Medicare Fraud and Abuse

Chris Jennings has asked me to write to you with respect to our activities designed to combat fraud and abuse in the Medicare program. As you know, some key members on the Hill are very interested in this issue. This memo outlines the administrative and legislative proposals to address this serious problem.

I. Senator Harkin's Concerns

As you know, Senator Harkin is interested in the appropriateness of Medicare payment for certain items and services such as, oxygen, surgical dressings, and ambulance services.

- ▶ Senator Harkin maintains that Medicare's payment for oxygen is inappropriately high by comparison to that of other payors. We agree. Unfortunately, we are not allowed by law to change our price for oxygen except by using a lengthy and administratively cumbersome authority called "inherent reasonableness." In response to the Senator, HCFA has set the inherent reasonableness authority process in motion to change our price. The process requires us to gather data on payment rates of other payors, such as private insurance companies and the VA, and to then go through full notice and comment rule-making. Because of the detailed statutory requirements of this process, we expect two years will be necessary to arrive at a new payment methodology for oxygen.

Because of the time that it takes to publish a regulation, we think it is important to submit to this Congress a legislative proposal to simplify our inherent reasonableness authority. Such a change would streamline the unnecessarily cumbersome process for achieving the best prices available for durable medical equipment. We estimate that potential savings would be less than \$100 million over five years.

- ▶ Senator Harkin also raised concerns about the possibility of inappropriate payments being made for surgical dressings. Based on substantial comments from beneficiaries and the industry, we recently modified our coverage policy for surgical dressings so that beneficiaries receive the items they need. Medicare will now pay for dressings used not only for surgical wounds but also for bed sores and other

decubitus ulcers. With this change in policy has come the potential for abuse. The regional durable medical equipment carriers are minimizing the abuse by incorporating specific computer edits for surgical dressings into their claims processing systems. When overuse occurs, carriers are able to more fully examine the claims and deny them when inappropriate. Because of this electronic claims screening, the number of surgical dressing claims has decreased dramatically since the change in our coverage policy but at the same time, beneficiaries are receiving the needed dressings.

- ▶ At present, Medicare pays for ambulance services based on the type of equipment used. Thus, we pay for trips using advanced life support (ALS) equipment even when not required by the patient's condition. While we do not dispute the value of ALS services when needed, we must revise our regulations to change our payment policy and thus to provide a strong incentive to curb excessive ALS billings when these services are not medically necessary. We are now developing a new regulation with industry input that will address this concern by basing ambulance payment on the patient's condition. We expect that the publication of the Notice of Proposed Rulemaking to be the Spring of 1996. Due to the public comment and review process, the regulation will not be in final form before 1997.

II. Additional Efforts to Control Fraud and Abuse

The growth of the Medicare and Medicaid programs has been unfortunately accompanied by an overall increase in instances of health care fraud and program abuse. We have taken a very aggressive stance to protect Medicare and our beneficiaries from fraudulent activities by identifying and preventing such activities before prosecution of the bad actors becomes necessary. I have recently hired a Senior Advisor on Fraud and Abuse to spearhead our efforts and to liaison with the States and the enforcement agencies.

- ▶ HCFA is increasingly applying state-of-the-art techniques in analyzing our claims data to detect aberrant patterns that might reveal fraudulent behavior. To further improve HCFA's ability to screen Medicare claims for errors and fraud, the Medicare Transaction System, will standardize Medicare claims processing in a single, fully-automated system. In January of 1994, GTE was awarded the design contract which will take several years to complete. The system will be phased-in in 1997 and will be fully implemented in 1999.
- ▶ To better monitor fraud and abuse in a particularly problematic area, HCFA has changed the way durable medical equipment claims are handled. Suppliers no longer can game

the system by sending claims to the carrier that paid the highest amount or subjected them to the least scrutiny. They must now bill the regional carrier that services the area where the beneficiary lives.

- ▶ HCFA has provided funding to 22 of our claims processing contractors to hire Medicare Fraud and Abuse Information Coordinators. These coordinators identify new forms of fraudulent activity. They then alert each other and their partners, such as HCFA, Federal and State law enforcement agencies, provider and beneficiary organizations, Medicaid State agencies, and Medicare contractors.
- ▶ HCFA uses several systems to ensure that payments are appropriate. For example, claims processing contractors examine the reasonableness of the costs incurred by providers and disallow costs that are unreasonable or are not related to the Medicare program. In addition, medical review units of each contractor analyze claims data, to identify providers with aberrant billing and utilization practices and, to intervene where appropriate.
- ▶ HCFA is also expanding and strengthening efforts to root out fraud and abuse and to vigorously pursue those who commit such illegal activities. HCFA has strengthened relationships not only with the DHHS Office of the Inspector General, but also with the Department of Justice (including the FBI), State and local law enforcement agencies, and our contractors. Furthermore, we are increasingly exercising our authority to suspend payments to suppliers or providers when we discover reliable evidence of fraud.
- ▶ To address widespread fraud in South Florida, HCFA has formed a special fraud and abuse work group to concentrate on this region, involving HCFA regional staff, our Medicare contractors, and the State Medicaid agency. This group works closely with a law enforcement task force made up of Federal, State, and local law enforcement officials and the U.S. Attorney's office. The effort has achieved extremely productive and apparently unprecedented degrees of coordination among the various agencies. The work group will report in March on innovative policy and procedural changes that HCFA can implement quickly to prevent fraud and recommend longer-range changes.

III. Further Steps

While most of our initiatives have been implemented under current law, others may require legislative action. HCFA and the DHHS Inspector General have developed two innovative legislative proposals which Secretary Shalala and Director Rivlin have agreed will be included in the next "reinventing government" bill.

These proposals would create the Benefit Quality Assurance Program and the Fraud and Abuse Control Fund. Using funds recovered from anti-fraud and abuse activities, these programs would permit investment in new activities to combat fraud and abuse. While not scored by CBO, we believe that this proposal will generate an 8 to 1 return.

- ▶ The Benefit Quality Assurance Program will strengthen our existing medical and utilization review activities, coordination of benefits with other insurers, auditing of provider cost reports, and other anti-fraud and abuse activities.
- ▶ The Fraud and Abuse Control fund is similar to that envisioned in the President's Health Security Act. This fund would receive and retain civil monetary penalties, assessment amounts, and restitution payments. Money from this fund would be available to the Office of the Inspector General and to HCFA to carry out subsequent fraud and abuse enforcement responsibilities.

We welcome your advice on how to best publicize these anti-fraud efforts and to ensure that the administration gets the credit it deserves. Please let us know how we can best assist you. We think that working together on the mammography initiative has given the issue a new level of public attention. We would like to build on our relationship and look forward to working with Chris Jennings if you have further interest.

Hartford, CT 06106

Hartford Courant Monday 2/20/95

Pentagon accused of withholding evidence of gulf war chemical use

By THOMAS D. WILLIAMS
Carew Staff Writer

A former U.S. senator says the Pentagon withheld critical evidence from a congressional inquiry into illnesses affecting veterans of the Persian Gulf War.

Donald W. Riegle Jr., a Michigan Democrat who recently retired, said a 1991 chemical incident log — obtained by a Georgia veterans group in January — would have eased an investigation he conducted in 1993 and 1994 as chairman of the Banking Committee.

In an interview last week, Riegle called the log "a very powerful piece of evidence" that shows what military authorities were thinking and doing about reported chemical and biological incidents during the war.

Many veterans complain they have failed to receive proper medical care, and Riegle has said it is crucial for doctors treating them to know what they were exposed to.

In March 1994, Riegle asked for such a log during his committee's investigation, but the U.S. Department of Defense responded: "Central Command has conducted a search and has identified no documents that meet that description."

Jim Turner, a Defense Department spokesman, said Riegle had been told the department could not find a "U.S. Central Command log" but would continue looking if Riegle could be more specific. Riegle never made another request, Turner said.

An aide to Riegle said they continued to make requests for the log but got nowhere.

Paul Sullivan, president of Gulf

War Veterans of Georgia, asked for the chemical and biological incident log from the U.S. Central Command, now based in Florida, last August and received parts of it in January. He turned it over to a former Riegle aide.

It is unclear why the log could not be located earlier, or why many dates are still missing.

"Why did they hide it from us? Did it now get out in a purposeful way or did it get out by accident?" asked Riegle, now an instructor at the University of Michigan and an adviser to a Washington, D.C., public relations firm.

The daily log, which contains military jargon and shorthand, records reports of chemical or biological incidents that Central Command received during the gulf war. The log's three columns break down the reports into time, incident and action taken.

Some complaints or reports are described as unfounded. Others do not show any action taken or any conclusions made. In several instances, an incident is discounted before any subsequent action is reported in the log. The log records reports that some chemical testing equipment showed positive readings for chemical warfare gases.

For example, the log reports:

- Jan. 18, 8:05 p.m.: "Israeli police confirmed nerve gas probably."
- Jan. 20, 8:17 p.m.: "Czech recon... report detected GA/GB (sarin and tabun, two warfare nerve gases)" and that hazard is flowing down from factory/storage bombed in Iraq. Predictably, this has become a going to become a problem."
- Jan. 21, 8:15 p.m.: "Czechs were called who reported trace

quantity of Tabun [nerve gas], Sarin [nerve gas] and Yperite [mustard gas] ... which was caused by fallout from bombing of Iraqi CW [chemical weapons] storage/weapon sites."

At least 57,000 American servicemen and women of the 697,000 who served during the war are seeking treatment for post-traumatic stress disorder, cancer, heart disease, nerve and digestive disorders, and a variety of other illnesses including some contagious diseases. More than 2,380 veterans have died from sickness.

The parts of the log released last month contain only four days in January 1991 and three days in March 1991. Absent are weeks when the air war and the ground war were ongoing.

Riegle, who suspects that Iraqi chemical weapons in the Persian Gulf did contribute to the continuing sickness of some U.S. troops, says the rest of the log needs to be made public.

James Tuite III, Riegle's former investigative aide, said he has given the log to staff members in both political parties working for the Senate Armed Services Committee.

"The withholding of [the logs] not only interfered with the conduct of a congressional committee's investigation, but also inhibited medical research efforts into this issue for a period of nearly one year," Tuite said.

Turner, the Defense Department spokesman, said an independent medical commission reviewed the logs and other evidence and concluded none of the troops were exposed to chemical or biological weapons.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

January 18, 1994

EXECUTIVE ORDER

ADVISORY COMMITTEE ON HUMAN RADIATION EXPERIMENTS

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Establishment. (a) There shall be established an Advisory Committee on Human Radiation Experiments (the "Advisory Committee" or "Committee"). The Advisory Committee shall be composed of not more than 15 members to be appointed or designated by the President. The Advisory Committee shall comply with the Federal Advisory Committee Act, as amended, 5 U.S.C. App. 2.

(b) The President shall designate a Chairperson from among the members of the Advisory Committee.

Sec. 2. Functions. (a) There has been established a Human Radiation Interagency Working Group, the members of which include the Secretary of Energy, the Secretary of Defense, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, the Attorney General, the Administrator of the National Aeronautics and Space Administration, the Director of Central Intelligence, and the Director of the Office of Management and Budget. As set forth in paragraph (b) of this section, the Advisory Committee shall provide to the Human Radiation Interagency Working Group advice and recommendations on the ethical and scientific standards applicable to human radiation experiments carried out or sponsored by the United States Government. As used herein, "human radiation experiments" means:

- (1) experiments on individuals involving intentional exposure to ionizing radiation. This category does not include common and routine clinical practices, such as established diagnosis and treatment methods, involving incidental exposures to ionizing radiation;
- (2) experiments involving intentional environmental releases of radiation that (A) were designed to test human health effects of ionizing radiation; or (B) were designed to test the extent of human exposure to ionizing radiation.

Consistent with the provisions set forth in paragraph (b) of this section, the Advisory Committee shall also provide advice, information, and recommendations on the following experiments:

more

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- (1) the experiment into the atmospheric diffusion of radioactive gases and test of detectability, commonly referred to as "the Green Run test," by the former Atomic Energy Commission (AEC) and the Air Force in December 1949 at the Hanford Reservation in Richland, Washington;
- (2) two radiation warfare field experiments conducted at the AEC's Oak Ridge office in 1948 involving gamma radiation released from non-bomb point sources at or near ground level;
- (3) six tests conducted during 1949-1952 of radiation warfare ballistic dispersal devices containing radioactive agents at the U.S. Army's Dugway, Utah, site;
- (4) four atmospheric radiation-tracking tests in 1950 at Los Alamos, New Mexico; and
- (5) any other similar experiment that may later be identified by the Human Radiation Interagency Working Group.

The Advisory Committee shall review experiments conducted from 1944 to May 30, 1974. Human radiation experiments undertaken after May 30, 1974, the date of issuance of the Department of Health, Education, and Welfare ("DHEW") Regulations for the Protection of Human Subjects (45 C.F.R. 46), may be sampled to determine whether further inquiry into experiments is warranted. Further inquiry into experiments conducted after May 30, 1974, may be pursued if the Advisory Committee determines, with the concurrence of the Human Radiation Interagency Working Group, that such inquiry is warranted.

(b)(1) The Advisory Committee shall determine the ethical and scientific standards and criteria by which it shall evaluate human radiation experiments, as set forth in paragraph (a) of this section. The Advisory Committee shall consider whether (A) there was a clear medical or scientific purpose for the experiments; (B) appropriate medical follow-up was conducted; and (C) the experiments' design and administration adequately met the ethical and scientific standards, including standards of informed consent, that prevailed at the time of the experiments and that exist today.

(2) The Advisory Committee shall evaluate the extent to which human radiation experiments were consistent with applicable ethical and scientific standards as determined by the Committee pursuant to paragraph (b)(1) of this section. If deemed necessary for such an assessment, the Committee may carry out a detailed review of experiments and associated records to the extent permitted by law.

(3) If required to protect the health of individuals who were subjects of a human radiation experiment, or their descendants, the Advisory Committee may recommend to the Human Radiation Interagency Working Group that an agency notify particular subjects of an experiment, or their descendants, of any potential health risk or the need for medical follow-up.

(4) The Advisory Committee may recommend further policies, as needed, to ensure compliance with recommended ethical and scientific standards for human radiation experiments.

(5) The Advisory Committee may carry out such additional functions as the Human Radiation Interagency Working Group may from time to time request.

Sec. 3. Administration. (a) The heads of executive departments and agencies shall, to the extent permitted by law, provide the Advisory Committee with such information as it may require for purposes of carrying out its functions.

(b) Members of the Advisory Committee shall be compensated in accordance with Federal law. Committee members may be allowed travel expenses, including per diem in lieu of subsistence, to the extent permitted by law for persons serving intermittently in the government service (5 U.S.C. 5701-5707).

(c) To the extent permitted by law, and subject to the availability of appropriations, the Department of Energy shall provide the Advisory Committee with such funds as may be necessary for the performance of its functions.

Sec. 4. General Provisions. (a) Notwithstanding the provisions of any other Executive order, the functions of the President under the Federal Advisory Committee Act that are applicable to the Advisory Committee, except that of reporting annually to the Congress, shall be performed by the Human Radiation Interagency Working Group, in accordance with the guidelines and procedures established by the Administrator of General Services.

(b) The Advisory Committee shall terminate 30 days after submitting its final report to the Human Radiation Interagency Working Group.

(c) This order is intended only to improve the internal management of the executive branch and it is not intended to create any right, benefit, trust, or responsibility, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers, or any person.

WILLIAM J. CLINTON

THE WHITE HOUSE.
January 15, 1994.