Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Current Congressional Status and Suggested Upcoming Weeks (4 pages)	5/10/93	P5
002. memo	Chris Jennings, Steve Edelstein to Hillary Clinton Re; Metting with Senator Wellstone and Single Payer Groups (3 pages)	5/5/93	P5

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Acr)
OA/Box Number: 23754

FOLDER TITLE:

May 1993 HSA [3]

gf83

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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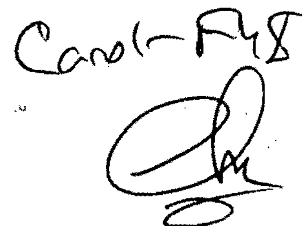

M E M O R A N D U M

TO: Hillary Rodham Clinton — May 6, 1993

FROM: Chris Jennings, Steve Edelstein

RE: Lists of Congressional Meetings - **REVISED**

Per your request, attached please find lists of your meetings on the Hill. There are four lists: Meetings with Senate Democrats, Meetings with Senate Republicans, Meetings with House Democrats and Meetings with House Republicans. At the top of each list is the number of total meetings with that group, the number of meetings you have attended with that group, as well as the number out of the total that have met with representatives of the Task Force.

In terms of overall numbers, by the end of this week you personally will have conducted **71 congressional meetings:**

BY CHAMBER:

28 Senate Meetings
32 House Meetings
11 Meetings with representatives of both Houses

BY PARTY:

6 Republican-Only Meetings
45 Democrat-Only Meetings
10 Bipartisan Meetings

You have met with all but eight Senators, three Democrats and five Republicans. The eight remaining are:

Joseph Biden (D-DE)
Robert Byrd (D-WV)
Richard Shelby (D-AL)

Hank Brown (R-CO)
Alphonse D'Amato (R-NY)
Trent Lott (R-MS)
John McCain (R-AZ)
John Warner (R-VA)

In addition, you or your designees have met with 28 of 175 House Republicans and 131 of 255 House Democrats.

SENATE DEMOCRAT MEETINGS

Number of Meetings (HRC or her designees) - 38 as of 5/6/93
Number of Senators Met With - 54 as of 5/6/93

DATE	MEMBERS	MET WITH	SUBJECT
2/4	MITCHELL	HRC/IM/JF	GENERAL
2/4	SENATE DEMOCRATS Mitchell Baucus Bingamen Boxer Breaux Conrad Daschle Feingold Bumpers Harkin Kennedy Kerrey Leahy Lieberman Metzenbaum Mikulski Moseley-Braun Moynihan Pell Pryor Riegle Rockefeller Robb Wellstone Wofford	HRC/IM/JF	GENERAL
2/10	ROCKEFELLER	HRC	GENERAL
2/11	Health Reform Conference WOFFORD	HRC	Event in Pennsylvania
2/11	Mitchell's Office	IM	GENERAL
2/25	SASSER/REIGLE and Mrs. Reigle	HRC	Pregnant women and children -UAW retirees

DATE	MEMBERS	MET WITH	SUBJECT
3/2	Congressional Black Caucus MOSELEY-BRAUN	HRC	GENERAL
3/2	WELLSTONE	HRC	Affordable Health Care
3/4	BREAUX/JOHNSTON	HRC	Health event in Lousiana

DATE	MEMBERS	MET WITH	SUBJECT
3/4	Democratic Policy Committee Mitchell Daschle Akaka Baucus Bingaman Boxer Bryan Campbell Conrad Dodd Exon Feingold Feinstein Graham Hollings Kennedy Kerrey Kerry Lautenberg Leahy Lieberman Levin Matthews Metzenbaum Mikulski Moynihan Pell Pryor Reigle Rockefeller Sarbanes Sasser Simon Wellstone Wofford	IM/JF	
3/6	FEINSTEIN	IM	
3/11	KENNEDY	IM	

DATE	MEMBERS	MET WITH	SUBJECT
3/11	Senate Woman's Caucus Milulski Boxer Feinstein Murray Moseley-Braun	HRC	Women's Health Issues Overall Reform
3/11	ROCKEFELLER	HRC	Veteran's Issues
3/11	MOYNIHAN	HRC	
3/12	RWJ Forum GRAHAM	HRC	Florida Health Event
3/15	RWJ Forum HARKIN	HRC	Iowa Health Event
3/15	Finance Committee Staff Staff Director- Lawrence O'Donnell	CJ/KP/SR	
3/17	Indian Health Meeting Inouye	HRC	
3/18	KERREY	HRC	
3/22	RWJ Forum RIEGLE and Mrs. Riegle DINGELL and Mrs. Dingell LEVIN	MEG/CR/DS	Michigan Health Event
3/23	DPC Staff	Begala/BB/CJ	Communications Strategy

DATE	MEMBERS	MET WITH	SUBJECT
3/24	Democratic Policy Committee Mitchell Akaka Baucus Bingaman Boxer Bryan Conrad Daschle DeConcini Dodd Feingold Glenn Graham Hollings Johnston Kennedy Kerry Leahy Levin Matthews Moseley-Braun Reid Wellstone Wofford	IM/JF	
4/16	KERREY	HRC	Nebraska Field Event
4/17	BAUCUS	HRC	Montana Field Event
4/20	Baucus Bradley Boren Riegle Breaux Daschle Conrad Moynihan	IM/HRC	GENERAL

DATE	MEMBERS	MET WITH	SUBJECT
4/20	Senate Finance Committee-(Bipartisan) Baucus Boren Bradley Mitchell Pryor Riegle Rockefeller Daschle Breaux Conrad	HRC	GENERAL
4/21	Rockefeller	HRC	GENERAL
4/22	Pryor	CJ	GENERAL

DATE	MEMBERS	MET WITH	SUBJECT
4/23	Senate Conference Jamestowm Akaka Baucus Bingaman Boxer Bradley Breaux Bumpers Conrad Daschle DeConcini Dodd Dorgan Exon Feingold Ford Glenn Graham Harkin Heflin Hollings Johnston Kennedy Kerrey Kerry Lautenberg Leahy Levin Lieberman Mathews Metzenbaum Mikulski Mitchell Moseley-Braun Moynihan Murray Nunn Pell Pryor Reid Riegle Robb Rockefeller Sarbanes Simon	HRC/IM/JF	GENERAL

DATE	MEMBERS	MET WITH	SUBJECT
4/23	Senate Conference at Jamestown (Cont.) Wellstone Wofford	HRC/IM/JF	GENERAL
4/26	Congressional Democratic Leadership MITCHELL	HRC/BC	
4/27	Senate Staff	IM/JF	GENERAL
4/30	Senate (Bipartisan meeting) Akaka Baucus Bingaman Bryan Conrad Daschle Dorgan Feingold Feinstein Graham (FL) Heflin Kennedy Kerrey Kerry Leahy Levin Lieberman Metzenbaum Mitchell Nunn Pell Pryor Riegle Robb Rockefeller Simon Wellstone Wofford	HRC/IM/JF	GENERAL

DATE	MEMBERS	MET WITH	SUBJECT
4/30	Mental Health Briefing WELLSTONE	MEG	Cost effectiveness and efficacy of mental health treatments
5/4	Senate Labor and Human Resources Committee (Bipartisan Meeting)	HRC	
5/5	Senate Leadership Mitchell Ford Pryor Daschle Moynihan Kennedy Rockefeller Riegle Breaux Mikulski	HRC/BC	Status of reform -- Consultation
5/6	Single Payer Advocates Wellstone Inouye Simon	HRC	Single Payer Concerns
5/6	Senate Aging Commitee Pryor Glenn Breaux Reid Graham Feingold Krueger Kohl	HRC	Individual Responsibility and Prevention Issues

SENATE REPUBLICAN MEETINGS

Number of Meetings - 19 as of 5/6/93
Number of Senators Met With - 38 of 43 as of 5/6/93

DATE	MEMBER(S)	MET WITH	SUBJECT
2/4	DOLE/CHAFEE	HRC, ICM, JF	process, general discussion
2/23	DURENBERGER	HRC, ICM	
3/10	Senate Republican Members Dole Chafee Bennett Bond Burns Coats Cochran Cohen Coverdell Craig Danforth Domenici Durenberger Faircloth Gregg Hatch Helms Jeffords Kassebaum Kempthorne Lugar Mack McCain McConnell Murkowski Nickles Packwood Roth Simpson Specter Stevens	HRC	general discussions about process and about directions for/components of reform
3/10	JEFFORDS	ICM	
3/11	KASSEBAUM (as part of Women Senators meeting)	HRC	Health Reform Issues of special interest to women
3/12	Senate Republican Staff	ICM	

3/23	Senate Republican Staff	Walter Zellman Rick Kronick Lois Quam	New System Development Governance
4/1	Senate Republican Staff Sheila Burke Christy Ferguson Ed Mihulski	ICM	short-term controls
4/17	Health Forum Burns	HRC	Montana Field Event
4/19	Senate Republican staff	Gary Claxton	Insurance Reform
4/20	DURENBERGER	ICM	Overall Reform
4/20	Senate Finance Commitee: (Bipartisan Meeting) Chafee Packwood Danforth Roth Grassley Hatch Wallop	HRC, ICM, JF	Overall reform, costs, financing
4/29	Senate Republican Staff	Lois Quam	Rural Health Care

4/30	Entire Senate Bennett Bond Burns Chafee Coats Cochran Cohen Coverdell Danforth Dole Domenici Durenberger Gorton Gramm Grassley Gregg Hatch Hatfield Jeffords Kempthorne Murkowski Pressler Simpson Smith Specter Stevens Thurmond	HRC, ICM, JF	
4/30	Congressional Mental Health Briefing Domenici	MEG	Cost effectiveness and efficacy of mental health treatments
5/4	Senator Chafee	IM	
5/4	Senate Labor and Human Resources Committee (Bipartisan Meeting) Kassebaum Thurmond Gregg Durenberger Jeffords Coats Hatch	HRC, ICM, JF	Overall Reform

5/6	Senate and House Republican Leadership Dole Chafee Kassebaum Durenberger Danforth Packwood Jeffords Cohen Hatch	HRC, BC	Status of Reform -- Consultation
5/6	Senate Aging Committee Bipartisan Cohen Pressler Simpson Durenberger Craig Burns Grassley	HRC	Individual Responsibility and Prevention issues

HOUSE DEMOCRAT MEETINGS

Number of Meetings - 52 as of 5/6/93
Number of Members Met With - 131 out of 255 as of 5/7/93

DATE	MEMBER	MET WITH	SUBJECT
2/3	GEPHARDT	HRC	
2/4	STARK	IM/HP	
2/15	McDERMOTT	IM	
2/16	HOUSE DEMOCRATIC LEADERSHIP Foley Gephardt	HRC/IM/JF	
2/16	HOUSE DEMOCRATS Andrews Bonior Cardin C. Collins Cooper Conyers de la Graza Derrick Fazio Ford Hoyer E.B. Johnson Johnston Levin Lewis Matsui McDermott Meek Obey Richardson Rose Rostenkowski Slattery Slaughter Stark Stenholm Strickland Synar Waxman Williams Wyden	HRC/IM/JF	

2/18	ROSTENKOWSKI	HRC	
2/18	FORD	HRC	
2/18	DINGELL	HRC	
2/23	Congressionial Women's Caucus Schroeder Furse Kaptur Lambert Lowey Maloney Mink Slaughter Waters	HRC	
2/23	STARK	HRC	
2/23	WAXMAN	HRC	
2/23	WILLIAMS	HRC	
2/24	House Democratic Leadership and Committee Chairs Gephardt Lewis Richardson Rostenkowski Stark Dingell Waxman Ford Williams	HRC/IM/JF	

3/2	Congressional Black Caucus Clayton Collins Conyers Flake McKinney Meek Mfume Norton Rangel Stokes Waters Watt	HRC	
3/2	Congressional Hispanic Caucus Serrano Roybal-Allard Pastor de la Garza de Lugo Ortiz Richardson Torres Becerra Guttierrez Mendez Romero-Barcelo Tejeda Velazquez Underwood	HRC	
3/4	JEFFERSON	HRC	
3/9	CONYERS	HRC	
3/9	McDERMOTT	HRC	

3/9	Energy and Commerce Committee Dingell, Chairman S. Brown Hall Kreidler Lambert Lehman Margolies-Mevzinski Markey Pallone Richardson Schenk Slattery Studds Tauzin Towns Waxman	HRC	
3/11	WYDEN	HRC	
3/11	MONTGOMERY/ROWLAND	HRC	Veteran's Issues
3/11	Gephardt Rostenkowski Stark Dingell Waxman Ford Williams	IM/JF	
3/12	RWJ Forum GIBBONS	HRC	
3/15	RWJ Forum NEAL SMITH	HRC	

3/17	Democratic Ways and Means Committee Members Rostenkowski Andrews Cardin Gibbons Hoagland Jefferson Kennelly Kopetski Levin Lewis Matsui McDermott McNulty Neal Payne Reynolds	HRC	
3/17	JACK BROOKS	HRC	
3/18	Andrews Cooper Stenholm L. Payne	HRC	
3/18	REYNOLDS	HRC	

3/25	Democratic Committee Members of: Education and Labor Ways and Means Energy and Commerce Andrews Cooper Engel Cardin Lambert Levin McDermott Synar Tauzin Pallone Woolsey Slattery Rostenkowski Dingell Waxman Richardson Markey Hall Studds Margolies-Mezvinski Kennelly Hoyer Fazio Kreidler Bryant Klink Sawyer	IM	

3/30	Mainstream Forum McCurdy Bacchus Browder Carr Danner Glickman Geren Green Moran Payne Penny Peterson Price Orton Rowland Slattery Spratt Tanner	IM	

3/31	House Democratic Caucus Barlow Cooper DeLauro Derrick Dingell Durbin Filner Gephardt Geren Gordon Hamilton Hochbrueckner Hoyer Hughes Inslee D. Johnson E.B. Johnson Kaptur Kennelly Lancaster Levin Lewis Lloyd Lowey McDermott Moran Obey Olver Pomeroy Richardson Romero-Barcelo Sawyer Shepard Sisisky Skaggs Smith Stark Stupak Synar Thurman Velazquez Volkmer Wise Woolsey	IM/JF	

3/31	Ways and Means Subcommittee on Health Stark Levin Cardin McDermott Andrews Klezka	IM/JF	
4/8	House Leadership	IM	
4/14	Ways and Means Subcommittee on Health Stark Cardin Levin Andrews McDermott	HRC/IM	
4/15	VA Meeting Rockefeller Brown Montgomery	HRC	
4/15	House Leadership Staff Meeting	IM/Roz Lasker/Ken Thorpe	
4/16	CBO Meeting House and Senate Leadership Staff Energy and Commerce Staff Finance Staff Labor and Human Resources Staff	IM/Ken Thorpe/Rick Kronick	
4/16	HOAGLAND	HRC	NEBRASKA EVENT
4/17	WILLIAMS	HRC	MONTANA EVENT
4/20	Chairman Moakley	HRC	

4/20	Valentine	CJ	
4/26	Congressional Democratic Leadership FOLEY/GEPHARDT	HRC/BC	
4/27	DINGELL	HRC	
4/27	BONIOR	HRC	
4/27	House Democratic Leadership Foley Gephardt Rostenkowski Stark Dingell Waxman Ford Williams Bonior Kennelly	HRC/BC	
4/27	Congressional Hispanic Caucus	IM	
4/28	Congressional Border Caucus Coleman	JF/Richard Veloz	
4/29	Town Meeting VALENTINE	HRC	Health Care Reform Teleconference
4/29	Jim McDermott	HRC	Single Payer Concerns

4/30	Mental Health Briefing Lowey Kopetski Markey Mazzoli Romero-Barcelo Strickland Wise	MEG	
5/5	Democratic Caucus	Ken Thorpe	Current Status of Employer/ Employee Health Insurance
5/6	McCurdy	HRC, IM	BasiCare provisions

HOUSE REPUBLICAN MEETINGS

Total Number of Meetings - 15 as of 5/6/93
Total Number of Members Met With - 28 out of 175 as of 5/6/93

2/16	House Republican Leadership Michel Gingrich Hastert	HRC/IM/JF	GENERAL
2/16	House Republicans Bilirakis Bliley Goodling Goss Grandy Gunderson Hoke N. Johnson Kasich McCrery Moorhead McMillan Roberts Roukema Thomas Walker	HRC/IM/JF	GENERAL
2/23	Congressional Women's Caucus Snowe Morella	HRC	GENERAL
3/2	Congressional Black Caucus Franks	HRC	GENERAL
3/2	Congressional Hispanic Caucus Ros-Lehtinen Bonilla Diaz-Balart	HRC	GENERAL

3/11	House Republicans Bliley Gingrich Goss Hastert Johnson Thomas	IM	GENERAL
3/18	House Republicans Bliley Goss Grandy Hastert N. Johnson McMillan Thomas	IM	MALPRACTICE
3/25	House Republicans Bliley Goss Grandy Hastert N. Johnson McMillan Thomas	IM	GLOBAL BUDGETS
4/1	House Republicans Bliley Goss Grandy Gunderson Hastert N. Johnson McMillan Roberts Thomas	Lois Quam	RURAL HEALTH CARE
4/21	House Republicans	IM/JF/Robyn Stone	OVERALL REFORM LONG TERM CARE
4/27	Congressional Hispanic Caucus (Bipartisan) ROS-LEHTINEN	IM	ISSUES OF CONCERN

4/28	Congressional Border Caucus Kolbe	JF	ISSUES OF CONCERN
4/29	House Republicans	IM	OVERALL REFORM FINACING
5/6	Senate and House Republican Leaders Lunch Michel Gingrich N. Johnson B. Thomas Bliley Moorhead Roukema	HRC/BC	STATUS OF REFORM -- CONSULATION
5/6	House Republicans	Gary Claxton	Insurance Reform

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This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23754

FOLDER TITLE:
May 1993 HSA [3]

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MEMORANDUM

12 May 1993

TO: Judy Feder, Ira Magaziner

FROM: Robert Valdez RV

SUBJECT: UNIVERSIAL COVERAGE DEFINITION SUMMARY

COPY: Chris Jennings, Richard Veloz

This memo summarizes the recommended coverage policy under the reform plan. The background and analysis for this recommendation are contained in my 22 April 1993 memorandum to you.

RECOMMENDATION: FOR PURPOSES OF PROGRAM ELIGIBILITY THE CURRENT MEDICAID STANDARD REGARDING RESIDENCE AND CITIZENSHIP SHOULD BE MAINTAINED FOR THE REFORM GUARANTEES WITH PROVISIONS FOR EMERGENCY CARE FOR THOSE EXCLUDED FROM THE SYSTEM. OBRA-86 PROVISIONS REQUIRE COVERAGE OF EMERGENCY SERVICES. FURTHERMORE, PARTICIPATION IN FEDERALLY FUNDED COMMUNITY HEALTH CENTERS AND MIGRANT HEALTH CENTERS SHOULD REMAIN SILENT ON THESE ISSUES ALLOWING THEM TO SERVE ALL RESIDENTS OF THEIR COMMUNITIES ON A FUNDS AVAILABLE BASIS.

The current provisions read as follows:

MEDICAID EXCLUDES FROM PARTICIPATION ANY INDIVIDUAL WHO IS NOT:

(I) A CITIZEN, OR (II) AN ALIEN LAWFULLY ADMITTED FOR PERMANENT RESIDENCE OR OTHERWISE PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW (INCLUDING ANY ALIEN WHO IS LAWFULLY PRESENT IN THE UNITED STATES AS [A CONDITIONAL ENTRANT, ASYLEE, REFUGEE, OR PAROLEE]).

IN ADDITION SECTION 1903(v) OF THE SOCIAL SECURITY ACT PROVIDES FOR COVERAGE OF OTHERWISE ELIGIBLE INDIVIDUALS FOR EMERGENCY CONDITIONS. THE PROVISIONS READ AS FOLLOWS:

(1)...EXCEPT AS PROVIDED IN PARAGRAPH (2), NO PAYMENT MAY BE MADE TO A STATE UNDER THIS SECTION FOR MEDICAL ASSISTANCE FURNISHED TO AN ALIEN WHO IS NOT LAWFULLY ADMITTED TO PERMANENT RESIDENCE OR OTHERWISE PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.

(2) PAYMENT SHALL BE MADE UNDER THIS SECTION FOR CARE AND SERVICES THAT ARE FURNISHED TO AN ALIEN DESCRIBED IN PARAGRAPH (1) ONLY IF -

(A) SUCH CARE AND SERVICES ARE NECESSARY FOR THE TREATMENT OF THE EMERGENCY MEDICAL CONDITION OF THE ALIEN, AND

(B) SUCH ALIEN OTHERWISE MEETS THE ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE UNDER THE STATE PLAN APPROVED UNDER THIS TITLE (OTHER THAN THE REQUIREMENT OF THE RECEIPT OF AID OR ASSISTANCE UNDER TITLE IV [AFDC], SUPPLEMENTAL SECURITY INCOME BENEFITS UNDER TITLE XVI, OR A STATE SUPPLEMENTARY PAYMENT).

The latter provision allows states flexibility in implementing these provisions. OBRA-86, however, requires states to provide emergency services. These provisions raise maintence of effort definitional concerns. Furthermore, it begs the question of the role of public health in the health care reform.

Federally funded Community Health Centers and Migrant Health Centers are silent on the eligibility issue. Thus, they serve all residents in a community on the basis of available funds.

M E M O R A N D U M

TO: Chris Jennings

FROM: Jill Adleberg, Rep. John Dingell 5-4071

DATE: May 12, 1993

RE: Important Health Care Anniversary

Per your conversation with Don Shriber earlier today, June 3 marks the fiftieth anniversary of the introduction of the first national health insurance bill in the U.S. Congress. The legislation, known as the Dingell-Murray-Wagner bill, was introduced by Chairman Dingell's father, Rep. John D. Dingell, in the House, and Senators James E. Murray (D-MT) and Robert F. Wagner (D-NY).

Dingell-Murray-Wagner was introduced in the aftermath of World War II to provide a safety net of services to all Americans. Many of the provisions of the bill were subsequently enacted into law in the form of changes to the Social Security program and the establishment of Medicare and Medicaid.

Senator Wagner commented on the bill's introduction: "The plan provides for a practical program within our ability to pay. The program is a practical one in a much higher sense. Our democracy could provide no better bulwark against communism, no better safeguard against fascism and rabble-rousers in the troubled times ahead, than to develop this dignified, all-embracing plan for social security upon which the individual family could build its own future by its own efforts."

As the President and the Task Force prepare to unveil the details of the Administration's health care reform proposal, this anniversary takes on great significance. In fifty years, we have come a long way in providing health care to the elderly, the poor, and the disabled. Finally, though, the President and the Congress are collectively ready to demonstrate a commitment to providing basic health benefits to all Americans.

Doing so will fulfill the full scope of the ideas represented in the Dingell-Murray-Wagner bill.

Mr. Dingell has reintroduced a similar version of this bill every session since he has served in the House. The bill serves primarily as a reminder of the direction in which we should be heading.

The Chairman would be delighted if the President and the Task Force would make appropriate reference to this important anniversary. Please let me know if you would like any more information, or if we can be helpful.

78TH CONGRESS
1ST SESSION

H. R. 2861

IN THE HOUSE OF REPRESENTATIVES

JUNE 3, 1943

Mr. DINGELL introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To provide for the general welfare; to alleviate the economic hazards of old age, premature death, disability, sickness, unemployment, and dependency; to amend and extend the provisions of the Social Security Act; to establish a Unified National Social Insurance System; to extend the coverage, and to protect and extend the social-security rights of individuals in the military service; to provide insurance benefits for workers permanently disabled; to establish a Federal system of unemployment compensation, temporary disability, and maternity benefits; to establish a national system of public employment offices; to establish a Federal system of medical and hospitalization benefits; to encourage and aid the advancement of knowledge and skill in the provision of health services and in the prevention of sickness, disability, and premature death; to enable the several States to make more

79TH CONGRESS
1ST SESSION

S. 1161

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IN THE SENATE OF THE UNITED STATES

JUNE 3 (legislative day, MAY 24), 1943

Mr. WAGNER (for himself and Mr. MURRAY) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide for the general welfare; to alleviate the economic hazards of old age, premature death, disability, sickness, unemployment, and dependency; to amend and extend the provisions of the Social Security Act; to establish a Unified National Social Insurance System; to extend the coverage, and to protect and extend the social-security rights of individuals in the military service; to provide insurance benefits for workers permanently disabled; to establish a Federal system of unemployment compensation, temporary disability, and maternity benefits; to establish a national system of public employment offices; to establish a Federal system of medical and hospitalization benefits; to encourage and aid the advancement of knowledge and skill in the provision of health services and in the prevention of sickness, disability, and premature death; to enable the several States to make more

yv Ude.

A HEALTHY HISTORY OF DEBATE

At the start of the century, a diverse group of advocates including the American Medical Association, the Socialist Party and President Theodore Roosevelt, began calling for government-paid health insurance for all Americans. A long, often fierce series of battles ensued, swinging between populist calls for a strong government role in health care and calls for a private, free market approach.

Here are some milestones in the debate:

1910-1919: Bills were introduced in several state legislatures to cover workers and dependents in state-administered plans financed by employers, employees and taxes. The idea was originally backed by the American Medical Association, then doctors and medical societies around the country forced the AMA to reverse its stand, and the idea died.

1933: The American Hospital Association endorsed a new plan, Blue Cross hospital insurance. The AMA attacked the plan as "half-baked," but private health insurance, the kind most Americans now have, was born.

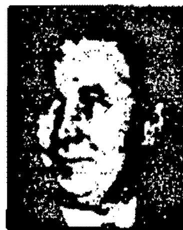
1935: President Franklin D. Roosevelt endorsed the principle of compulsory national health insurance but did not ask Congress to adopt it.

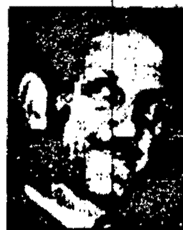
1943: A Democratic trio—New York Sen. Robert F. Wagner, Montana Sen. James E. Murray and Michigan Rep. John D. Dingell Sr.—introduced the first Wagner-Murray-Dingell national health insurance bill. It called for a payroll tax on employers and employees, and government-paid doctors. The bill was introduced in some form every session for 14 years without ever making it to the floor of either house, yet keeping the issue alive. (Dingell's son and successor, Democratic Rep. John D. Dingell Jr. (D-Mich.) introduces a similar bill each session.)

1945: FDR, elected to a fourth term, promised to deliver a strong health message to Congress, but died. President Harry S. Truman adopted the idea, and backed a plan similar to the Wagner-Murray-Dingell bill. A hot national debate ensued. The American Medical Association launched an expensive public relations campaign and labled the Truman plan "socialized medicine." The AMA then warmly embraced private, voluntary health insurance programs like Blue Cross. The Truman effort got lost amid the Korean War effort.

FIRST TO INTRODUCE A HEALTH CARE BILL

Sen. Robert F. Wagner (D-N.Y.)


Sen. James E. Murray (D-Mont.)


Rep. John D. Dingell Sr. (D-Mich.)

1950: Lacking support for a federal health plan, advocates of government health insurance began to think of covering the elderly as politically salable, and a foot in the door for later universal plans. Truman's Federal Security Agency head, Oscar Ewing, talked of making 60 days' hospital care a year part of Social Security.

1953: President Dwight D. Eisenhower killed all efforts at a government plan, unsuccessfully proposing measures that would strengthen private health insurance.

1958: Sen. Robert S. Kerr (D-Okla.) and Rep. Wilbur D. Mills (D-Ark.), chairman of the House Ways and Means Committee, sponsored the Kerr-Mills plan giving states modest matching federal funds to care for the aged poor. With backing from the AMA and Republicans, the measure passed.

1960: Sen. John F. Kennedy hit the presidential campaign trail promising care for the elderly financed with an increase in the Social Security payroll tax.

1964: President Lyndon B. Johnson and Rep. Mills reached a compromise. The aged would be taken care of by Medicare and a new federal-state Medicaid plan would cover more of the poor. Poorer states, like Mills's Arkansas, benefited from a disproportionate share of the federal dollars.

1965: Congress enacted both Medicare government coverage for the elderly and Medicaid, despite AMA opposition. They went into effect in 1966.

1974: With millions of Americans still uncovered, President Richard M. Nixon proposed a Comprehensive Health Insurance Program (CHIP) to mandate or order most employers to cover their workers. Under the system, patients would pay both a modest deductible before any coverage and 25 percent of all bills, limited to a maximum annual liability. Mills and a new player, Sen. Edward M. Kennedy (D-Mass.) endorsed a similar but more generous plan. Democratic and Republican support was weak or split for either plan. Mills lost credibility when he became involved with a dancer named Fanne Foxe. Watergate distracted Nixon's and the nation's attention, and nothing happened.

1991-1992: With ever more millions uninsured, health care returns to the front burner. More than 30 bills are introduced in Congress. Most take one of four approaches: Tax credits and vouchers, with encouragement for managed care such as health maintenance organizations; pay or play, under which employers must either provide health insurance or pay into a government fund for the uninsured; stronger private health insurance; or universal, government-administered health care as practiced in Canada.

—Compiled by by Victor Cohn

ISSUES RELATED TO INTEGRATION OF WORKERS' COMPENSATION MEDICAL COSTS INTO THE NEW HEALTH CARE SYSTEM

INTRODUCTION

The purpose of this paper is to outline the primary options for integrating workers' compensation health benefits into the new health care system in the context of the key issues that must be addressed if integration is to occur. State experiments with what has been called 24-hour coverage in the workers' compensation area have been limited to date and generally have not considered the additional problems of a system in which employees, not employers, control the choice of health plan. This paper looks at each of the key issues related to integration and discusses how they would be addressed under each option.

SUMMARY OF ISSUES AND CONCLUSION

Summary

There are a number of ways to integrate the health benefits of workers' compensation into the contemplated health care system. The working group offered two primary options for integration.[1] The first is to partially integrate the two systems by keeping the risk for work-related health benefits with existing workers' compensation insurers but providing treatment for work-related injuries through the health plans chosen by workers under the new system. The second is to transfer the risk of work-related health benefits to the new system by placing the health plan chosen by a worker under the new system at risk for the treatment of any work-related injuries sustained by the worker. These two options are very different in terms of potential cost savings, complexity, and disruption of current arrangements.

The key factors in deciding between the two options would appear to be the complexity and lack of actual experience associated with transferring the risk to the new system, balanced against the inferior incentives and reduced potential for cost savings associated with the partial integration option.

The transfer of risk option has the advantage of placing

[1]A third option, which would be a complete merger of workers' compensation health into the new system with no special treatment, was not recommended for reasons discussed in the next section.

health plans at risk for the total medical care needs of their enrollees, leading to a more integrated and cost conscious approach to treatment. At the same time, this option, especially in a system of employee-choice of health plan, involves the addition of complex new elements to the health care and workers' compensation systems. These include: (1) developing a method of capitating health plans for the risk of work-related medical benefits; (2) potentially modifying the comprehensive benefit package to include the additional medical benefits now provided in the workers' compensation system; (3) developing methods of coordinating back to work activities between health plans and workers' compensation indemnity carriers; (4) potentially developing a new premium collection method (that may be experience rated) for work-related injuries; (5) potentially developing a system for adjusting payments to health plans based on their success in facilitating early return to work for injured workers; (6) developing national benefits for work-related injuries and an administrative system to assure portability of work-related benefits across differing state systems; and (7) managing the potential for transfer of risk for large employers to small employers if larger firms are permitted to be outside of the alliance.

The partial integration model, in contrast, is much simpler and involves much less disruption of the current system. At the same time, its potential for cost savings is not as great because health plans are not put at risk for treatment of work-related injuries. Because risk remains with workers' compensation carriers and is funded through the current method, there is much less need to develop new systems or to address across state variations.

Recommendation

The transfer of risk approach, although very complicated, would appear to be the superior approach in the long run. The short-term implementation problems are severe, however, and additional problems with implementation will no doubt be discovered.

It is recommended that the partial integration approach be adopted as a short run -- injured workers would be required to receive treatment through there health plan and health plans would be reimbursed at rates that reflect the overall efficiency of the health plan. It is further recommended that a commission be appointed to report in two years to the President with a plan to transfer the risk of work-related injuries to health plans. The charge to the commission should be stated such that it is their job to develop a plan of implementation and not to debate the merits of that choice.

BACKGROUND

Workers' compensation programs represent a social contract, in which employees injured at work trade the right to sue their employers for negligence in return for a strict liability system that provides medical and cash benefits. Workers' compensation coverage is mandatory for most employers and 87 percent of all employees are covered. Gaps include domestic workers, agricultural workers, and some state and local government employees. Coverage is voluntary in New Jersey, South Carolina and Texas, although most employers in those states have coverage. In 1990, private insurers paid about 60 percent of workers' compensation benefits, state and federal funds paid about 20 percent, and self-insurers paid about 20 percent.

Workers' compensation provides first dollar coverage with no dollar limits for all necessary work-related medical treatment. Workers' compensation medical payments were $18-20 billion in 1992, about 40 percent of total workers' compensation expenditures. About 80 percent of workers' compensation claims are medical-only cases, which account for about 15 percent of workers' compensation medical costs. For example, in 1989 in Alabama, the average medical-only claim was $222; the average medical costs of a claim that involving lost wages was $bout $5,700.

Workers' compensation premiums are based primarily on occupation -- rating organizations establish premium rates, called manual rates, for about 700 industry classifications. For mid-size and larger employers, those rates are modified by the employer's claims experience. These experience modifications are applied prospectively, based upon the previous three years of claims experience of the employer. Large employers also are subject to retrospective experience rating, in which the employer's current-year premium are adjusted based on current-year claims.

Workers' compensation reserves are set up very differently than health insurance reserves. In workers' compensation, when an injury occurs, the insurer sets aside an amount intended to fund the entire losses that will occur as a result of that injury (i.e., the present value of future claims). Rates are set to provide sufficient funds for the insurer to reserve the entire amount of losses in the occurrence year. For health insurance, premiums are established to fund losses only through the current policy year. For example, under current workers' compensation practices, if premiums for the health component of workers' compensation for a firm were $10 in a given year, about $3.50 would go to pay for services in that year and $6.50 would be reserved to pay for services in future years.

SUMMARY OF OPTIONS

To assist understanding of the following discussion, the two options are briefly outlined below. Key variations to the options are shown parenthetically. A third option -- which involves a more complete merger of the two systems -- is also described because it is a preferred option of many advocates of 24-hour coverage. This option was not recommended by the working group because it potentially reduces benefits and transfers costs to workers.

Partial Integration

Under the partial integration model:

- Employers would continue to purchase workers' compensation insurance from workers' compensation insurers,[2] who would remain at risk for health and non-health workers' compensation benefits.

- Employees would receive treatment for work-related injuries from their health plans. State laws regarding choice of provider for workers' compensation would be overridden (exceptions would be necessary in cases of disputes).

- Health alliances would negotiate fee schedules with each health plan for the treatment of work-related (and probably automobile-related) injuries. The schedules should, to the extent possible, reflect prices and efficiency achieved by the health plan generally in treating non-work-related injuries.[3] The alliance would be free to negotiate DRG-type case payments with health plans. Workers' compensation insurers could negotiate separate arrangements with health plans if each agreed to a different reimbursement arrangement.[4]

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[2]Unless otherwise stated, the term workers' compensation insurer includes an employer that provides workers' compensation benefits through self-funding.

[3]In the case of the fee-for-service health plans, the alliance or state might want to establish the fee schedule to be used by fee-for-service providers. A number of states already have fee schedules for workers' compensation medical benefits.

[4]This is an area where market forces are not operating: employees have chosen the health plan for reasons not related to workers' compensation health benefits and the workers' compensation

- [Option. Each health plan would be required to have a workers' compensation case manager to coordinate the treatment and rehabilitation of injured workers. The case manager would be responsible for assuring that the health plan complies with medical/legal requirements related to the workers' compensation and that the health plan works cooperatively with the workers' compensation insurer and the employer to facilitate rapid return to work.]

- The workers' compensation insurer would be financially responsible for work-related health care costs and would establish reserves for a case at the time of injury (which is the practice today). If a worker with an injury requiring on-going treatment leaves employment or moves to another state, the workers' compensation insurer would continue to fund the needed medical care received by the worker in whatever health plan the worker chooses in his or her new state of residence.

- Injured employees of employers that self-fund for workers' compensation also would receive services through the health plans they select; the employer would be responsible for funding all future health claims related to the injury.

<u>Transfer of Risk Option</u>

Under the transfer of risk option approach:

- The risk for health benefits for work-related injuries would be placed with the health plan chosen by an employee for all of their health care needs.

- Each year alliances would collect sufficient funds from employers to cover the actual costs of treating work-related injuries <u>in that year</u>. This amount could be collected as a separate premium [which varies by occupation and/or employer claims experience] or it could be combined in the premium or payroll contribution which funds new system benefits [Note: the additional amount should be loaded entirely on the employer portion of the

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insurer has no ability to influence the employee's choice of provider for treatment. Thus, the health plan has no incentive to negotiate with the C insurer. The alliance, as the representative of payers and consumers, would have the incentive and the market power to negotiate with the health plan.

premium or contribution].

- Alliances would negotiate a per worker payment (i.e., capitation) each year with each health plan, which would fund the expected costs of treating work-related injuries for the specified year. Payments from the alliance would vary by occupation and other relevant factors. Health plans would bear the risk of providing treatment within the capitation amounts received. Payments from the alliance to health plans would be risk-adjusted to correct for differences in disability-status and other factors that would affect the need for work-related health benefits. The risk of certain high-cost cases could be shared within the alliance through a capitated reinsurance approach.

  [There are two alternatives for payment to health plans. Under the first alternative, the revenue raised to cover workers' compensation health benefits could be calculated only to provide the benchmark level of work-related health benefits to each employee. This benchmark amount would be provided to each health plan. Plans above the benchmark would collect additional amounts needed to fund work-related health benefits through premium contributions charged to wi choosing the plan.[5]

- Because individuals have the choice of changing health plans each year, reserving for work-related health benefits would be done on an annual rather than on an occurrence basis.[6] This would result in much lower workers' compensation premiums for health benefits in the first year of integration, with substantial increases each year until premiums reach current levels. A levelling system (in which wac than needed premiums are wi in early years and returned to employers in later

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[5]This type of distribution is complicated by the fact that the relative levels of efficiency of plans in providing general health care and in treating work-related injuries probably will not be the same.

[6]Under an annual funding method, premiums will cover only the yearly cost of treatment in that year. Under an occurrence basis, an amount equal to the full anticipated future health care costs is set aside when an injury occurs. Thus, under the annual method, each year's premium in part goes to fund treatments for injuries which occurred in previous years. Under an occurrence method, those costs are already funded through reserves held by an insurer.

years) would needed to provide for a smooth transition.

- Each health plan would be required to have a workers' compensation case manager to coordinate the treatment and rehabilitation of injured workers. The case manager would be responsible for assuring that the health plan complies with medical/legal requirements related to the workers' compensation and that the health plan works cooperatively with the workers' compensation insurer and the employer to facilitate rapid return to work.

- Alliances would develop target schedules for return to work and payments to health plans would be reduced or enhanced on the basis of the plan's performance in assuring timely return to work. Alliances would be required to develop a formal method of consulting with workers' compensation insurers on the schedule and on health plan performance in meeting it. The incentive payments would be handled through a withhold arrangement or adjustments to future payments.

- A uniform benefit package for work-related benefits would be developed. The federal agency would be charged with recommending benefits, which would be approved by the national health board or through legislation. The benefit package would be available for work-related injuries in all states.

- Eligibility of workers for the extra benefits provided for work-related injuries would be determined under the current laws in each state (state laws as to causation and eligible workers differ). Injured workers who change their state of residence would remain eligible for additional benefits, even if the injury would not have been considered work-related if it had occurred in the new state of residence.

<u>Complete Merger Option</u>

Some advocates of 24-hour coverage suggest folding the risk of workers' compensation health benefits into the new system and eliminating any determination of whether an injury was work-related. [An option would involve a determination of work-relatedness only when additional benefits (e.g., longer-term disability or long-term care) were warranted].

Under this approach:

- Health plans would take the risk for all health benefits,

no matter their source (e.g., this would include health costs v, from work-related and automobile accidents).

- Treatment for work-related and non-work-related health benefits would be handled in the same manner by health plans. Enrollees would be responsible for premiums and cost sharing for health benefits without regard to source of injury.

- [Option. Health plans would provide additional medical benefits now provided by workers' compensation carriers, including long-term rehabilitation and care services that are required to treat work-related injuries and illnesses. Health plans would be required to make a determination of whether an injury was work-related for the purposes of these extra benefits. Controversies could be handled through the traditional workers' compensation system.][7]

- Health plans would include the costs of treating work-related health benefits in their premium bids to the health alliance. These benefits would be funded as part of the premiums (e.g., per capita or payroll-based contributions) charged to employers and employees (with subsidies where appropriate).

This option was not recommended by the working group for a number of reasons. Although there is potential for administrative savings and simplicity with a complete merger, workers would (probably) perceive this approach as a reduction of the rights and benefits they receive wv current law. Potential problems for workers include:

- ► Workers could lose benefits under this approach as compared to the current system. For example, workers would be responsible for cost-sharing (i.e., co-payments and deductibles) that are not currently charged in workers' compensation system.

- ► Unless additional benefits are added to the comprehensive benefit package for work-related injuries, workers under this approach also could lose access to long-term rehabilitation or long-term care services now provided

[7]Injuries involving these additional benefits would probably involve a claim for lost wages, so a determination of work-relatedness would probably need to be made in the workers' compensation system in any event.

under workers' compensation. Alternatively, those benefits could remain in the workers' compensation system, but some (maybe much) of the administrative cost-savings of integration would be lost if some medical benefits remain with workers' compensation carriers. Further, continuity of coverage and efficient treatment would be compromised if medical benefits are split across the two systems.

- Workers would be required to pay for part of the premiums for work-related injuries under this approach. Workers' compensation currently is entirely employer financed (with a few exceptions). Placing twenty percent of the burden on employees (and potential subsidy burdens on the government) would be a significant transfer of responsibility. Adding the costs to premiums also would require nonworkers to contribute to the costs of work-related injuries.

- This approach eliminates any option to have experience rating of employers for causing work-related injuries, which would lessen the incentives for workplace safety and could reduce employer incentives to return injuries workers to work.[8]

For these reasons, the working group did not view this option as viable. If it is considered, much of the discussion in the following section related to the transfer of risk approach would be equally applicable to this approach.

KEY ISSUES

There are a number of difficult policy and technical issues involved with integration. The following is a discussion of the key issues and how he two primary approaches to integration would address each issue.

1. Cost savings. The issue is to what extent either approach will reduce medical expenses for work-related injuries and illnesses.

Workers' compensation medical costs are increasing faster than

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[8]Advocates of this suggest that the experience rating of the wage-loss protection is sufficient to encourage safety. This is true to some extent, although the relative importance of medical and wage-loss claims to experience rating modifications varies across industries.

general medical costs for several reasons. These include: (1) physician appear to charge more for work-related treatments paid by workers' compensation carriers than for comparable treatment paid by group health insurance;[9] (2) workers' compensation is overwhelming a fee-for-service system, which has little ability to manage volume or assure appropriateness of services; (3) workers' compensation is prone to fraudulent claims (apparently severe in a few states); (4) the adversarial nature of some severe claims; (5) problems in the economy that produce a greater number of wage loss claims (with accompanying medical expenses).

The partial integration model addresses several of these issues. The fee schedules address the problem of high physician charges for workers' compensation, and providing services through health plan providers should address the fraud issue, at least for integrated health plans. Advocates of integration also argue that providing for treatment of work-related injuries by a person's normal health plan will reduce the adversarial climate because both employers and employees will have more confidence in the diagnoses and treatment. This degree of trust does not exist if the physician is chosen after the injury by either the employer or employee (or the employee's lawyer).

The transfer of risk approach addresses the same issues as the partial integration approach, but with one important addition: health plans will be at risk for treatment of work-related injuries and therefore will have incentives to control utilization and reduce the amount of inappropriate treatment. Treating work-related injuries through managed care and integrated health plans appears (apparently) has produced significant savings in the few instances where it has been tried.

Both approaches should produce lower costs for treating work-related injuries. The transfer of risk approach has the potential for larger savings because the risk is transferred to providers and increased opportunities for managed care are present.

2. Benefit differences. The issue is how to address the fact

[9]Because workers' compensation has the goal of returning injured workers back to their jobs, there will be some additional intensity of services in the workers' compensation system that result in legitimately higher charges.

that workers' compensation provides health benefits that may not otherwise be covered by the health care system. For example, workers' compensation health benefits include long-term rehabilitative therapy and custodial long-term care services for people injured at work. Workers' compensation benefits also are provided as first-dollar coverage (i.e., there are no copayments or deductibles) and there are no lifetime limits on medical services.

There are two parts to this issue: (1) cost sharing and (2) additional benefits for work-related injuries. With respect to cost sharing, some states that have authorized 24-hour coverage are applying health insurance-type cost sharing to work-related benefits. Others are not. From a technical standpoint, it is not difficult to waive cost sharing for work-related injuries for either type of integration. Waiving cost sharing reduces cost containment but maintains the advantages of the current system for workers. Also, many would argue that it is unfair to impose individual responsibility for costs that are work-related.

With respect to additional benefits, both partial or full integration are more rational if health plans provided the full array of medical benefits. If some benefits are provided by health plans and others left with the traditional workers' compensation system, coordination of care and overall efficiency would suffer. It would be possible to leave rehabilitation or long-term care benefits with the workers' compensation system, but it could lead to disputes regarding the point at which responsibility switches from the health plan to the workers' compensation insurer. However, if some medical benefits are left in the workers' compensation system, this is better handled by the partial integration approach because the workers' compensation carrier is at risk for all benefits.

3. Differences across states. The issues is how to recognize the significant differences among state workers' compensation systems. There are three key differences that affect the availability of health benefits across states: (1) different health benefits (there is not much variation); (2) different standards for causation (i.e., whether an injury arose out of and in the course of employment)[10]; and (3) different

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[10]State law regarding the circumstances under which an injury is considered to arise out of or occur in the course of employment varies tremendously

eligible populations[11].

These differences are important because injured workers might be eligible for additional benefits and because they relocate from state to state.[12] In the current system, injuries are fully funded at the time of injury according to the benefits and rules established in the state where the worker was employed (or in some cases, where the injury occurred, if different). This practice can continue under the partial integration model, because the workers' compensation insurer is financially responsible for all benefits, present and future.

Under the full integration model, however, a person's current health plan is responsible for providing benefits for past work-related injuries. If that person has relocated to a new state, the benefits to which they would have been entitled in their previous state of residence may not match the work-related benefits commonly provided in their new state of residence.[13]

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[11]About 13 percent of workers are not covered by workers' compensation as a result of various exclusions across the states. At least 20 percent of workers are not covered in at least nine states (estimate from John Burton, Rutgers). In three states, Texas, South Carolina and New Jersey, coverage is voluntary.

States have a wide variety of excluded categories of workers, including casual workers, farm labor, domestic workers, and real estate brokers.

[12]State differences also are important if workers' compensation health benefits will be funded with separate premiums, because it will be necessary to be able to classify treatment that is for a work-related injury.

[13]For example, take the situation of two people, Person A and Person B, who sustain exactly the same injury playing softball for their employer's softball team. In State X the injury is covered as a work-related injury and Person A is entitled to additional benefits (for rehabilitation beyond what would otherwise be covered). In State Y the injury is not considered work-related, so Person B is entitled to no extra benefits. Both workers now move to State Z (which would consider the injuries as work-related under their laws). How should the injuries be treated by the new health plan in State Z?

To make the full integration model work without correcting for all state variation (which would be a huge change to state workers' compensation systems), it would be possible to use the eligibility and causation determinations in the original state to determine eligibility for work-related benefits. This would mean that a person covered for an injury in California could receive benefits in Colorado even if Colorado normally would not have provided compensation in the injury had occurred there. In order to assure that benefits are available everywhere, however, we would need to move to a uniform system of health benefits for work-related injuries. This should not be too controversial because health benefits do not vary widely across states.

4. <u>Coordination of work-related health benefits with coverage for lost wages</u>. The issue is how to assure that integration does not actually increase workers' compensation costs in the wage loss area. The health and wage-loss components of workers' compensation are closely related because a person's medical status affects the amount of time the person is not at work, and hence the person's claim for lost wages.

   Workers' compensation insurers argue that these two risks must remain together so that the health and wage-loss risks can be coordinated to facilitate rapid return to work. The more successful carriers (including one HMO in the field) argue that by managing the total risk they can better work with employers to develop loss control programs and to arrange for light duty or other return to work options. Further, they are skeptical that health plans would provide the intensity of services necessary to facilitate rapid return to work, especially of the health is capitated and has a financial disincentive to provide any extra services.[14] They also want the leverage of payment over the medical provider to assure that the provider sees the patient quickly and fills out the necessary forms.

   Coordination between the health and wage-loss risks can be accomplished in either integration model. The partial integration model keeps all of the risk with the workers' compensation insurer and therefore best preserves the type of coordination that exists in the current system.

   In the full integration model, the health and wage-loss risk

[14]They liken workers' compensation to sports medicine, where the goal is not medical recovery but recovery to a level where the patient can preform his or her prior function.

are separated, so additional methods are needed to assure desired coordination. One method would be to require each health plan to have a workers' compensation case manager who could work closely with the insurer of the wage-loss piece to coordinate treatment delivery and return to work. An additional component would be to adjust health plan reimbursement to place incentives on them to assure rapid return to work. Alliances also should build a formal method of consultation with workers compensation insurers so that protocols and targets can be developed by which to judge the performance of health plans in this area.

It is unclear whether the methods of coordination built into the full integration model would permit the level of total case coordination now claimed by the workers' compensation system. Dividing the risk among two insurers necessarily reduces control. It may be that states could give alliances greater authority in this area to bring both insurers together to focus their education efforts on employers.

5. Capitation of health plans. The issue is how, in the full integration model, to design payments to health plans for the risk of work-related injuries. With full integration, alliances would need to negotiate per-worker payments that capitate health plans for the annual costs of providing work-related health benefits. Since each health plan would attract a different percentage of workers and nonworkers as well as workers from a different mix of industries, these payments would need to vary at least by industry and occupation code.

   Unfortunately, there is very little actual experience with health plans taking risk for workers' compensation costs, and no examples where annual capitation rates have been developed. Thus, the success of the full integration model depends, in part, on creating a new system of capitating workers' compensation costs. This problem may be especially acute for less-integrated health plans, who would not be in a good position to share the risk with health care providers.

   This concern could be reduced, to some extent, by incorporating mandatory reinsurance into the model, at least for the early years. This would help spread part of the risk across all health plans and protect them from incurring unreasonably high losses. The risk adjustment mechanism also would protect health plans from attracting a disproportionate share of higher-cost enrollees.

   This concern also could be reduced if the risk for work-related injuries were completely integrated into the risk

borne by the health plans

The partial integration model does not have this concern because the risk remains with workers' compensation insurers.[15]

6. Method and collection of premiums. The issue is whether work-related health benefits should be funded through separate contributions or whether their cost should be added to premiums or contributions already being collected by health plans. A related issue is, if separate premiums are collected, on what basis should they be assessed?

   Workers' compensation currently is paid for entirely by employers. Premiums for workers' compensation insurance are based on a combination of occupational and experience rating. Employers in riskier occupations pay higher premiums than those with lower risk, and employers with poorer safety records pay additional premiums to compensate for their worse claims experience.

   Under the partial integration approach, premiums could (and probably should) continue to be collected in the same manner as they are today. Since workers' compensation insurers would continue to bear the financial risk for work-related health benefits, there is no reason to disrupt the premium systems that exist in each state.

   There are several options for collecting the needed revenue under the transfer of risk approach, including (1) assessing a separate premium on employers, which can either be community rated, rated based on industry and occupation, and/or experience rated; (2) assessing a surcharge on existing health or workers' compensation premiums; or (3) building the cost into the premiums assessed to pay for non-work-related health benefits.

   Assessing a separate premium on employers has the advantage of being the most accurate -- the premium can vary to the extent desired to correspond to the risk imposed by the employer. For example, employers of different occupations can be assessed different premiums that recognize the different risks

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Alliances or workers' compensation carriers may wish to negotiate DRG-type payments with health plans for the treatment of specific illnesses. This type of risk transfer is not large enough to put health plans at jeopardy.

of injury. Experience modifications can be assessed (as under the current system) to reward employers with safe workplaces and assess extra costs to employers with poorer safety records. Experience rating also builds incentives for employers to assist return to work (by creating light duty opportunities, etc).

The key disadvantage to occupation and experience rating is that it is administratively complex -- a separate rate must be calculated for and collected from each employer. Since the employees of each employer are spread in different health plans, the employee data must be aggregated so that the employer's experience can be assessed. Alliances could use existing workers' compensation systems to perform this function, but the costs would clearly be higher than use of a more simple funding option. Alternatively, a simple community rate could be assessed (either as a per-worker assessment or a surcharge on the employer contribution). This would be much less costly than experience rating.

The second option, a flat assessment on the wage-loss portion of the workers' compensation premium, would also be a relatively simple way to fund the work-related health risk borne by the health plans. Unlike the separate premium option, this option would not involve a separate calculation for each employer. In addition, assessments on the wage-loss portions of workers' compensation premiums would reflect the experience rates paid by employers under that system, thereby reinforcing the incentive for workplace safety.

The disadvantage of this option is that it is not very accurate and, worse yet, it appears more accurate than it really is. The relationship between the workers' compensation wage-loss and medical risks varies across industries, which means that a flat surcharge on the wage-loss premium would not be an accurate reflection of the medical risk in many instances.

The third option, simply folding the risk into health plan premiums, was discussed above. This option would be simple because there would be only one premium for each health plan. The key disadvantage is that this method of funding would shift costs from employers to workers, nonworkers and the government (through subsidies).

The transfer of risk approach could be funded in any of these ways. The accuracy associated with the using separate, occupational and experience-rated premiums would protect the plan from criticisms that employers with safe workplaces are

being forced to subsidized those with poor safety records. The community rate or simple assessment options are simpler and cheaper options, although fairness and incentives for safety would be sacrificed.

7. Employers outside of the alliance. The issue is how integration would affect employers outside of the alliance.

A number of employers, especially larger employers, self-fund their workers compensation benefits. Unlike traditional health benefits, however, these self-funded arrangements are generally subject to state laws and regulations, including regulation of financial capacity.

Both integration approaches would affect large employers that self-fund for workers' compensation benefits by requiring that work-related medical benefits be provided through health plans. [Option: if non-alliance employers are not required to offer choice of health plans to employees, the partial integration approach could waive this requirement. This would preserve employee choice of provider for workers' compensation in states that permit it.]

In the transfer of risk approach, the risk for work-related health benefits would be transferred to the health plans chosen by employees, which could be the self-funded plan sponsored by the employer. It is necessary that non-alliance employers operate under the same rules that apply in alliances so that injured workers can be assured portability of benefits if they switch employers. Unfortunately, because of the annual funding of these benefits in the transfer of risk approach, it is likely that there will be a systemic transfer of costs from non-alliance employers to the alliances of the medical costs associated with totally permanently disabled workers and partially permanently disabled workers. This transfer occurs because disabled workers who leave their jobs are (presumably) likely to get their coverage in alliances, where their health plans would become responsible for funding on-going treatment of the disability.[16]

This problem could be addressed, in part, by surcharging non-alliance employer premiums to collect an amount equal to the transfer of costs. However, the problems of identifying which

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[16]An actuary at W.M. Mercer roughly estimated that up to one third of workers' compensation medical costs are incurred by disable workers after they leave the service of the employer that "caused" the injury.

employers to assess, the amount to assess, and which health plans to distribute the funds to, is very complicated. At present, we do not have a good answer for this problem.

CONCLUSION

The transfer of risk approach has the potential to fundamentally transform the incentives for treatment of workers' compensation medical injuries and to produce large savings for employers. It also has the potential to improve medical outcomes because treatment would be moved away (somewhat) form an adversarial process to a coordinated care setting. At the same time, it is new, untried, and extremely complicated.

The partial integration approach, on the other hand, will also produce savings and is much easier to implement because it involves much less disruption of current arrangements. It also could serve as a bridge to a more ambitious integration.

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo	Chris Jennings, Steve Edelstein to Hillary Clinton Re; Metting with Senator Wellstone and Single Payer Groups (3 pages)	5/5/93	P5

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COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Acr)
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FOLDER TITLE:
May 1993 HSA [3]

gf83

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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Numbers File

To: Interested Parties
From: Rick Kronick
Re: Change in Premium as the Threshold for Alliance Participation is Reduced
Date: May 13, 1994

SUMMARY: Per capita benefits for an alliance with a firewall at 1,000 are likely to be between 4% and 7% higher than an alliance that includes all employed persons. Per capita benefits for an alliance with a firewall at 100 would probably be 7% to 12% higher than benefits in an alliance that includes all employed persons. Since the CBO estimate of the HSA implicitly assumes that all persons are in the alliance, an alliance with a firewall at 1,000 is likely to have higher premiums than the premiums estimated by CBO. The extent of increase depends, in part, on assumptions made about the behavior of families with more than one full-time worker (do they choose the regional or corporate alliance)? Further information on the magnitude of increase in premium (as opposed to per capita benefits) could follow from additional simulation work at AHCPR.

1) There is consensus that non-workers have higher per capita expenditures than do workers, and, as a result, the premium in the alliance will increase if a firewall is constructed and some workers are excluded from the community rate.

2) The question of how much the premium changes depends primarily on two factors:

estimates of the difference in per capita expenditures between workers and non-workers; and

estimates of the number of workers who are excluded from the community rate as the threshold for alliance participation declines.

3) Lewin and HCFA each estimate that per capita expenditures for non-workers are approximately twice as high as expenditures for workers and dependents. AHCPR estimates that per capita expenditures for non-workers are 53% higher than expenditures for workers and dependents. I have not been able to successfully explain the reasons for the differences in estimates. Since AHCPR conducts NMES, it makes sense to put more weight on the AHCPR estimate than the HCFA or Lewin estimates.

4) AHCPR estimates that expenditures per capita for workers and dependents in large private firms are lower than expenditures for workers in the public sector and in smaller firms. Expenditures per capita for non-workers are 66% greater than expenditures for workers and dependents in firms of 1000 and greater.

5) Estimates of how many workers and dependents are excluded from the community rate by firewalls at various thresholds are very sensitive to assumptions that are made about the behavior of workers in two worker families. With a firewall at 5,000, 35 million workers and dependents will be excluded from the community rate if 'split' families prefer the regional alliance, while 57 million will be excluded if split families prefer the corporate alliance (see attached table).[1] A firewall at 100 excludes between 100 and 125 million from the community rate, depending on assumptions about the behavior of split families. Assuming that split families follow the higher earner, HCFA and Lewin agree almost precisely on the number of workers and dependents who are excluded by firewalls from 100 to 5000.

6) The AHCPR analysis uses a hybrid assignment rule for split families: families with one worker in a company with more than 5,000 employees and one worker below 5,000 prefer the regional alliance; families with two workers below 5,000 follow the higher earner. This assignment rule should show more people being excluded from a firewall at a given size than using a 'pure' families prefer the regional alliance rule, and fewer people excluded than a 'pure' families follow the higher earner rule. Surprisingly, however, the AHCPR analysis finds fewer people excluded than HCFA estimates for the pure families prefer the regional alliance rule.[2] Given the similarity of the HCFA and Lewin results and the strange properties of the 'hybrid' assignment rule used by AHCPR, the HCFA/Lewin estimates of the magnitude of change in alliance size as firewalls are constructed should probably be taken as more reliable than the AHCPR results on alliance size.

7) AHCPR estimates that an alliance with a firewall at 5,000 would have per capita benefit payments that are 4.5% higher than an alliance including all employed persons. This estimate is similar to the HCFA estimate of 4.9% under the assumption that split families prefer the regional alliance. Averaging the AHCPR estimates for firewalls at 5,000, 1,000, and 100 and comparing these estimates with the HCFA estimates under the assumption that split families prefer the regional alliance, the AHCPR estimates are, on average, approximately 68% as large as the HCFA estimated effects.

8) Assuming that split families follow the higher earner, the HCFA and Lewin estimated effects are similar. At a firewall of 1,000, HCFA estimates a 7.6% increase in premium; Lewin estimates an 8.9% increase in premium. Assuming that the AHCPR estimate would be approximately 68% as large as the HCFA/Lewin estimates, the AHCPR estimate would be approximately a 6% increase. HCFA and Lewin estimate that a firewall at 100 would have benefit payments 15% higher than an alliance that included all employed persons. Again multiplying by 68% to get a rough approximation of a hypothetical AHCPR estimate, the hypothetical AHCPR estimate for a firewall at 100 would be approximately 10%.

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[1] This result, like all those reported here, assumes that public employees are in the regional alliance regardless of the size of the public entity.

[2] In part, this may result because HCFA has more people in total than AHCPR, but this would not appear to explain most of the difference.

9) Assuming that split families prefer the corporate alliance, HCFA estimates per capita benefit increases of 10% for a firewall at 1,000 and 19% for a firewall at 100. Multiplying by .68, the hypothetical AHCPR estimates under the assumption that split families prefer the corporate alliance would be 7% for the firewall at 1,000 and 12% for the firewall at 100.

10) The behavior of split families will be influenced by the availability of subsidies, particularly on the 20% share. Under many of the subsidy proposals being considered, it seems reasonable to assume that split families would either follow the higher earner (whose employment is presumably more stable), or, even more likely, prefer the corporate alliance, where the premiums should be lower and the perception of quality may be higher.

11) If further analysis is desired, it would make sense to ask AHCPR to:

> Estimate per capita benefits under the three assumptions concerning the behavior of split families (prefer regional alliance, follow higher earner, prefer corporate alliance);
>
> estimate not just per capita benefits, but also premiums per policy type (single, single parent family, etc.); and
>
> estimate the effects of premium changes on federal subsidies under one or more of the models of most interest.

Summary of Estimates of Change in Per Capita Benefits As the Alliance Threshold Changes

	Firewall at 5,000 compared to all persons in the community rate	Firewall at 1,000 compared to all persons in the community rate	Firewall at 100 compared to all persons in the community rate
HCFA -- Split families prefer regional alliance	2.4%	4.9%	11.0%
AHCPR -- Split families follow hybrid rule[1]	1.0%	4.5%	7.0%
HCFA -- Split families follow higher earner	4.3%	7.6%	15.3%
Lewin -- Split families follow current coverage	6.7%	8.9%	15.6%
HCFA -- Split families prefer corporate alliance	5.8%	9.7%	19.1%

[1] Families with one worker in a company with more than 5,000 employees and one worker below 5,000 follow the worker below 5,000; families with two workers below 5,000 follow the higher earner.

Estimates of Change in Number of people in the Alliance as the Threshold Changes Relative to the Number of People in an Alliance that Includes all Workers

	Firewall at 5,000	Firewall at 1,000	Firewall at 500	Firewall at 100
HCFA -- Split families prefer regional alliance	34.7 million	59.3 million	70.1 million	100.3 million
AHCPR -- Split families follow hybrid rule[1]	29.3	51		82.7
HCFA -- Split families follow higher earner	47.7	73.9	85.1	114
Lewin -- Split families follow current coverage	45.2	79	89	115.8
HCFA -- Split families prefer corporate alliance	57.3	84.2	96.2	124.6

[1] Families with one worker in a company with more than 5,000 employees and one worker below 5,000 follow the worker below 5,000; families with two workers below 5,000 follow the higher earner.