FIRST LADY HILLARY RODHAM CLINTON
TALKING POINTS FOR MEDICARAVAN
AT MT. SINAI MEDICAL CENTER
OCTOBER 23, 1995

[Introduction by Dr. John "Jack" Rowe (President, Mt. Sinai Medical Center)]

- I'm glad to join the New York City Democratic Congressional delegation's "Medicaravan" to talk about the impact that the Republican Medicare and Medicaid cuts will have on New York.

- I'd like to say a special thanks to Congressman Engel and Congresswoman Maloney for the work they've done to put this caravan across the city together.

- We are here because last week the House Republicans passed $270 billion in Medicare cuts. And because they continue to charge ahead with their plan to take over $180 billion from Medicaid.

- The Republicans say that we need these huge cuts in Medicare to strengthen the trust fund.

    - But we can secure the trust fund -- as Democrats in Congress and the President have shown -- with about $90 billion, rather than $270 billion.

    - We can do it without making health care unaffordable for Medicare beneficiaries -- 75 percent of whom have incomes of less than $25,000 a year.

    - And without threatening urban hospitals. According to the American Hospital Association, a typical urban hospital would lose $25 million in Medicare revenue over seven years under the Republican plan. For the many hospitals in urban areas that are already struggling financially, a $25 million cut simply will be unsustainable.

- The Republicans tell you that we need to give states more flexibility under Medicaid. But by taking over $180 billion and block granting the program, they may force states to cut coverage for ~~almost~~ over 9 million children, older Americans and people with disabilities. We can make reasonable, moderate reforms in Medicaid, while *keeping our guarantee to children and older and disabled Americans.*

- This morning I visited Babies and Children's Hospital to release an analysis of the Republican budget cuts on children. While I was there, I talked with parents and children about what the Medicaid cuts will mean to them and the hospitals where they get treatment. I spoke with hardworking families whose children are critically ill or severely disabled who simply will have nowhere to turn for the services their children need if Medicaid is not there for them. Nowhere but the good will of hospitals like Mt. Sinai that already bear tremendous costs for the many patients who have no insurance and no way to pay their medical bills.

- When you couple these huge Medicaid and Medicare cuts, the impact on American families and on the hospitals the caravan is visiting today will be just devastating. And *unnecessary*.

- The issue is not *whether* to balance the federal budget. The President and I believe that we should. The President has said for a long time that we need to balance the budget to lift the burden of debt off of our children and to strengthen our economy. And he has also said that we need to slow the rate of inflation in federal health care programs.

- But we need to do it in a way that reflects the values that we have always held dear in this country. Values like giving every American the opportunity to make the most of his or her own life, strengthening our families, and respecting the duty we all owe to each other. This budget debate is not just about programs and dollars; it's about providing for our children's futures and honoring our parents.

# # #

October 21, 1995

MT. SINAI MEDICARAVAN EVENT

DATE:	October 23, 1995
LOCATION:	Mt. Sinai Medical Center, Manhattan
TIME:	1:15 p.m.
FROM:	Eric Eve and Amanda Crumley, Political Affairs

I. PURPOSE

To participate in a "Medicaravan" with Democratic Members of the New York City Congressional Delegation to highlight the impact Medicare and Medicaid cuts will have on New York.

II. BACKGROUND

The New York Congressional Delegation will launch a "Medicaravan" following a town hall meeting in The Bronx where they are expecting a crowd of 200 people. Before arriving at Mt. Sinai, the delegation will have lunch with seniors at the Bayside Senior Center in Queens. Following the Mt. Sinai event, they will make stops at the Cobble Hill Nursing Home and the Woodhull Medical Center, both in Brooklyn. The Members will make remarks at each stop.

Representative Charlie Rangel (15th CD)

Representative Rangel is serving in his 15th term. He currently is the second ranking Democrat on the Ways & Means Committee and he also serves on the Joint Taxation Committee. The 15th Congressional District includes all of Harlem and most of Northern Manhattan which includes not only the majority black population of Harlem, but also the white liberal Upper West Side. Given the makeup of his district, Rangel has long heralded the need for government aid and racial preferences to aid the problems plaguing Harlem. Given his first hand experience as to how drugs affect communities, he has also been very vocal on the denunciation of drug trade and he chaired Select Committee on Narcotics Abuse for ten until it was abolished in 1993.

Representative Eliot Engel (17th CD)

Representative Engel is serving in his fourth term. He currently serves on the Economic & Educational Opportunities; and International Relations Committees. Engel has one of the most liberal voting record in the House. In his position on the Economic & Education Opportunities Committee, he is able to back the public sector programs that are part of the core of New York life - public housing, education spending, and mental health services. On the International Relations Committee, Engel was the prime sponsor of the resolution to make

Jerusalem the capital of Israel and other issues of importance to the large number of ethnic groups in his Bronx district.

Representative Carolyn Maloney (14th CD)

Representative Maloney is serving in her second term. She currently sits on the Banking and Financial Services; and Government Reform & Oversight Committees. Maloney's district includes the affluent Upper East Side of Manhattan and smaller enclaves of the Lower East Side and Upper West Side. Although the district is heavily Democratic - giving the President 69% of the vote in 1992 - Maloney faced serious opposition in 1994, because her Republican opponent was able to use her vote for the President's budget and tax package against her in the wealthy district. Maloney pulled through with 64% of the vote, but in a district as heavily Democratic as the 14th, that could mean that she will again be vulnerable in 1996.

III. PARTICIPANTS

HRC
Dr. John Rowe, President, Mt. Sinai School of Medicine & of Mt. Sinai Hospital **(Note:** a bio on Dr. Rowe is attached.)
Jim Butler, President, AFSCME Local 420
Democratic Members of New York City Congressional Delegation:
Representative Charles Rangel, Dean of the New York Democratic Congressional Delegation
Representative Gary Ackerman
Representative Eliot Engel
Representative Floyd Flake
Representative Nita Lowey
Representative Caroyln Maloney
Representative Tom Manton
Representative Jerrold Nadler
Representative Major Owens
Representative Charles Schumer
Representative Jose Serrano
Representative Ed Towns
Representative Nydia Velazquez

(Note: Representatives Schumer and Flake may not be able to attend this event.)

IV. PRESS PLAN

Open.

V. SEQUENCE OF EVENTS

* Before **HRC** arrives, all of the Representatives present will make brief one minute remarks. (Note: If there is time permitting before HRC arrives, Jim Butler, President of AFSCME Local 420, will make a brief statement during this time as

well.)

* Representative Rangel introduces **HRC** and Dr. John Rowe on to stage;
* Dr. John Rowe makes brief remarks and introduces **HRC**;
* **HRC** makes brief remarks, works a ropeline and departs.

VI. REMARKS

Talking points on Medicare and Medicaid will follow, but you should mention the following:

* Today's "Medicaravan" event was created to help educate New Yorkers on the Draconian cuts in Medicare and Medicaid. I want to give a special thanks to Representatives Eliot Engel and Carolyn Maloney and their staffs for their hard work in putting this day together. Without their personal attention, this day would not have been possible. I would also like to thank Representative Charlie Rangel and the rest of New York's Democratic Congressional Delegation for making this day a success.

Note: Representatives Eliot Engel and Carolyn Maloney were the leaders putting this event together. It would be a nice gesture give them both a special thanks in your remarks. We ask that you acknowledge Representative Rangel because he is the Dean of the Delegation and Mt. Sinai is in his Congressional District.

MEMORANDUM

TO: Hillary Clinton

October 20, 1995

FR: Chris Jennings

RE: Republican Medicare Proposals

The President requested the attached quick summary analysis of the House Republican Medicare Structural plan that was passed yesterday through Harold Ickes. I thought you might find it helpful as well.

The first document is a two page narrative of the highlights of the plan. The second document is a more detailed analysis of those provisions that are likely to be of particular concern.

This document is written in such a way as to be critical of the Republican plan. I hope the President and you find it useful. Please call with any questions or any further requests on this issue. I can be reached at 456-5560.

HOUSE REPUBLICAN MEDICARE RESTRUCTURING PACKAGE

Yesterday the House of Representatives passed H.R. 2425, legislation to transform the Medicare program and reduce its spending by $270 billion over seven years. Though this bill is generally consistent with legislation reported earlier this week by the House Ways and Means and Commerce Committees, it did incorporate some last minute changes designed to shore up Republican votes.

Trust Fund

Although Republicans defend the bill as necessary to save the Medicare Part A trust fund from bankruptcy, the majority of savings come from Part B. Through last minute budgetary gimmickry, Republicans credited the Part A trust fund with an additional $90 billion of savings (see discussion below of "11th hour amendments"). This does not change the fact, however, that all of their Medicare savings will be scored as revenue that could be used to offset the cost of their tax cut.

Beneficiary impact and the expanded choices issue

H.R. 2425 claims to offer beneficiaries broader choice, but will in fact, undermine beneficiary protections. The bill establishes a new program, called MedicarePlus. Seniors can elect to remain in traditional Medicare or choose coverage from an array of new plans, such as medical savings accounts (MSAs) and provider sponsored plans (PSOs), under MedicarePlus.

However, different rules apply to these two programs. For example, balance billing that is prohibited in Medicare is permitted under the new MedicarePlus physician fee-for-service option. Insurance companies establishing themselves as "associations" (one can imagine the elderly joggers health plan) can cherry-pick under MedicarePlus; this is prohibited under Medicare. Medigap insurance is regulated in Medicare, but not MedicarePlus. And a widely disproportionate number of the budget cuts in provider payments come from those health providers participating in the current Medicare program.

The net effect of these uneven rules is to make traditional Medicare less attractive to providers and MedicarePlus more expensive to beneficiaries. In addition to direct increases in their Part B premiums, the skewed rules will raise beneficiary costs and limit their choice. For example, if providers migrate to MedicarePlus to escape fee cuts and limits on balance billing, beneficiaries will be forced to follow them. However, if insurers are permitted to charge more for coverage in MedicarePlus, low income beneficiaries may be stranded in whatever is left of traditional Medicare.

Provider Impact of the new "choices"

By contrast, health insurance plans and providers will benefit from the uneven rules. For example, balance billing in MedicarePlus would permit certain providers to shift some of the Medicare budget cuts onto seniors. Relaxed antitrust rules for certain MedicarePlus plans could permit price-fixing by physicians. In addition to these "hidden" benefits, H.R. 2425 offers direct relief to providers to soften the impact of the deep budget cuts. The AMA, for example, won antitrust relief, caps on malpractice damages, and other regulatory relief (see below). For-profit hospitals won a small increase in their Medicare capital payments. Teaching hospitals were rewarded by a new graduate medical education trust fund.

Fraud and abuse

H.R. 2425 also claims to crack down on Medicare fraud and abuse. However, the bill includes a number of so-called regulatory relief provisions that will, in fact, make it easier for providers to abuse the program and harder for law enforcement to stop them. For example, the bill eliminates prohibitions against physicians referring patients to entities they own and raises the standard of proof for prosecuting kickbacks and false claims.

Eleventh-hour amendments

In the last 48 hours before the vote, H.R. 2425 was amended, reportedly to shore up uncertain Republican votes. In particular, Republicans responded to the charge that their plan and Administration's plan yield the same net savings to the Part A trust fund. Two last minute changes added $90 billion to this trust fund. One transferred $36.6 billion in general revenue funds to the Part A trust fund to offset the social security tax cut passed by the House this spring fund. The second transferred approximately one-third of the Medicare Part A home health benefit to Part B of the program, thereby reducing Part A outlays by about $54 billion according to CBO estimates. (This may enable the Republicans to claim that they have "strengthened" the trust fund beyond 2010.)

Another last minute amendment increased MedicarePlus payments to health plans in rural areas. (This was apparently paid for through cuts in payments to HMOs and other managed care plans in areas of the country, such as California and Florida, whose current payment rates have enabled them to provide additional benefits for Medicare beneficiaries.) Physicians also received a last minute change that reduced their payment cuts by $300 million. Northeastern states, especially New York and New Jersey, would benefit from a change increasing payments to teaching hospitals training foreign doctors. Finally, a new section imposing criminal penalties on some fraudulent behavior was added, though this would not change the regulatory relief provided elsewhere in the bill.

A summary of some key provisions in H.R. 2425 that cause particular concern follows.

Summary of Key Provisions and Concerns in H.R. 2425

Medicare spending cuts are excessive

H.R. 2425 cuts $270 billion from Medicare spending over the next seven years. It would constrain the Medicare per person growth rate to 30 percent below what the Congressional Budget Office projects the per person private sector rate to be over the next seven years. (CBO projects 7.1 percent for the private sector and projects the Republican cuts to reduce Medicare from 8.2 percent per person to 5.1 percent).

Republicans use gimmicks to strengthen the trust fund and justify their Medicare cuts

The legislation seeks to inflate its protective impact on the Part A trust fund and deflect criticisms about the Republican tax cut through gimmickry. First, H.R. 2425 transfers $36 billion from general revenues to the Part A trust fund to offset the Social Security cut passed by the House this spring.

H.R. 2425 also transfers about one-third of the Part A home health benefit into Part B. For patients needing extended home health care, visits after 165 days would be paid for by Part B. This would have the effect of reducing Part A outlays by $54 billion. Beneficiary premiums and coinsurance would not be affected by this benefit transfer.

Finally, H.R. 2425 establishes a so-called "lock box" that would deposit remaining savings from H.R. 2425 into a new trust fund. It has been claimed that the "lock box" will prevent excess Medicare savings from financing the Republican tax cut for the wealthy. However, under the Congress' own budget rules these monies would, in fact, offset the cost of the tax cut. In addition, under H.R. 2425, the "lock box" funds could, in fact, be used for purposes unrelated to Medicare after several years.

Beneficiaries bear the burden of Republican Medicare cuts

The Medicare cuts in H.R. 2425 also are excessive relative to beneficiaries' ability to pay. The bill imposes $54 billion in new financial burdens on beneficiaries in the form of higher Medicare Part B premiums. Most of this increase results from setting the Medicare Part B premium to cover 31.5 percent of program costs. In addition, higher income Medicare beneficiaries will see their Part B premiums more than triple. H.R. 2425 then compounds these direct new burdens on beneficiaries by many hidden cuts that will force them, over time, to pay much more for their health care services.

Republican false promise of choice obscures threats to beneficiaries

Though it claims to offer beneficiaries a broader choice of health plan options, H.R. 2425 actually creates divisions and inequalities within Medicare that will cripple the program and coerce beneficiaries into either paying more or making do with less.

H.R. 2425 establishes a new program, called MedicarePlus, which will be available in addition to traditional, fee-for-service Medicare. Alternative fee-for service and managed care plans will be offered under MedicarePlus, as will new types of specifically structured health plans such as provider sponsored organizations (PSOs), medical savings accounts (MSAs), and association plans.

Republicans promise Medicare beneficiaries will have free choice between traditional Medicare and all the plan options under MedicarePlus. However, the legislation applies distinctly uneven rules to Medicare and MedicarePlus with the effect of making traditional Medicare much less attractive to providers than MedicarePlus. These incentives would reduce the willingness of providers to serve beneficiaries in traditional Medicare, leading to coercion of beneficiaries into MedicarePlus plans, thus restricting beneficiary choice rather than enhancing it.

Balance billing is permitted in MedicarePlus

Traditional Medicare protects beneficiaries from "balance billing," the practice whereby providers charge beneficiaries more than Medicare approves. Traditional Medicare permits no balance billing by hospitals and only limited balance billing by physicians. However, balance billing will be widely permitted under MedicarePlus plans. Providers in fee-for-service MedicarePlus plans will be permitted to charge patients <u>any amount they want</u> for health care services. The same will be true for patients electing MSA plans.

Balance billing will be permitted in managed care plans, as well, whenever patients receive non-emergency care outside of the plan, even if such care is authorized by the plan or permitted under a point-of-service option. Given the very tight budget imposed by H.R. 2425, provider pressure to balance bill will grow. If providers begin to move to MedicarePlus plans in order to escape balance billing limits, beneficiaries will be faced with the choice of following them and paying more, or remaining in traditional Medicare where fewer doctors and hospitals are able to care for them.

Provider payment cuts caused by the "failsafe" are deeper in traditional Medicare

The Medicare budget is enforced by a "failsafe" mechanism that triggers automatic cuts in payments to doctors, hospitals, and other providers whenever Medicare spending rises above the permitted amount. While growth caps will apply to Medicare

premiums paid to MedicarePlus plans, the "failsafe" cuts only apply to traditional Medicare provider payments.

Further, by law these cuts must be 133 percent of the level necessary to keep Medicare spending within the budgeted amounts. As the "failsafe" drives traditional Medicare payments down, providers will have even greater incentives to move to MedicarePlus where the cuts can be shifted, at least in part, to beneficiaries.

Republicans place an arbitrary cap on Medicare spending

H.R. 2425 establishes in law the absolute dollar amounts available for Medicare each year. Effectively, the bill constrains Medicare spending growth to an average rate of about 5 percent per person per year from 1996 to 2002, or about 30 percent less than growth rates projected in the private sector. The absolute dollar amounts do not vary to accommodate changes in enrollment, medical inflation, technology or health care needs; the very essence of the Medicare entitlement. Critics charge that limiting Medicare in this way has great potential to place beneficiaries' access and quality of care at risk.

New "MSAs" in MedicarePlus will raise Medicare costs to benefit the wealthiest

A new option under MedicarePlus will permit beneficiaries to enroll in health plans with a deductible as high as $10,000. Medicare will deposit the difference between the cost of such a plan and regular Medicare coverage in a tax favored Medical Savings Account, or MSA. If people in MSAs don't get sick, they would be rewarded with a tax break. The MSA option is likely to attract the healthiest and wealthiest beneficiaries who would otherwise require little or no health care services in a year. Indeed, preliminary CBO estimates indicate that MSAs will cost Medicare between $2 and $4 billion over seven years. It is ironic that legislation, professing to save critically needed Medicare funds, would introduce such a costly new feature to the program.

In addition to the financial cost, risk selection caused by MSAs threatens to undo Medicare's protection for all beneficiaries. As the healthiest individuals are drawn out of the Medicare program, the average cost of those remaining will climb. The resulting growth in spending for traditional Medicare spending will trigger more failsafe cuts, further weakening the program.

"Association plans" will fuel risk selection in MedicarePlus

MedicarePlus also permits the introduction of new "association" plans. Unlike other MedicarePlus plans, association plans may restrict enrollment to association members

only. However, the association is not required to bear risk; it can contract with an insurance company or a PSO. Therefore, insurance companies and PSO could "shop" for associations with healthier-than-average members in order to maximize their health plan profits. Such risk selection, again, would raise the average cost of traditional Medicare for other beneficiaries.

Medigap rules will not protect beneficiaries in MedicarePlus

Today, insurance that supplements Medicare, or Medigap, must meet minimum standards that guarantee value and that facilitate plan comparison. Under H.R. 2425, these rules will not apply to the portion of MedicarePlus plans that supplement basic Medicare benefits. Absence of these rules will make it harder for beneficiaries to make apples-to-apples comparison of health plans. Further, beneficiaries will not be assured that the premium charged for MedicarePlus plan for extra benefits (if any) does not go to pay for excessive health insurer profits and bureaucracy. In fact, insurers could raise the portion of their MedicarePlus premium that pays for Medigap benefits to offset losses they might experience from the limited premium Medicare pays for basic coverage under the Republican bill.

If Medigap insurers become attracted to the less stringently-regulated MedicarePlus market, beneficiary access to traditional Medigap policies could suffer. Again, this disparity could affect the real coverage choices available to beneficiaries.

At the same time H.R. 2425 changes Medigap rules for MedicarePlus plans, it leaves in place rules for traditional Medigap policies that will further frustrate beneficiary choice. Under current law, Medigap plans must offer open enrollment to beneficiaries only when they first become eligible for Medicare. Under H.R. 2425, if a beneficiary tries to return to traditional Medicare after leaving for MedicarePlus, there is no guarantee that Medigap coverage will again be available. Once a beneficiary has developed a significant health care problem, barriers to finding supplemental coverage could severely constrain choice of health plans.

Severe provider cuts and other changes threaten quality and access

While the structure of MedicarePlus is designed to shift costs onto beneficiaries, the magnitude of cuts in H.R. 2425 also threatens some providers. Of particular concern are those providers who constitute the safety net of our health care system. Rural hospitals and clinics, already in precarious financial condition, will be hard pressed to absorb reductions required in H.R. 2425. In addition, cuts in Medicare DSH payments will impact urban safety net hospitals.

The legislation's cuts in Medicare home health payments are structured to create incentives for providers to avoid patients with the most costly home health needs.

Similarly, cuts in payments for "heavy-care" patients in skilled nursing facilities could endanger quality of care for the frailest Medicare beneficiaries.

In another threat to quality, H.R. 2425 exempts physician office laboratories from the quality requirements under the Clinical Laboratory Improvement Act of 1988 (CLIA). Even though surveys have shown that some of the most severe lab testing quality problems are found in physician office labs, "regulatory relief" takes precedence over quality of care concerns in H.R. 2425.

Finally, the provisions relating to quality of care in skilled nursing facilities abandon the recently-developed bipartisan nursing home quality assurance program and replaces it with an untried system involving state regulation. In light of the financial burdens placed on States by the Medicaid Transformation Act, States will be hard pressed to find the resources to carry out these new nursing home quality responsibilities.

AMA sweetheart deals will invite fraud, raise health costs, and harm beneficiaries

The authors of H.R. 2425 have declared war on fraud and abuse, but have conceded the battle on some of the most significant fronts. In particular, in the name of "regulatory relief," H.R. 2425 relaxes critical rules that today outlaw kickbacks and that require providers to exercise due diligence in submitting accurate and true Medicare claims. CBO has determined that these provisions of H.R. 2425 will cost the Medicare program over $1 billion from 1996 to 2002.

The AMA also won antitrust relief. H.R. 2425 immunizes a broad range of anticompetitive conduct by physicians. Law enforcement would find it difficult, if not impossible, to challenge medical society activities, such as boycotts of insurance companies, as long as they were undertaken in the name of promoting quality or policing professional conduct. H.R. 2425 also affords special antitrust treatment for provider service networks.

Finally, H.R. 2425 imposes a $250,000 cap on medical malpractice damages, a change long sought by the AMA.

HOUSE REPUBLICAN MEDICARE BILL WEAKENS BATTLE AGAINST HEALTH CARE FRAUD AND ABUSE

THE HOUSE REPUBLICAN MEDICARE PLAN WEAKENS ANTI-KICKBACK LAWS

- **The House Republican plan would make it difficult, if not impossible, to prosecute doctors and other health care providers for accepting kickbacks -- money or other compensation in return for referring patients.**

- Currently, Medicare prohibits *any form of remuneration* in exchange for patient referrals. The House plan would prohibit such payments only if the *significant purpose* of the payment was to induce referrals.

- Kickbacks can corrupt medical providers' decision making -- often replacing patient welfare with profit. Kickbacks also can lead to inappropriate medical care, including unnecessary hospitalization, surgery, drugs, tests and equipment.

- Most kickbacks have sophisticated disguises that are hard for the government to penetrate. For the vast majority of present day kickback schemes, the Republican Medicare bill would place an insurmountable burden of proof on the government.

- In the past 15 months, the Clinton Administration was able to prosecute and settle two major cases involving kickbacks, obtaining convictions and settlements of $540 million, returning significant savings to the Medicare Trust Fund and the Treasury.

THE HOUSE REPUBLICAN MEDICARE PLAN WEAKENS PENALTIES FOR FRAUD

- **The House Republican plan would make it more difficult to impose civil monetary penalties (CMP) on doctors and other health care providers who file fraudulent claims.**

- Existing CMP laws penalize doctors and other medical providers who "know" or "should know" that their practices are fraudulent. That standard places a duty on health care providers to use "reasonable diligence" to ensure that claims submitted to Medicare are true and accurate.

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THE HOUSE REPUBLICAN MEDICARE PLAN ENCOURAGES ABUSIVE PHYSICIAN SELF-REFERRALS

- **The House Republican bill would seriously undermine the current bipartisan prohibition on doctors referring their Medicare patients to health care facilities in which they have a financial interest.**

- Under current law, Medicare and Medicaid do not pay for certain designated health services where the physician who orders the services has an ownership or investment interest in or a compensation arrangement with the facility or business entity that provides the service.

- Physicians who refer their patients to facilities where they have a financial relationship can have their medical decisions affected by their profit motives.

- Before the current prohibitions were in effect, the HHS Office of the Inspector General (OIG) found that patients of physicians who owned or invested in independent clinical laboratories received 45 percent more of such services than all Medicare patients in general.

- Since the 1989 OIG study, nine more major studies have been published which, taken as a whole, clearly demonstrate that utilization rates of medical items or services tend to increase as a result of financial incentives directed to physicians who order those items or services.

THE HOUSE REPUBLICAN MEDICARE PLAN ELIMINATES QUALITY STANDARDS FOR CLINICAL LABS IN PHYSICIANS' OFFICES

- **The House Republican Medicare plan would repeal the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as applied to physician office labs.** (89,000 of the 152,000 clinical labs registered under CLIA are physician office labs.)

- CLIA requires all clinical labs, including physician office labs, to meet minimum quality standards based on the complexity of the tests they perform. CLIA surveys and proficiency testing provide physician office labs with feedback about problems of which they are unaware, helping them to improve their testing quality.

- Working with physicians, HHS has already taken steps to streamline CLIA oversight. Further fine-tuning -- not gutting -- is what is needed.

THE HOUSE REPUBLICAN MEDICARE PLAN ELIMINATES QUALITY STANDARDS THAT PROTECT NURSING HOME RESIDENTS

- **The Republican proposal to block grant Medicaid would repeal a 1987 law, signed by President Reagan, that established quality standards for nursing homes and institutions caring for people with mental retardation. The GOP Medicare proposal would gut similar quality standards for Medicare beneficiaries.**

- A 1986 report by the Institute of Medicine documented an epidemic of substandard care in nursing homes around the nation. In 27 states, IOM found *at least one-third of facilities* had care so poor that it jeopardized the health and safety of residents.

- The bipartisan 1987 law has led to dramatic improvements in the quality of nursing home care. The use of chemical and physical restraints has dropped significantly and the number of registered nurses on duty in nursing homes has increased, as has the training of nurses' aides.

THE HOUSE REPUBLICAN MEDICARE PLAN ELIMINATES PROTECTIONS AGAINST EXTRA CHARGES TO MEDICARE BENEFICIARIES

- **The Republican proposal would allow physicians participating in many of the new health plans to impose unlimited charges on beneficiaries at the time they receive care.**

- Current law prohibits hospitals and doctors from charging patients large amounts above Medicare's recognized fees. Doctors who do not agree to accept Medicare fees as payment in full can only charge 15% above those fees.

- The average Medicare beneficiary has an income of $13,000 a year and spends 20% of that on out-of-pocket medical expenses for things like prescription drugs and Medicare cost-sharing.

- Beneficiaries in so-called Medicare-Plus plans could be forced to pay even more out of their pockets for covered Medicare services.

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****PLEASE NOTE CHANGED ENTRANCE FOR MT. SINAI EVENT****

NYC Democratic 'Docs', Hillary Clinton, to Make 'Rounds' to Save Medicare, Medicaid

Washington-- The New York City Democratic Congressional delegation and First Lady Hillary Rodham Clinton will be participating in a "Medicaravan" on Monday, October 23, 1995, beginning at 9:30 am. The Caravan will be visiting medical facilities to highlight the enormous impact that draconian Medicare and Medicaid cuts will have on New York.

The Caravan will depart following a Town Hall meeting at Montefiore Medical Center in The Bronx. Montefiore is the number one provider of Medicare-related care in the nation. Media representatives will be able to travel with the caravan for all or part of the day. The members of the New York City Democratic Congressional Delegation are: **Rep. Gary Ackerman, Rep. Eliot Engel, Rep. Floyd Flake, Rep. Nita Lowey, Rep. Carolyn Maloney, Rep. Tom Manton, Rep. Jerrold Nadler, Rep. Major Owens, Rep. Charles Rangel, Rep. Charles Schumer, Rep. Jose Serrano, Rep. Ed Towns, Rep. Nydia Velazquez.** The Medicaravan itinerary follows:

NYC Medicaravan Schedule
Monday, October 23, 1995

9:30 AM - 10:30 AM **Bronx event**
*Montefiore Medical Center
Cherkasky Auditorium
111 E. 210th Street

10:30 AM - 11:15 AM **Travel**

11:15 AM - 12:15 PM **Queens event**
*Bayside Senior Center
221-15 Horace Harding Expressway

12:15 PM - 1:00 PM **Travel**

1:00 PM - 2:00 PM **Manhattan event**
*Mt. Sinai Medical Center
Guggenheim Pavilion, Hatch Auditorium- 2nd Floor
100th St. & 5th Ave.

2:00 PM - 2:45 PM **Travel**

2:45 PM - 3:45 PM **Brooklyn event**
*Cobble Hill Nursing Home
380 Henry Street

3:45 PM - 4:15 PM **Travel**

4:15 PM - 5:00 PM **Brooklyn event**
Woodhull Medical Center
760 Broadway (Corner of Graham, Flushing and Broadway)

John Cavelli
Engel
225-2464

News from

CONGRESSMAN ELIOT L. ENGEL

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Media Advisory

Contact: **Greg Howard, Rep. Eliot Engel @ 718-796-9700**

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June 26, 1995

THE MOUNT SINAI MEDICAL CENTER

The Mount Sinai Hospital
(1994 Statistics)

Founded:	1852
Beds:	1,171
Attending Physicians:	1,710
Residents:	664
Fellows:	215
Nurses (RN's):	1,786
Inpatient Days (Excluding Newborns/Total):	360,277 / 372,905
Admissions (Excluding Newborns/Total):	38,868 / 44,210
Discharges (Excluding Newborns/Total):	39,340 / 44,198
Newborn Deliveries (Live Births):	5,342
Outpatient Visits:	284,796
Emergency Room Visits:	80,750

Mount Sinai School of Medicine
(1994 Statistics)

Chartered:	1963
Students:	
MD	518
MD/PhD	49
PhD	123
Research Grants:	$60 million (Federal FY 94)

The Mount Sinai Health System

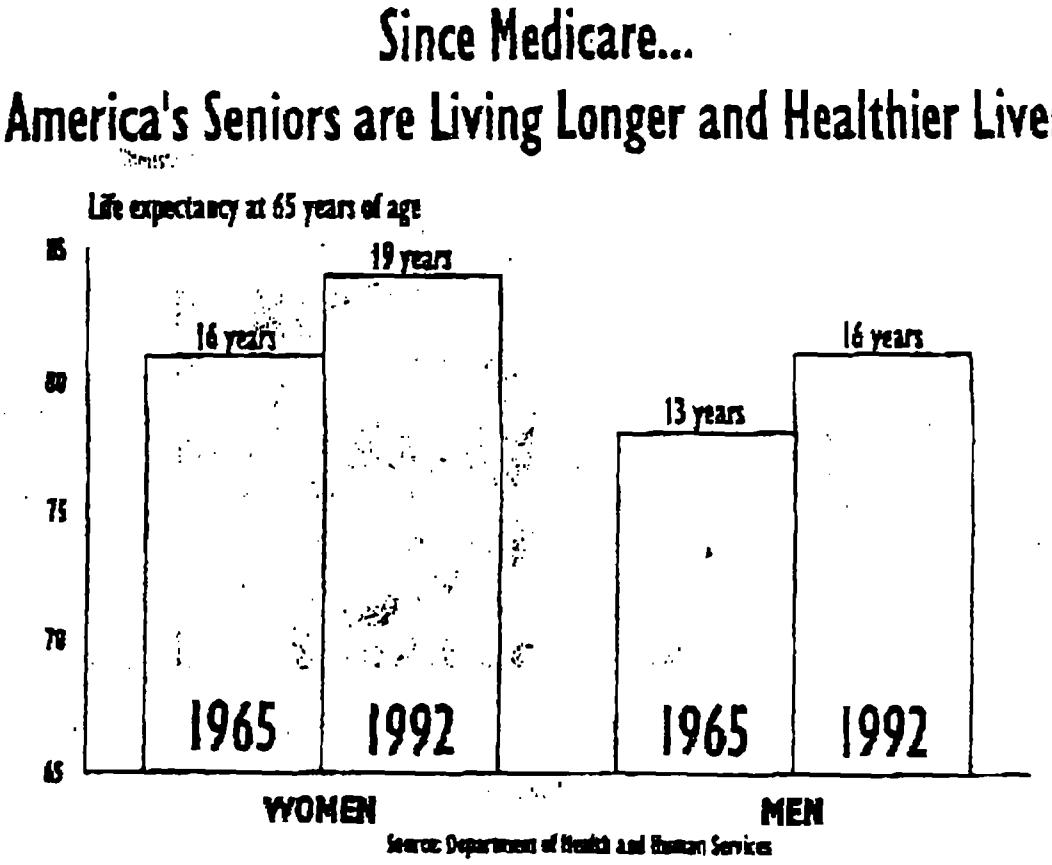
The Mount Sinai Health System is a regional network encompassing twenty-one hospitals, eleven long-term care facilities, and associated medical staffs and practices throughout the Metropolitan Area.

History of Present Illness

Lab Report:

Since Medicare America's Seniors are Living Longer and Healthier Lives

Medicare has increased access to service for America's most vulnerable population- the elderly. Since it's inception, Medicare has dramatically increased the length and quality of senior citizen's lives.



[Dr.s Note:" I guarantee you that these reductions would be bad for quality health care... not just for our senior citizens but also for working families. If Medicare and Medicaid cuts are too deep, hospitals and doctors will shy away from serving the elderly and poor or will try to push costs to the non-elderly, which could further increase the number of uninsured. Or the quality of the whole health care system could decline." Greg Ganske, R-IA, Des Moines Register, 10/3/95]

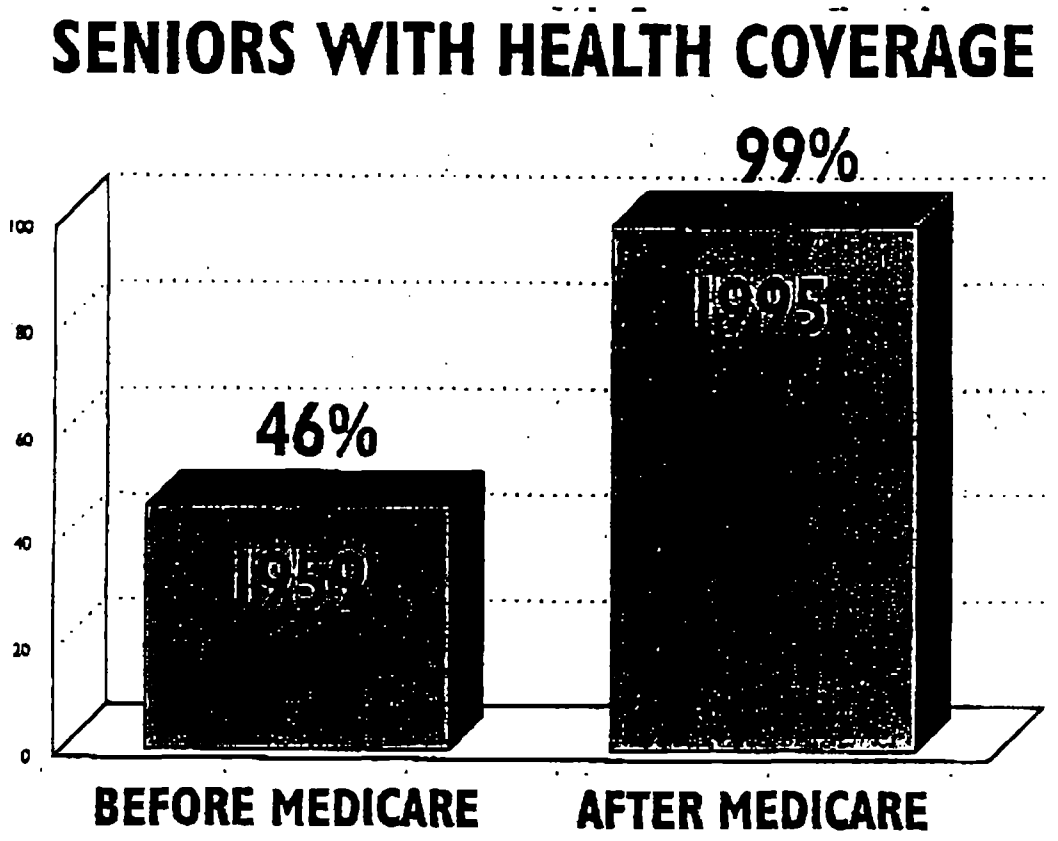
History of Present Illness

The patient was born in 1965. It did not receive one Republican vote when enacted. Before Medicare, 30% of seniors lived in poverty. After Medicare, that number decreased to 12%. Death due to stroke and heart disease has declined. Today, because of Medicare, seniors are living longer and with greater dignity.

Lab Report:

Medicare Means Access To Health Care Service

In 1959, only 46% of seniors had health coverage. Today, 99% of seniors have health coverage.



Source: CQ, 4/29/61, Social Security Administration
Prepared by the House Democratic Caucus and House Democratic Policy Committee, 7/95

[Drs. Note: "We're not on board with the proposed budget reductions. Neither Medicare patients nor the health care delivery system can absorb budget cuts of the magnitude proposed." Dr. Gerald E. Thompson, President, American College of Physicians. N.Y. Times, 10/6/95]

Press packet prepared to resemble Patient Medical Chart

Patient Profile

Patient Name:	**Medicare**
Attending Physicians:	Congressional Democrats
Chief Complaint:	The patient has suffered severe trauma, sustaining numerous life-threatening lacerations that go through the fat into the muscle and bone.
Mechanism of Injury:	Patient was victim of vicious assaults in the Ways and Means and Commerce Committees of the United States House of Representatives. The patient was bound, gagged and robbed of $270 billion by Republican assailants intent on using it to fund tax cut for the wealthiest of Americans. A number of hardened, vicious senior citizens, armed with their walking canes, some in wheel chairs, were arrested in the incident. The Republicans are still at large.
Preliminary Assessment of Patients Condition:	The patient has sustained significant long-term damage which could lead to increased morbidity and mortality among beneficiaries. The patient is on life support systems.
Prescribed Treatment and Prognosis:	The patient has been robbed of $270 billion. Required treatment includes restoration of funding that the Republicans have cut to fund their tax cut. Prior to the assault, the patient required minor corrective surgery to maintain its strength. Patient now needs major reconstructive surgery to assure the health and safety of tens of millions of beneficiaries.

[Drs. Notes: (Medicare is) "... a program I would have no part of

7/11/95

Mount Sinai

The Mount Sinai Medical Center
The Mount Sinai Hospital
Mount Sinai School of Medicine

One Gustave L. Levy Place
New York, NY 10029-6574

MOUNT SINAI SCHOOL OF MEDICINE

The Mount Sinai School of Medicine of the City University of New York was established in 1963 and admitted its first students in 1968. Today the School enrolls nearly 700 MD and PHD students each year taught by a full and part-time faculty of 3,614. The School was the first in the nation to establish a Department of Geriatrics and Adult Development in 1982 and recently established The Morchand Center, one of this country's first centers for clinical competence aimed at improving doctor/patient relationships.

As an active center for research of international significance, Mount Sinai School of Medicine is engaged in more than 650 ongoing projects in fields ranging from microbiology and genetic engineering to the prevention and treatment of cancer and cardiovascular disease. Mount Sinai School of Medicine is a national center for research in Alzheimer's disease, schizophrenia, alcoholism, and environmental and occupational hazards and disease.

THE MOUNT SINAI HEALTH SYSTEM

The Mount Sinai Health System is a regional network encompassing twenty-one hospitals, eleven long-term care facilities, and associated medical staffs and practices throughout the Metropolitan Area.

Mount Sinai

The M Sinai Medical Center
The Mount Sinai Hospital
Mount Sinai School of Medicine
One Gustave L. Levy Place
New York, NY 10029-6574

John W. Rowe, D.
President

Box 1074

Tel (212) 241-6393

John W. Rowe, M.D.

Dr. Rowe is President of the Mount Sinai School of Medicine and The Mount Sinai Hospital in New York City, where he also serves as a Professor of Medicine and of Geriatrics. Mount Sinai one of the nation's largest academic health science centers, has the only formal medical school department of geriatrics in the United States. Before joining Mount Sinai in 1988, Dr. Rowe was a Professor of Medicine and the founding Director of the Division on Aging at Harvard Medical School and Chief of Gerontology at Boston's Beth Israel Hospital. He has authored over 200 scientific publications, mostly in the physiology of the aging process, and a leading textbook of geriatric medicine. Dr. Rowe has received many honors and awards for his research and health policy efforts regarding care of the elderly. Dr. Rowe is Director of the MacArthur Foundation Research Network on Successful Aging. He served on the Board of Governors of the American Board of Internal Medicine and is a member of the Institute of Medicine of the National Academy of Sciences.

Mount Sinai

The Mount Sinai Medical Center
New York, NY 10029-6574

The Mount Sinai Hospital
Mount Sinai School of Medicine

THE MOUNT SINAI MEDICAL CENTER

The Mount Sinai Medical Center in New York City encompasses one of the country's oldest and largest voluntary hospitals and one of the nation's outstanding medical schools.

Since Mount Sinai's establishment, in 1852, its physicians have gained international recognition for some of the most important medical advances of the past century, including the development of the first safe method of blood transfusion and the first portable machine for kidney dialysis. Many illnesses and procedures bear the names of the Mount Sinai physicians who first identified them, including Crohn's, Buerger's and Tay Sachs disease, the Schick test for diphtheria, and the Master cardiac stress test.

THE MOUNT SINAI HOSPITAL

Today, Mount Sinai is a 1,172 bed, tertiary-care teaching hospital located on New York City's Upper East Side. Mount Sinai employs over 10,000 individuals, including 1,171 physicians, 879 residents and clinical fellows in training and 1,550 registered nurses. Each year nearly 44,000 people are treated at Mount Sinai on an inpatient basis, while its clinic and emergency room receive approximately outpatient visits annually.

The Hospital is a regional center for brain-injury rehabilitation, hemophilia, AIDs, neonatal special care services, and pediatric respiratory disease. It is also home to the nation's first hospital division of environmental and occupational medicine and the world's only center for the diagnosis and care of Jewish genetic diseases. Mount Sinai's obstetrics, gynecology and reproductive medicine services include the treatment of infertility and menopause, the first ovum donation program in New York City, and the care of high risk infants.

The Hospital has well-known services for the care of juvenile diabetes, inflammatory bowel disease, and other autoimmune diseases. Mount Sinai also is recognized for its care of large patient populations with Parkinson's disease and with relatively rare diseases including myasthenia gravis, amyotrophic lateral sclerosis (Lou Gehrig's Disease) and sarcoidosis.

In 1967, one of the first kidney transplantation programs in New York State was established at Mount Sinai, and in 1988, the first liver transplant in the State was performed here. Today, Mount Sinai provides a full-range of transplantation services including heart, lung, liver, kidney, bone marrow and heart/lung transplants. Mount Sinai's Children's Heart Center performs pediatric heart transplants and complex, life-saving cardiac surgery on infants and children.

Mt. Sinai Medical Center
1:00 PM - 2:00 PM

Members of Congress participating:
Gary Ackerman
Eliot L. Engel
Nita Lowey
Caroline Maloney
Thomas Manton
Jerrold Nadler
Major Owens
Charlie Rangel
Jose Serrano
Ed Towns
Nydia Velazquez

Representatives from the following groups are participating:
*East Harlem Interagency Council for Older Persons
*local elected officials
*local Labor leaders such as James Butler, President Local 420 AFSCME (NYC Health and Hospitals Corporation) and Carl Haynes, President, Local 237, Teamsters.
*East Harlem Health Care Providers - Settlement Health and Medical Services, Boriken
*Metropolitan Hospital Center
*Mt. Sinai Auxiliary Board
*Mt. Sinai Community Advisory Board
*Mt. Sinai employees
*Neighborhood Health Center
*New York Academy of Medicine

Schedule:
1:00 PM - 1:30 PM
Hon. Charlie Rangel will be the 1st Congressional speaker at the Rally. He will be followed by other members of the Congressional delegation and local labor leaders.

1:30 PM - 1:35 PM
Introduction of First Lady by Dr. John "Jack" Rowe (President, Mt. Sinai Medical Center)

1:35 PM - 1:55 PM
First Lady speaks

2:00 PM
Bus departs for Cobble Hill Nursing Home

Note: The schedule can be adapted to coincide with the First Lady's. Let me know if there are any problems.

contact: John Calvelli w/ Rep. Engel bpr.800-386-3859
Mary Medina, Gov't Affairs Office (Mt. Sinai)
o.212-241-6447 h.201-343-5391 bpr212-389-3477
Jeremy Rabinovitz h.301-530-6521

October 20, 1995

To: Lisa Villareal o.456-5315 fax456-5340
*First Lady's scheduling office
Amanda Crimley o.456-6257 fax456-7929
*Political Affairs
Stacey Rubin o.456-2230 fax456-6220
*Legislative Affairs

From: John Calvelli
Congressman Eliot Engel's Office
Friday 10/20 till 6:30 PM: o. 202-225-2464 fax202-225-5513
Weekend: h. 202-546-9364
Sunday 10/22 after 6PM h.914-738-4135
beeper (24 hours): 800-386-3859

Re: First Lady's participation in Medicaravan event

As you requested, the following schedule and background information deals with the Mt. Sinai Medical Center stop on the Medicaravan. The entire New York delegation has been alerted to the First Lady's participation.

We would respectfully request that you inform the First Lady of the work Congressman Engel and Congresswoman Maloney have done to put this program together. Without their personal attention, the event would never have been possible. It would be greatly appreciated if the First Lady would mention this in her remarks.

If you have any questions, please feel free to contact me.