THE WHITE HOUSE

WASHINGTON

March 24, 1994

The Honorable Edolphus Towns
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Towns:

Enclosed please find answers to questions you submitted after the First Lady testified before the Committee on Energy and Commerce. It recently came to my attention that answers to these questions may never have been submitted for the record.

I apologize for the extensive delay. Please feel free to contact me with any additional requests or concerns.

Sincerely yours,

Jennifer Klein
Special Assistant to
the President for
Domestic Policy

cc: The Honorable John D. Dingell

QUESTION: The President's plan proposes to restructure and reduce graduate medical education and indirect medical education payments. Inner city hospitals currently use GME and IME payments to provide both primary health care and to address numerous social problems. Under the Administration's proposal, on these payments, in the Budget Reconciliation bill, New York hospitals would have lost $90 million a year.

While I support the idea that we must increase the numbers of primary care providers, wouldn't a market-based approach which restructured reimbursements to physicians so that primary care providers were paid substantially the same as specialists achieve the results we all desire without penalizing inner city hospitals?

ANSWER: There is a serious imbalance of health professionals, with far too many in specialties other than primary care. Between 1988 and 1992 alone, hospitals added about 15,000 new residency training positions. Approximately 94% of new positions were in non-primary care specialties.

This excess supply of practitioners in specialties and subspecialties is not merely a product of market forces at work. To a very large degree it is an unintended consequence of existing federal policies. Federal action to limit growth in non-primary care specialties is needed to assure that we have an appropriate workforce in the future.

For example, Medicare's GME payments strongly encourage non-primary care physician specialization. This is in part because the payments focus nearly exclusively on hospital-based training, rather than on the development of training sites needed for primary care experiences. In addition, GME payment rates create incentives for hospitals to train large numbers of physicians in highly specialized fields.

It is important to note, however, that even with the federal actions proposed in the Health Security Act, New York hospital revenues are projected to increase steadily.

QUESTION: Given the important role pap tests play in preventing cervical cancer, shouldn't we allow a woman's health provider the discretion to determine whether a pap test should be administered annually?

ANSWER: The Health Security Act significantly improves coverage for women's health services by specifying a package of clinical preventive services provided without cost sharing. This package of services is designed for average populations at average risk.

The periodicity for pap smears -- annually for three years until three negative smears are obtained and then every three years -- is based on strong scientific evidence. Although the effectiveness of cervical cancer screening increases when pap testing is performed more frequently, a major study involving 1.8 million women has shown that there is little added benefit below three year intervals. In addition, since 1988, the American Cancer Society, the National Cancer Institute, the American College of Obstetricians and Gynecologists, the American Medical Association, the American Nurses Association, the American Academy of Family Physicians and the American Medical Women's Association have recommended annual smears until three negatives are obtained and less frequent testing after that at the discretion of the health professional.

In fact, the effectiveness of cervical cancer screening is more likely to be improved by extending testing to women who are not currently being screened and by improving the accuracy of pap smears than by increasing the frequency of testing. Women who are at greatest risk of cervical cancer are often the very women least likely to have access to testing.

The Health Security Act recognizes, however, that some women may require additional services because they are at higher risk for certain diseases. The Act therefore gives the physician the ability to provide more frequent pap smears without cost sharing if a woman is at risk for fertility-related infectious illnesses. The Act also gives the National Health Board the authority to increase the frequency of services in the clinical preventive package for populations at risk. Finally, the Act covers, with standard copayments, medically necessary or appropriate tests provided more frequently than specified in the preventive package.

QUESTION: The President's proposal will give management boards within each health alliance the power to decide issues of the cost and the type of health care options available within each alliance. Unfortunately, African Americans and other racial minorities have generally been excluded from participating on corporate boards. How will you ensure adequate representation of African

Americans and other minorities on each management board, when decisions about who sits on these boards are made at the State level?

ANSWER: Health alliances do not have power over the "cost and type of health options available within each alliance." Alliances must contract with all health plans that meet State certification requirements, except if a plan's premium substantially exceeds the alliance's premium target.

Health alliances increase the purchasing power of individuals and businesses who are forced today to buy expensive small group and individual insurance. The Health Security Act requires regional alliance boards to include an equal number of consumers and employers whose employees purchase coverage through the alliance.

The regional alliance has an obligation to ensure that all individuals in an area are enrolled in health plans and receive coverage for the comprehensive benefit package. In order to ensure real access, the Act also includes specific anti-discrimination protections for minority consumers and providers. For example:

- In establishing alliance boundaries, States may not discriminate on the basis of race, language, national origin, socio-economic status or certain other personal or demographic characteristics.

- Plans may not discriminate or engage in any activity that has the effect of discriminating against: (1) an individual on the basis on race, language, national origin, socio-economic status or certain other personal or demographic characteristics; and (2) a provider based on the socio-economic status, disability, health status or anticipated need for health services of a patient of the provider.

QUESTION: Many states and cities, particularly large urban areas, are complaining that they do not have the money to implement the sweeping array of new duties for which they would be responsible under the President's proposal. How do you propose to help those states who cannot afford to implement this plan?

ANSWER: The Secretary of HHS will make planning grants and start-up support available to states to implement the

new system. In addition, the Act makes grants available through the Public Health Service to support infrastructure development in underserved areas.

States and cities cannot afford the status quo. In recent years, for example, record high growth rates in the Medicaid program have consumed state budgets, taking limited resources from other state programs such as education.

The President's approach to health reform will produce savings for all states. Three independent experts -- the cost accounting firm of Lewin-VHI, the Congressional Budget Office, and the Urban Institute -- all agree that states will save under reform. In fact, the Administrations estimates are conservative. Both Lewin-VHI and CBO show overall savings to state and local governments that are greater than those projected by a study by the Department of Health and Human Services.

According to Department of Health and Human Services estimates, states will experience significant savings under the Health Security Act from a decrease in the rate of growth in Medicaid costs, the establishment a long-term care program that enables states to qualify for increased federal revenues, and a decrease in the rate of growth in health insurance premiums for public employees.

cc: Melanne
Chris

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

October 5, 1993

PAM OCT 12 1993

Mrs. Hillary Rodham Clinton
First Lady of the United States
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

In connection with your appearance last week at the opening hearing of our Committee on the President's health care reform proposal, Congressman Ed Towns has submitted in writing several questions to which he requests your response. A copy of his request is enclosed.

Pursuant to your agreement at the conclusion of the hearing to respond to such questions for the record, I would appreciate if you would provide your answers to the Committee and to Mr. Towns at your earliest possible convenience. Thank you for your assistance and cooperation.

With best wishes.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Enclosure

cc: The Honorable Edolphus Towns

EPHUS "ED" TOWNS
MEMBER OF CONGRESS
10TH DISTRICT, NEW YORK

ENERGY AND COMMERCE
HEALTH AND THE ENVIRONMENT
COMMERCE, CONSUMER PROTECTION, AND COMPETITIVENESS

GOVERNMENT OPERATIONS
ENVIRONMENT, ENERGY AND NATURAL RESOURCES
CHAIRMAN:
HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

Congress of the United States
House of Representatives
Washington, DC 20515-3210

WASHINGTON OFFICE
SUITE 2232
RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-3210
(202) 225-5936

BROOKLYN OFFICES:
545 BROADWAY, 2D FLOOR
BROOKLYN, NY 11206-2962
(718) 387-8696
16 COURT ST., SUITE 1505
BROOKLYN, NY 11241
(718) 855-8018

September 29, 1993

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JOHN D. DINGELL
U.S. HOUSE OF REP.

The Honorable John D. Dingell
Chairman
House Energy & Commerce Committee
2125 Rayburn HOB
Washington, D.C. 20515

Dear John:

I would like to submit the following questions on the President's health care reform proposal to the First Lady, Hillary Rodham Clinton, for her consideration and for the September 28th full Committee hearing record.

1) The President's plan proposes to restructure and reduce graduate medical education and indirect medical education payments. Inner city hospitals currently use GME and IME payments to provide both primary health care and to address numerous social problems. Under the Administration's proposal, on these payments, in the Budget Reconciliation bill, New York hospitals would have lost $90 million a year.

While I support the idea that we must increase the numbers of primary care providers, wouldn't a market-based approach which restructured reimbursements to physicians so that primary care providers were paid substantially the same as specialists achieve the results we all desire without penalizing inner city hospitals?

2) 4,500 women die from cervical cancer each year. Over 300 of these deaths are in New York State. According to the New York State Department of Health, cervical cancer is responsible for over 5,200 hospital admissions and 44,000 hospital days. Yet, statistics indicate that there is almost a 100% survival rate if this cancer is detected early. In view of the importance of prevention in the Administration's proposal, I am troubled by the Administration's proposal that pap tests for cervical cancer will be covered once every three years after three negative annual exams and that for women over 65, no coverage will be available at all for the test. In addition, this restriction is particularly troubling given that Black women are 2.5 times more likely to die from cervical cancer than other women.

Given the important role pap tests play in preventing cervical cancer, shouldn't we allow a woman's health provider the discretion to determine whether a pap test should be administered annually?

3) The President's proposal will give management boards within each Health Alliance the power to decide issues of the cost and the type of health care options available within each Alliance. Unfortunately, African Americans and other racial minorities, have generally been excluded from participating on corporate boards. Chris/Margie

How will you ensure adequate representation of African Americans and other minorities on each management board, when decisions about who sits on these boards are made at the State level?

4) Many States and cities, particularly large urban areas, are complaining that they do not have the money to implement the sweeping array of new duties for which they would be responsible under the President's proposal. How do you propose to help those States who cannot afford to implement this plan? Chris/Margie

Thank you for your assistance in this matter.

Sincerely,

Ed Towns
Member of Congress