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Research Agenda Brief

January 1994

Can Private Health Plans Achieve the Cost Containment Targets of Market Reform?

A Review of Risk Issues

Based on discussion by a work group including:

George Barry, FSA
John Cookson, FSA
Guy King, FSA, MAAA
Alice Rosenblatt, FSA
Barbara Schiel, FSA
Gordon Trapnell, FSA

and Lynn Etheredge, Consultant

Prepared by *Stanley B. Jones,* during development of a new George Washington University project on health reform, with funding from the Robert Wood Johnson Foundation.

The George Washington University
WASHINGTON DC

INTRODUCTION

A key objective of "market reform" approaches to health care reform is a health insurance market which encourages aggressive pricing among competing health plans, to the end of containing future increases in health insurance premiums.

Another key objective of health care reform is to extend health insurance coverage to the entire population, including individuals and employers who will need subsidies. The costs of such subsidies come largely from the "savings" achieved by health plans' containing future premium increases.

The proposals raise the question, "How much 'savings' or cost containment can health plans achieve, and how fast?" The Clinton proposal sets caps on annual premium increases that are intended to achieve needed savings over five years. Other proposals set targets without caps (Cooper) or set targets but phase in universal coverage only if savings are achieved (Chaffee, Dole).

A question behind the question of "How much how fast?" is "What is the capacity of the health insurance/health plan industry to adapt to the new market and contain insurance premium increases?" A key determinant will be whether health plans can estimate future costs in the reformed market with enough certainty to allow aggressive (low) premium setting. A related determinant is how plans can establish reserves needed for aggressive pricing, given greater uncertainty and risk.

To review these risk-related questions, a work group of actuaries met on January 5 and 6, 1994, to assess how the Clinton market reform proposal—as a proxy for all the market reform proposals, because it demands the most of the health plans—affects uncertainty and risk and how it might be constructively modified or implemented to give plans a better chance of meeting its targets. Specifically, the meeting's goals were:

- To describe the key provisions of the Clinton proposal that influence levels of uncertainty in estimating future costs (see page 3 and Appendix A).
- To sketch out changes in market reform proposals that would reduce uncertainty and risk or strengthen insurers' capacity to bid aggressively in spite of higher uncertainty and risk (see page 9).
- To describe short-term research that would further clarify these issues (see page 11).

The meeting was funded by the Robert Wood Johnson Foundation, under the direction of Stanley B. Jones. The following observations and suggestions do not reflect a formal consensus of the participants.

KEY PROVISIONS OF THE CLINTON PROPOSAL MOST LIKELY TO INFLUENCE THE ESTIMATION OF FUTURE CLAIMS COSTS AND INCREASE PREMIUMS

The primary source of "risk" in insurance is uncertainty in estimating the claims costs for enrollees some 6 months before the contract period begins and some 18 months before the contract period ends. In market reform proposals, the health plan in fact sets its premium before the open season when its enrollment pool is determined. Claims costs are by far the largest part of the health plans' premiums. If health plans' uncertainty about future claims costs increase, they must either increase their premium estimates to cover the possibility of costs higher than they estimate, or they must set aside a portion of their financial reserves to cover these costs should they occur. Financial reserves are a measure of health plans' capacity to bid aggressively (i.e., low) for business in the face of uncertainty. As uncertainty increases, the plan must set higher premiums or have access to higher reserves.

In addition to these risk reserves, a plan must maintain reserves to cover its incurred but not received claims. Because of administrative lags and other factors, claims come into fee-for-service plans many months after the end of the year for which premiums are paid. These liabilities of the plan are the primary reason state insurance commissioners require plans to maintain reserves large enough to cover one or more months of claims for all of their insured business.

Market reform proposals increase uncertainty. This leads to increases in premiums or to use of reserves in the near term—and increases in premium to make them up in the longer term. While this is of course contrary to the cost containment goals of market reform, it is a transitional problem.

The first two to three years of the new market created by the Clinton market reform proposal are the time of greatest uncertainty for health plans. As the effects of the changes in the insurance and health care market settle in, estimation of future claims costs with higher degrees of certainty should become easier. It comes down to how to develop the data and gain the experience needed to estimate future claims costs based on experience in the new environment.

Many provisions were cited as contributing to uncertainty. Those cited as creating the most uncertainty include (not in priority order):

NEW INSURED POPULATIONS

■ Health plans at risk for costs of everyone who enrolls with them

Many insurers today, especially those who sell coverage to large employers, carry the risk for only a small portion of their enrollees. Large employers usually self-insure. Employers of as few as 100 often self-insure to some degree.

The new system puts the insurer at risk for all enrollees. This increases the total financial risk the insurer must be prepared to take for all of the uncertainties listed below.

■ One health plan rate for everyone who enrolls from the alliance area

Health plans at present are basing estimates of future claims costs on data from only the employer groups and individuals they currently insure in an area.

This rating pool is not necessarily satisfactory as a basis for estimating the claims of the group of employees/individuals who will enroll with their plan when it is offered to everyone in the area during an open season. Plans will vary greatly as to how large and how representative their current "rating pools" are relative to the populations of the areas they serve.

■ Requirement for health plans to include Medicaid, CHAMPUS, VA, American Indian, previously uninsured populations, and some Medicare eligibles

Health plans do not have data in their rating pools on these 60 million people who are now uninsured in the private sector. Nor are other actuarially useful data (e.g., their prior utilization, age and sex characteristics, and areas of residence) readily available.

■ Elimination of preexisting condition clauses and other medical underwriting practices

Health plans' current rating pools will reflect the effects of these practices in the present market. How the elimination of these practices will influence future claims costs is uncertain.

NEW BENEFITS

The greatest uncertainty regarding benefits in the proposal is with regard to mental health benefits. The uncertainty is increased by the eligibility under the proposal of residents of government mental hospitals, institutions for the retarded, and residential substance abuse centers.

NEW PROVIDER RELATIONS

■ Required payment by all-payer fee schedule

Many health plans pay by fee schedules that differ in amounts and types of fees from what will be negotiated by the alliance. Shifting to the alliance's fee schedule is likely to produce different claims costs.

■ Changes in provider practice patterns in the new market

Many health plan rating factors are likely to prove unreliable in the new market. For example, factors for anticipating provider service volume increases to offset price cuts and provider willingness to shift the cost of discounts to other plans are likely to change, given revenue pressure on providers from "direct billing" and no "balance billing" requirements, reduced opportunities for cost shifting to private payers, further cuts in Medicare payments, rising pressure from HMOs and managed care systems for competitive prices, and the proposal's requirement that providers absorb the losses from lower cost sharing for AFDC eligibles.

Health plans will be at risk for the estimates of this type of increase they include in their rates. As government sets fee schedules and orders reduced fees by health plans that exceed the premium cap, plans will also be at risk for the government's estimate of this volume increase.

■ Changes to provider networks, e.g., required use of centers of excellence and essential community providers

Health plans whose rating pools do not include use of these providers in the ways specified and use of the payment arrangements laid out in the proposal will not be confident of volumes of service and ultimate claims costs in these institutions.

GOVERNMENT-SPECIFIED PRICING LIMITS AND ASSUMPTIONS

■ Overly tight government limits on premiums

Premium caps or targets are not necessarily inconsistent with aggressive competitive bidding in this market environment. The question is whether the caps or targets (*a*) are high enough to give plans room to quote premiums that will cover their uncertainty and (*b*) permit year-to-year premium increases high enough to allow plans to bid aggressively.

The work group could not resolve the question of whether the caps are high enough. However, the year-to-year premium increases permitted by the Clinton plan seem too rigid and rapid.

If insurers are to bid aggressively in the face of uncertainty, they must be able to adjust future premiums, within the constraints of the competitive market, to recover reserves lost if their bids prove too low. Rigid limits increase the risk of aggressive bidding in the early years.

The relatively rapid movement to impose tighter annual premium caps and phase in populations and benefits also increases risk, because of the "data-lag" problem. Plans must bid for the second year's business under market reform proposals with less than six months experience and less than three months claims data on their first year's bids. By the time health plans have the complete data from their first year under the new system and can make a final evaluation of their rating assumptions, they will already have had to commit to the third-year premium, which is capped more tightly than the first year's. This data lag makes for a slow learning curve that increases risk associated with rapid change.

■ "Blended rate" approach to paying for the Medicaid population

The adequacy of the "blended rate" to cover the claims costs of combined Medicaid and private enrollees hinges on new fees to providers negotiated to reflect their previously differing fees from these two sources.

Fee-for-service health plans are dependent on the alliance to negotiate fee schedules for providers in the area that accomplish this sensitive blend. Health plans that pay by other than fee schedules must negotiate a similar blend. Health plans are at risk for higher costs of claims if either the alliance or they do this difficult task poorly.

■ Factors under control of the alliance or the government for which a health plan is at risk

Under the proposal, a health plan is obliged either to use a number of government-generated data or rating factors or to live under caps based on these factors. It is also dependent on government or the alliance for the timeliness of these factors and data. In most of these cases, the health plan, not the government or the alliance, is at risk for losses if the data or assumptions are wrong. This increases uncertainty. These items include:

- Alliance revenue shortfalls.
- Data provided by an alliance on demographics of its area.
- Alliance-negotiated fee schedules that produce higher claims costs for plans than a blended Medicaid/plan premium can cover.
- Alliance factor for converting per-capita premium bids into single, couple, single parent and children, or two parents and children bids.
- Government wrongly estimates the costs of new benefits as they are added and raises alliance premium targets inadequately to cover them.
- Government or alliance failure to issue data and regulations in place before health plan bids must be developed.

- Legal challenges to government law/ regulations or alliance actions that force payment of claims considered non-covered.
- Government sets unrealistically low caps on alliance or plans based on poor data or analytics.

NEW INSURANCE MARKET VOLATILITY

■ High annual open enrollment shifts during open season resulting from changes in available plans, early plans' failures, movement of VA and CHAMPUS eligibles to private plans, and inclusion of early retirees

Health plans can count on relatively limited changes in year-to-year enrollment in the current multiple-choice systems. In the new system, especially in the early years, many individuals will be changing plans during open season, potentially changing the plans' risk pools substantially through risk selection. This high volume results from the different mix of plans that are certified to offer choices in the first few years of implementation; the wider choice of plans available to individuals; the collapse of mismanaged or unlucky plans in the early years; the large number of individuals previously uninsured in the private sector who will be picking a private plan; and individuals who have choice or private insurance for the first time switching often until they learn what suits them.

This "churning" of enrollees in early years greatly increases the uncertainty attendant to risk selection, which is only partially ameliorated by the proposal.

■ Irresponsible pricing and gaming by competitors

Health plans jockeying for competitive advantage in the first and subsequent years of the new system may well set prices that are not reasonable based on risk. For example, they may push their premium above the premium target for the area in the first year in the hope that enough individuals will enroll in cheaper plans to produce an average weighted premium under the target. Or they may quote premiums that are unrealistically low or bite off more enrollees than they can responsibly insure because of the attraction of market share in these early years. Some may gamble that the government will relent on its caps and in some way prevent plans, especially large ones, from going under.

These practices are likely to produce a large number of insolvencies in the early years of the plan, especially when combined with bad luck and bad rating. The financial results of these activities seem to come back on the other plans in the area through assessments for the guarantee fund or lower caps in future years. Health plans can not foresee the amount of these costs. These provisions put all insurers at risk together for each others' behavior.

■ Changes or savings in insurer/plan administrative costs

Insurers should realize administrative savings in the areas of premium collection, underwriting, fee schedule negotiation, and perhaps marketing. They should see increases in costs in some aspects of managed care administration and computer systems updates and changes to meet new requirements. How these will offset each other for rating purposes is uncertain.

KEY PROVISIONS OF THE CLINTON PROPOSAL INTENDED TO SIMPLIFY THE ESTIMATION OF FUTURE CLAIMS COSTS

■ **All-payer fee schedules negotiated by the alliance**

After the initial years, knowing the rate of increase in future-year provider fees set by the alliance will somewhat decrease the uncertainty of fee-for-service health plans.

■ **Passing on mandatory premium reductions to providers**

By requiring plans who exceed their premium caps to pass premium cuts back to providers in the form of reductions in fees or other payments, the Clinton proposal passes cost cuts in this situation to the provider. It does not reduce the insurer's risk, however, since the original insurer premium bid, which included risk, is reduced proportionate to the reduction in fees. Essentially, the risk that claims costs will exceed premium income after the cut remains the same as before. The insurer in fact carries the additional risk that the government will not cut fees enough to offset cuts in premiums.

■ **Adjustment for and control of risk selection**

These provisions are all to the good, but should not be thought to eliminate all selection risk. Health plans will and must rate for the population they believe they will enroll during the open season, taking into account as best they can the value of proposed risk adjusters or constraints on risk selection as these become known and demonstrated.

■ **State reinsurance pools**

The possibility of sharing among competing health plans the costs of difficult-to-rate populations, or populations who could become a cause of risk selection, could help reduce risk, especially during the transitional years. See research suggestion below.

HOW COULD INCREASED RISK UNDERMINE THE OBJECTIVES OF REFORM?

Unless corrected for by measures such as those described below, the increased risks resulting from the above provisions are likely to create health plan actions during the transition period that are contrary to the cost containment objectives of market reform.

Some sources of uncertainty affect all companies, e.g., the addition of over 60 million new insureds to the private insurance roles, limits on plans' ability to increase premiums, and a lack of adequate data for future claims estimation for the plans' enrollees. Other sources of uncertainty affect different plans in different ways. The possible responses include the following:

■ Plans could set premiums as high as possible (i.e., up against the cap) in the early years to preserve their reserves and cover as much as possible of the greater uncertainties and risk they face. The present structure of the caps encourages this tactic, because from the second through fifth years the plan is limited to a progressively smaller increase over the amount it bids in the first year. Consequently, if the plan bids too low by underestimating the risk (or because of greed), it will not be able to bid higher premiums to make up the reserves it loses for many years.

■ Plans with reserves lower than needed to carry outside estimates of risk will also have to bid high or set limits on how many people it will enroll as permitted by the proposal. Since many plans may come out of our current era of "self-insurance" with low reserves, an alliance may find it is offered fewer enrollment slots than it needs to offer real choices to its population.

■ Plans with high reserves from the "old" market, not necessarily gained by competing according to the enlightened rules of the "new" market, may take the opportunity to buy market share by bidding low. These may not be the most desirable competitors.

■ Plans will make mistakes and become insolvent in this high-risk situation, because there will be too little room under the proposed caps for making mistakes and recovering as part of the transition process until actuaries can develop data and techniques for rating in the new system and until the system stabilizes somewhat. Inexperienced new risk carriers such as physician hospital organizations and other provider-based plans are likely to be especially at risk because of their lack of risk management experience.

■ Some health plans may resort to unconstructive means to survive in a market where they are handicapped by low reserves or poor rating tools. They may invest extensively in hedging their bets through creative risk selection beyond what the law and alliance can police. They may attempt to capture control of the alliance (or Congress) politically. Large plans may spend their reserves to finance low premiums to expand market share to the point where they believe the alliance will not be able to reject them without angering too many subscribers or destabilizing the system. They may assume at worst they can survive for decades as a fee-for-service payer with rates decreed by the National Board.

■ The worst consequence of the increased risk levels would be a "system collapse" in an alliance where one or more very large plans are obliged to leave the market, requiring their many enrollees to move to other plans in a single open season. These other plans also may well withdraw or limit their enrollment tightly, because they can not increase their premiums adequately to cover the added risk.

CHANGES IN MARKET REFORM PROPOSALS THAT WOULD REDUCE UNCERTAINTY AND STRENGTHEN INSURERS' CAPACITY TO BID AGGRESSIVELY

If the nation is serious about building a reformed health system, built around competition among private-sector health plans, it can take steps to reduce the risks involved in this transition. The following are several suggestions from members of the actuarial group.

■ **Modify premium caps or targets.**

Caps need to make clear to all of the health care and health insurance industry that major reform is unavoidable. However, they also need to give the best in the industry incentives and opportunity to perform at their best toward the goals of the reform. Several possible changes in the premium targets would help critically to these ends:

(*a*) Set year two and later premium targets for health plans based on the same weighted average per-capita premium approach used in the first year, rather than tying plans to their first-year bids.

(*b*) Or, eliminate the plan-specific premium targets, but enforce the alliance target.

(*c*) Or, eliminate the annual premium target for each plan and alliance in favor of a five-year "performance standard," i.e., leave the plans and alliances room to achieve their "savings" in whatever years the plans' maturity, reserves, market position, and other transitional problems permit. This five- year target might include:

- A "glide path" with a high and a low boundary within which the plan must remain over the five years and regular reports to the plan and alliance on where it stands.
- A three-year check point at which the alliance has authority to review both the plan's performance in detail and the likelihood of its achieving the target, and to reject its bid on these grounds.

(*d*) Or, stretch out the time frame within which alliances and the industry must meet the targets to more than five years. This would be especially important in areas where the health plans and health care system have a past record for achieving cost containment, i.e., where the easy savings may be gone.

■ **Give the alliance more tools:** within any of the above premium target arrangements, allow the alliance to use tools similar to those used by large employers to achieve targets, e.g., allow them:

- As in the current proposal, to eject plans over 120% of average per-capita premium.
- To prohibit new enrollees to plans with premiums, say, 110%, above the average per-capita premium.
- To limit numbers of new enrollees in high-premium plans that are pushing the weighted per-capita premium over alliance targets.
- To require plans over 110% of average per-capita premium to increase deductibles in order to bring the premium rate down to a level that will allow the alliance to meet its average weighted premium. (Research shows consumers understand best of all the meaning of deductibles.) The increase would allow the plans' enrollees to pay more for the

privilege of staying or leave for other lower premium/lower cost-sharing plans.

■ **Sunset the premium targets for the plans that perform and survive the five years, so plans have something to work for.** Otherwise, they will feel whatever gains they manage to make the government will take away.

■ **Federal or state government, as appropriate, could organize and provide actuarially useful data on new populations to be insured by health plans so that estimates of future claims costs can be made with greater certainty.**

Data on Medicaid, CHAMPUS, VA, American Indian, early retirees, and the previously uninsured would include past health care utilization and payment levels for the area; age, sex, family composition; geographic area of residence; and service within the alliance.

With regard to the presently uninsured, government could assemble existing relevant data and produce actuarial guidelines for use by plans. Such data could reduce uncertainty, premium levels, and reserves requirements on plans in the early years.

■ **Rating requirements for health plans could be amended to:**

(*a*) Clarify Sec. 1341(a)(1) so as to make clear each health plan will quote one rate for all who enroll but can base its rate not on what it would be if it enrolled all eligibles in the alliance, but on what subset of the alliance population it believes is likely to enroll.

(*b*) Audit health plans' rates that fall above or below a credible corridor (e.g., more than 120% and less than 80% of the average weighted premium) for possible risk selection or irresponsible rating. (Remember, this system puts all insurers at risk together for the improprieties and greed of some.) Alternatively, require plans to file actuarial certification of their premium.

■ **Phase in or delay implementation of difficult to rate new benefits.** Mental health coverages are by far the most difficult and uncertain.

■ **Establish reasonable risk sharing by government and alliance:**

(*a*) For factors over which government or an alliance has control but for which a health plan bears the risk, such as those listed above.

(*b*) And for situations where an alliance can achieve an acceptable level of competition, coverage of all areas of the alliance, or the overall premium targets only by sharing in the risks of undercapitalized plans.

Both of the above should be structured on a cost-sharing basis, e.g., the plan pays a flat initial amount of the overage plus a percentage of the remainder.

Both might be implemented by allowing the plan to pay back a portion of its share over several future years if it and the alliance agree.

Both might also be implemented by allowing a plan to exceed its target or performance standard in the event (*a*) or (*b*) above is involved.

■ **Allow insurers to establish systems for sharing or distributing risk and costs of unratable factors among insurers in the early years.** The "reinsurance pool" of the Clinton plan might be used for such purposes as suggested in the research proposals below.

SHORT-TERM RESEARCH THAT WOULD FURTHER CLARIFY THESE ISSUES

- What is the capital status (reserves) of the health insurance industry in the United States, and what is it likely to be at the time the new system is put in place? Will the capital be adequate and appropriately distributed to support the increase in risks proposed for the industry? For aggressive bidding? For providing a range of choices to all enrollees? This is an empirical study and could be accomplished to determine whether coverages or eligibility for alliances need to be phased in order for the industry to build up reserves.

- Assess what actuarially useful data can be collected and made available on a crash basis to insurers on new populations for the first-year bids of the new system.

- What amount of "wiggle room" is needed in year-to-year rating to reasonably accommodate the uncertainties in the new system until the system settles into place and trends become more stable.

- Model different types of caps (year-to-year, five-year cumulative with "glide path," no plan cap with stronger alliance) on health plan competitive strategies to test which provokes the strongest and most desirable insurer market behavior while not destroying the capital and risk-bearing capacity of the industry.

- Test various levels of starting baselines for caps and caps over a five-year period to determine effects on above models of types of caps.

- What kind of interplan pooling mechanisms might be workable and encouraged or allowed under the law?

- Assessment of what difficult-to-rate populations, as well as high-cost diagnoses, etc., might be put in the "reinsurance pool." For example, might residents of state mental hospitals be included?

- Study what other large buyers (employers) have done in the past in situations where health plans were asked to take large risks and make substantial changes in their product and rating. What risk-sharing techniques did these insurers enter into with plans? What steps have employers taken to conserve costs among competing plans? Which of these might be allowed to the alliance or converted into state or federal risk-sharing schemes?

Appendix A:

KEY PROVISIONS OF CLINTON HEALTH REFORM PROPOSAL THAT ARE PARTICULARLY RELEVANT TO ESTIMATING FUTURE CLAIMS COSTS FOR A HEALTH PLAN COMPETING IN A CLINTON PLAN HEALTH ALLIANCE

Stanley B. Jones

GOAL OF PROPOSAL

The goal of the Clinton approach to purchasing health insurance is to achieve universal and comprehensive coverage while encouraging health plans to compete with one another for enrollees by containing future increases in the costs of health care (and their plan premiums). The proposal presumes that, to be successful, health plans will move as rapidly as possible to more tightly managed care/vertically integrated HMOs and that individuals over time will gravitate to these plans because of their price and cost-sharing advantages.

In the Clinton system, the health alliance serves as the sole health insurance purchasing agent for most (about 80%) of the employees and individuals in its geographic area (as many as one million people). The alliance collects all premium contributions from employers and individuals, contracts with health plans certified by states, and pays the total premium to the health plans for individuals and families who enroll with each plan. Plans compete for enrollees in annual open seasons.

NEW MARKET ENVIRONMENT

Following is a summary description of this new market environment and what the health plan must do to enter it.

The Buyers

- One "alliance" in each geographic area will contract with at least one "fee-for-service plan" and two or more managed care plans to offer the standard benefits to individuals.

- All individuals in the alliance, except undocumented aliens, are mandated to enroll and pay usually 20% of the plan's premium, as follows:

  - Employees of all firms of less than 5,000 employees.
  - Employees of larger firms who elect not to exercise their one-time option to set up their own corporate plan when the new law is enacted.
  - Employees of larger firms who decide to close down their corporate plan at some point in the future and enroll their employees in the alliance.
  - Early retirees (age 55-65 and ineligible for Medicare).
  - AFDC and SSI individuals in the area.
  - Federal, state, and local employees (feds start in 1998).
  - Any other individuals who are not undocumented aliens. For example, residents of mental hospitals, institutions for the mentally retarded, prisoners, homeless

persons, and others will all be eligible for benefits. If other federal, state, or local government programs are currently covering the costs of covered services to these populations, they are likely to fold them into alliance health plans.

- Individuals who do not enroll will be offered choice when they seek care or will be randomly assigned to a plan.

■ Other individuals are given the choice of enrolling.

(*a*) CHAMPUS, VA, and American Indian eligibles may choose the alliance over their government-sponsored plans.

(*b*) Individuals who become eligible for Medicare after the law is passed may choose to continue their private coverage by paying the difference between its premium (adjusted for age) and 95% of Medicare's AAPCC for the alliance.

■ Individuals must include their dependents (husband and wife and other dependents must be in the same plan) in their health plan. Dependents are as defined in state law, including foster and adopted children, unmarried disabled children who were disabled before age 21, children attending college, grandchildren when the parent is also claimed as a dependent of the grandparent.

■ Employers are not "buyers." They do not select among plans. They are mandated to pay the alliance on behalf of their employees a portion (usually 80%) of the average weighted premium for all eligible enrollees in all plans in the area for each class of enrollment (single, single-parent family, couple, two-parent family).

INSURANCE PRODUCTS THAT CAN BE OFFERED BY HEALTH PLANS

Benefits (See Appendix B: Table of Copayments and Coinsurance from S. 1757))

■ Standard benefits to be offered by all plans will be comparable to Fortune 500 packages, but richer in the area of mental health.

■ Certified plans can not add to or subtract from the standard benefits (beyond those few specifically designated as "discretionary" mental health services).

■ A "cost-sharing" supplemental policy to fill in all but copayments must be offered by all alliance plans to enrollees during open season.

■ In addition to standard benefits, state government and/or the alliance can direct or financially encourage one or more health plans to provide access to services of "centers of excellence," services to underserved areas, and special health related services needed by special populations.

■ "Professional services" include the services of physicians or of other professionals certified by the state to perform a service otherwise performed by a physician.

Types of health plan that can be offered

■ Fee-for-service plan paying all providers.

This plan pays *all* providers in the alliance area (no provider panels or gatekeepers) using standard fee schedules negotiated by the alliance. The plan can use utilization review, precertification, length-of-stay monitoring, and negotiated discounts from the alliance fee schedule. The "high cost sharing" package is assumed to be associated with the fee-for-service plans, but not mandated to be.

■ Managed care plans/HMOs with a point of service option:

This plan selects and organizes panels of providers with discounts from negotiated fee schedules, capitation, global fees, salaries, incentive arrangements, or other payment devices. The "low cost sharing" benefit package described is assumed to be the

choice of managed care and HMO plans, but is not mandated.

These managed care and HMO plans must also offer subscribers a point-of-service option that permits them to choose any provider in the area, with a higher premium and coinsurance (Sec. 1402[d]). This may be by contract with another vendor.

DESIGN FEATURES OF ALL TYPES OF PLANS

■ Contract with providers such that the providers "direct bill" the health plans first and do not "balance bill" patients beyond cost sharing specified in the standard benefits package. Any and all fee-for-service payments (including for emergency and non-network services) must be based on:

- fee schedules negotiated annually by the alliance for use by all plans, presumably lower than past fees to take account of blended Medicaid and private plan premiums;
- voluntary discounts from the alliance fee schedule given the plan by its providers; or
- mandatory discounts from the fee schedule ordered by National Board if the alliance and/or plan is out of compliance with the premium cap.

■ Pay for out-of-area services according to the fee schedule negotiated by the alliance in that area.

■ Include in their network and pay certain special providers as required.

(*a*) All must include "essential community providers" designated by the Secretary of HHS (e.g., Community Health Centers) and pay either the alliance fee schedule or Medicare rates—using no gatekeeper review.

(*b*) A state can order some plans to include services at "centers of excellence."

(*c*) An alliance can negotiate with some plans to offer services in hard-to-serve areas or offer special services to hard-to-serve populations.

■ Include in contracts with providers agreement to comply with premium cap enforcement requirements, under which health plans must implement pro rata reductions in fees/payments to providers when the National Health Board orders them for a forthcoming year in order to meet premium caps for the alliance or plan (Sec. 6012[a]).

When the average per-capita premium cost for an upcoming year, based on projections of likely enrollment for each plan, is *predicted* (each plan must submit an estimate of the number of enrollees it will capture along with its premium bid) to exceed the cap on total premiums for the alliance for the year, the National Board can first give plans a chance to negotiate lower rates and voluntarily reduce premiums. Failing that, it can order a pro rata reduction in payments to providers (including an increase for likely increased volume, to achieve a lower premium. If the cap is exceeded based on actual enrollment after open season, it is made up for by a downward adjustment in the succeeding two years' caps.

The premium caps allow the alliance as a whole annual weighted average increases in the amount of the CPI increase, plus costs reflecting alliance demographic and socioeconomic changes, plus 1.5% in 1996, 1.0% in 1997, .5% in 1998, 0% in 1999, and as recommended by the National Board and enacted by Congress thereafter (Sec. 6001[a]-[3]). An alliance's premium target/cap may or may not be made known to plans before bidding.

In the first year after implementation of the law, if the alliance exceeds its weighted average premium target for all plans, individual plans' premiums that exceed the target are restricted to the amounts that will reduce the weighted average premium to

the target. For the second through fifth years, however, the individual plan's premium can not increase over its first-year premium by more than the dollar amount of the increase in the alliance weighted average premium cap (Sec. 6011[d]).

■ Supplemental insurance can be marketed and priced completely separately, but must meet tight regulatory standards.

WHAT PLANS WILL BE COMPETING IN OPEN SEASONS FOR AN ALLIANCE'S EMPLOYEES?

■ At least one fee-for-service plan, but as many as meet state certification requirements will compete.

■ The alliance will seek to offer at least two managed care plans/HMOs, but will offer as many as meet state certification requirements.

■ Plans may be organized by insurers, providers, or any other agency that can meet certification requirements. The alliance can help providers organize to offer managed care plans.

WHAT ELSE MUST A HEALTH PLAN DO TO WIN AN ALLIANCE CONTRACT?

■ Bid one 12-month per-capita premium for the standard benefits to be offered to all enrollees throughout the alliance area, adjusted by a standard factor developed by the alliance for individual, couple, single-parent family, and two-parent family enrollment.

■ Submit a premium bid in the summer of the year preceding the national annual November open season; the bid must be based on data and factors made available by the alliance in April. If the bid is more than 20% above the weighted average premium bid in the area, the alliance manager can reject it. Otherwise he/she must accept it.

The provisions are ambiguous, but the bill may require the per-capita bid to represent what the plan's premium would be if all eligible individuals in the alliance were to enroll in the plan (Sec. 1341[a][1]).

■ Carry risk for all enrollees; self-insurance is illegal for an alliance and its employers.

■ Market to all eligible individuals in the area and accept all applicants and their families (all family members will be in the same health plan) without medical screening, preexisting condition clauses, or nonstandard limitations, exclusions, etc.—except that the plan may limit its enrollment if it can demonstrate it needs to do so because of limits in capacity to deliver services or to maintain financial stability (Sec. 1402[a][2]). In case of oversubscription, former enrollees have priority and the rest are randomly assigned by the alliance.

■ Accept per-capita premium payments only from the alliance (it will collect all premiums from employers, employees, individuals) adjusted to take account of:

- The number of employer contributors (i.e., the number of full-time workers) per family unit in the alliance;
- AFDC and SSI per-capita costs and percentage of population for the alliance area (the same Medicaid/private ratio will be used to construct a "blended Medicaid/plan premium for all plans);
- Risk selection between plans, (using a standard nationally developed algorithm) (Sec. 1541).

■ Pay into state-established reinsurance funds that pool the costs of specified classes of high-cost enrollees or specified high-cost treatments or diagnoses (Sec. 1541[c]).

■ Cooperate with laws regulating marketing and provider panel recruitment aimed at limiting discrimination among subscribers and providers based on anticipated need for health care.

■ Provide information on costs, utilization review and quality assurance protocols, and providers.

■ Pay providers according to its established payment procedures for health services financed by *workers compensation* or automobile insurance for its subscribers.

■ Meet capital/reserve requirements.

States will continue to set standards.

Minimum standards will be established by the National Health Board based on plan characteristics (Sec. 1551).

(3) shall require payment of a copayment in accordance with the lower cost sharing schedule described in section 1132.

(c) OUT-OF-NETWORK ITEMS AND SERVICES.—With respect to an out-of-network item or service (as defined in section 1402(f)(2)), the combination cost sharing schedule that is offered by a health plan—

(1) shall require an individual and a family to incur expenses before the plan provides benefits for the item or service in accordance with the deductibles under the higher cost sharing schedule described in section 1133;

(2) shall prohibit payment of any copayment; and

(3) shall require payment of coinsurance in accordance with such schedule.

SEC. 1135. TABLE OF COPAYMENTS AND COINSURANCE.

(a) IN GENERAL.—The following table specifies, for different items and services, the copayments and coinsurance referred to in sections 1132 and 1133:

Copayments and Coinsurance for Items and Services

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Inpatient hospital services	1111	No copayment	20 percent of applicable payment rate
Outpatient hospital services ...	1111	$10 per visit	20 percent of applicable payment rate

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Hospital emergency room services	1111	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Services of health professionals	1112	$10 per visit	20 percent of applicable payment rate
Emergency services other than hospital emergency room services	1113	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Ambulatory medical and surgical services	1113	$10 per visit	20 percent of applicable payment rate
Clinical preventive services	1114	No copayment	No coinsurance
Inpatient and residential mental illness and substance abuse treatment	1115	No copayment	20 percent of applicable payment rate
Intensive nonresidential mental illness and substance abuse treatment (except treatment provided pursuant to section 1115(d)(2)(C)(ii))	1115	No copayment	20 percent of applicable payment rate
Intensive nonresidential mental illness and substance abuse treatment provided pursuant to section 1115(d)(2)(C)(ii)	1115	$25 per visit	50 percent of applicable payment rate
Outpatient mental illness and substance abuse treatment (except psychotherapy, collateral services, and case management)	1115	$10 per visit	20 percent of applicable payment rate
Outpatient psychotherapy and collateral services	1115	$25 per visit until January 1, 2001, and $10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Case management	1115	No copayment	No coinsurance
Family planning and services for pregnant women (except clinician visits and associated services related to prenatal care and 1 post-partum visit)	1116	$10 per visit	20 percent of applicable payment rate
Clinician visits and associated services related to prenatal care and 1 post-partum visit	1116	No copayment	No coinsurance
Hospice care	1117	No copayment	20 percent of applicable payment rate
Home health care	1118	No copayment	20 percent of applicable payment rate
Extended care services	1119	No copayment	20 percent of applicable payment rate
Ambulance services	1120	No copayment	20 percent of applicable payment rate
Outpatient laboratory, radiology, and diagnostic services	1121	No copayment	20 percent of applicable payment rate
Outpatient prescription drugs and biologicals	1122	$5 per prescription	20 percent of applicable payment rate
Outpatient rehabilitation services	1123	$10 per visit	20 percent of applicable payment rate
Durable medical equipment and prosthetic and orthotic devices	1124	No copayment	20 percent of applicable payment rate
Vision care	1125	$10 per visit (No additional charge for 1 set of necessary eyeglasses for an individual less than 18 years of age)	20 percent of applicable payment rate
Dental care (except space maintenance procedures and intereceptive orthodontic treatment)	1126	$10 per visit	20 percent of applicable payment rate
Space maintenance procedures and interceptive orthodontic treatment	1126	$20 per visit	40 percent of applicable payment rate

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Health education classes	1127	All cost sharing rules determined by plans	All cost sharing rules determined by plans
Investigational treatment for life-threatening condition ...	1128	All cost sharing rules determined by plans	All cost sharing rules determined by plans

(b) APPLICABLE PAYMENT RATE.—For purposes of this section, the term "applicable payment rate", when used with respect to an item or service, means the applicable payment rate for the item or service established under section 1322(c).

SEC. 1136. INDEXING DOLLAR AMOUNTS RELATING TO COST SHARING.

(a) IN GENERAL.—Any deductible, copayment, out-of-pocket limit on cost sharing, or other amount expressed in dollars in this subtitle for items or services provided in a year after 1994 shall be such amount increased by the percentage specified in subsection (b) for the year.

(b) PERCENTAGE.—The percentage specified in this subsection for a year is equal to the product of the factors described in subsection (d) for the year and for each previous year after 1994, minus 1.

(c) ROUNDING.—Any increase (or decrease) under subsection (a) shall be rounded, in the case of an amount specified in this subtitle of—

JAN

President William Jefferson Clinton
Health Care Meeting Talking Points
January 3, 1994

- 1994 will be the year when we finally meet this nation's promise and guarantee every American health security.
- Make no mistake about it: this Administration is committed to working with Congress to pass the Health Security Act before this Congress goes home.
- To accomplish this goal, we've added to our already strong health care team, which has been ably led by the First Lady, Secretary Shalala and Ira Magaziner. I'm glad that Pat Griffin and Harold Ickes have signed on.
- As this debate proceeds, let's remember what's really at stake here: security for tens of millions of Americans who have good health insurance today but fear that this time next year or even next month, they'll lose it. Providing health security is not a Democratic or Republican challenge, it's an American challenge.
- In that spirit, let us all resolve not to let partisan fighting get in the way of accomplishing what the American people have sent us to Washington to do: protect their interests and their security. Let us work together, Democratic and Republican, to produce the best bill that we can.
- Let me make one thing clear, however: I will only sign a bill that guarantees universal coverage to every American. That's the only way we can provide security -- and the only way we can truly get control of exploding health care costs. Health care reform is critical to our nation's economic future.

MAP

Possible Sources and Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Tobacco Tax (phased-in)	1/	0.0	0.0	4.3	6.0	6.0	5.9	5.9	8.3	9.1	9.0	8.9	22.2	63.4
Medicare Savings	2/	0.0	0.5	3.4	4.9	6.6	9.1	11.8	14.1	16.6	19.6	22.6	24.5	109.2
Medicare Receipt Proposals	3/	0.0	1.4	2.9	2.6	2.8	3.0	3.3	3.6	4.0	4.3	4.8	12.7	32.7
Medicaid DSH Freeze	4/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Indirect Effects on Receipts	5/	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0
Medicaid Offset	6/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.5	12.1	15.7	18.3	21.7	25.5	31.2	35.8	39.8	44.1	70.3	246.7
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	7,8,9/	0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
Subsidies for Kids		0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	56.7
Subsidies for Temporarily Unemployed Adults		0.0	0.0	2.7	3.9	4.2	4.6	5.1	5.6	6.1	6.5	7.1	15.4	45.7
Net Effect on Unemployment Insurance Program	10/	0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	11/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Long-term Care Program	12/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	13/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	14/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
Total Uses of Funds:	15/	0.5	0.9	10.5	14.0	15.2	16.0	16.9	18.2	19.4	20.7	22.2	57.1	154.5
Impact on Deficit:	15/	0.5	-1.6	-1.6	-1.7	-3.1	-5.7	-8.5	-13.1	-16.4	-19.2	-21.9	-13.2	-92.3

NOTES:

All estimates are preliminary. Totals may not add due to rounding.

While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays. Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

1/ Increases from $0.24 to $0.64 1/1/97 and to $0.90 1/1/2002. Estimate from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy cost).

2/ Estimates from HCFA/OACT.

3/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Estimates from HCFA/OACT and Treasury.

4/ Includes 25% behavioral offset. Estimate from HCFA/OACT.

5/ Indirect effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy costs.)

6/ Medicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.

7/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

8/ Assumes that unemployed compensation is included in income determinations. Also assumes that kids and families with access to employer contriubtions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.

9/ Eligibility for subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

10/ Reflects increase in duration and incidence in Unemployment Insurance program as a result of health insurance subsidies. Net of offsetting UI reciepts.

11/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.

12/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.

13/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.

14/ Estimate from HHS/PHS.

15/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.

Possible Sources and Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Medicare Savings	1/	0.0	0.5	3.4	4.9	6.6	9.1	11.8	14.1	16.6	19.6	22.6	24.5	109.2
Medicare Receipt Proposals	2/	0.0	1.4	2.9	2.6	2.8	3.0	3.3	3.6	4.0	4.3	4.8	12.7	32.7
Medicaid DSH Freeze	3/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Indirect Effects on Receipts	4/	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0
Medicaid Offset	5/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.5	7.8	9.7	12.3	15.7	19.6	23.0	26.7	30.8	35.1	48.1	183.3
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	6,7,8,/	0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
Subsidies for Kids		0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	56.7
Subsidies for Temporarily Unemployed Adults		0.0	0.0	2.7	3.9	4.2	4.6	5.1	5.6	6.1	6.5	7.1	15.4	45.7
Net Effect on Unemployment Insurance Program	9/	0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	10/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Long-term Care Program	11/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	12/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	13/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
Total Uses of Funds:	14/	0.5	0.9	10.5	14.0	15.2	16.0	16.9	18.2	19.4	20.7	22.2	57.1	154.5
Impact on Deficit:	14/	0.5	-1.6	2.7	4.3	2.9	0.2	-2.6	-4.8	-7.3	-10.1	-13.0	9.0	-28.8

NOTES:

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While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays. Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

1/ Estimates from HCFA/OACT.

2/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Estimates from HCFA/OACT and Treasury.

3/ Includes 25% behavioral offset. Estimate from HCFA/OACT.

4/ Indirect effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy costs.)

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6/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

7/ Assumes that unemployed compensation is included in income determinations. Also assumes that kids and families with access to employer contriubtions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.

8/ Eligibility for subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

9/ Reflects increase in duration and incidence in Unemployment Insurance program as a result of health insurance subsidies. Net of offsetting UI reciepts.

10/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.

11/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.

12/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.

13/ Estimate from HHS/PHS.

14/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.

Possible Sources and Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Tobacco Tax	1/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare Savings	2/	0.0	0.5	3.4	4.9	6.6	9.1	11.8	14.1	16.6	19.6	22.6	24.5	109.2
Medicare Receipt Proposals	3/	0.0	1.4	2.9	2.6	2.8	3.0	3.3	3.6	4.0	4.3	4.8	12.7	32.7
Medicaid DSH Freeze	4/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Indirect Effects on Receipts	5/	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0
Medicaid Offset	6/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.5	7.8	9.7	12.3	15.7	19.6	23.0	26.7	30.8	35.1	48.1	183.3
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	7,8,9/	0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
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Long-term Care Program	12/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	13/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	14/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
Total Uses of Funds:	15/	0.5	0.9	10.5	14.0	15.2	16.0	16.9	18.2	19.4	20.7	22.2	57.1	154.5
Impact on Deficit:	15/	0.5	-1.6	2.7	4.3	2.9	0.2	-2.6	-4.8	-7.3	-10.1	-13.0	9.0	-28.8

NOTES:

All estimates are preliminary. Totals may not add due to rounding.

While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays. Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

1/ Increases from $0.XX to $0.64 in 1/1/9X. Estimate from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy cost).

2/ Estimates from HCFA/OACT.

3/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Estimates from HCFA/OACT and Treasury.

4/ Includes 25% behavioral offset. Estimate from HCFA/OACT.

5/ Indirect effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy costs.)

6/ Medicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.

7/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

8/ Assumes that unemployed compensation is included in income determinations. Also assumes that kids and families with access to employer contriubtions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.

9/ Eligibility for subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

10/ Reflects increase in duration and incidence in Unemployment Insurance program as a result of health insurance subsidies. Net of offsetting UI reciepts.

11/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.

12/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.

13/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.

14/ Estimate from HHS/PHS.

15/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.

Possible Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Kids Program (133% - 240%)	1,2,3/	0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	56.7
Temporarily Unemployed (100% - 240%) Only	3,4,5/	0.0	0.0	3.8	5.4	5.7	6.0	6.4	7.0	7.6	8.2	8.9	21.0	59.2
Subsidy Cost		0.0	0.0	3.3	4.7	5.2	5.7	6.2	6.8	7.4	8.0	8.7	18.9	56.0
Net Effect on Unemployment Insurance		0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	1 - 5/	0.0	0.0	7.4	10.2	10.7	11.1	11.7	12.4	13.2	14.0	15.0	39.4	105.6
Subsidy Cost		0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
Net Effect on Unemployment Insurance		0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	6/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Long-term Care Program	7/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	8/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	9/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0

SR

Pl Like under Responses to HSA Critiques

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release January 31, 1994

STATEMENT BY DEE DEE MYERS

The following documentation is in response to Elizabeth McCaughey's article entitled *"No Exit: What The Clinton Plan Will Do For You"*, that ran in last weeks New Republic.

The article contains numerous factual inaccuracies and misleading statements.

This documentation clarifies the facts surrounding the President's approach to health care reform.

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ANALYSIS OF THE NEW REPUBLIC ARTICLE

ARTICLE: *"The bill guarantees you a package of medical services but you can't have them unless they are deemed `necessary and appropriate.'"*

FACT: This is very misleading. Today, insurers can decide that procedures, treatments, etc., are inappropriate or unnecessary. No insurance plan guarantees you the right to unnecessary or inappropriate care. To imply that such decisions are made only by doctors and individuals today is deliberately misleading, at best. Under reform, most such decisions will be made by patients and their doctors. In fact, the Health Security Act gives consumers *more* guidance and *more* rights about what is necessary and appropriate.

In addition, the Act **does not**, as the statement implies, **forbid** a plan from delivering services -- even if it *does* consider them not necessary or inappropriate. It says they may do so. And under the Act you have clear means of immediate appeal should you feel you deserve different or additional care -- a guarantee that rarely exists today.

Most importantly, the bill (page 15-16) specifically states that "*Nothing in this Act shall be construed as prohibiting the following: (1) An individual from purchasing any health care services.*" There is nothing in the Act to prohibit any individual from going to any doctor and paying, with their own funds, for any service. There are also no restrictions on the purchase of supplemental insurance.

ARTICLE: *"That decision (whether or not care is necessary or appropriate) will be made by the government, not by you or your doctor."*

FACT: Untrue. If anything, the "necessary and appropriate" care provision in the bill delegates authority to the medical profession -- rather than imposing further government bureaucracy between the patient and the doctor. For most people today, their insurance company, not their doctor, has final authority over what is necessary, appropriate and therefore reimbursable. Today, insurers can decide that procedures, treatments, etc., are inappropriate or unnecessary. No insurance plan guarantees you the right to unnecessary or inappropriate care.

Michael Kinsley criticized this article, saying: "*It is pointless to compare the Clinton plan with some idealized version of the classic American system, in which you can go to any doctor you want, who can perform any treatment he wants, order any test she wants, prescribe any drug he wants, and charge whatever she wants, all paid for by insurance.*" [*"Health Care Nonsense"*, The Washington Post, 1/27/94]

Under reform, most such decisions will be made by patients and their doctors. The National Board has the authority to issue guidelines relating to what is necessary and appropriate. The authority to issue these guidelines does not infer that there are no options left to physicians and patients, only that a benefits package guaranteed to all Americans must be consistently defined across states.

Guidelines that are developed by the Board will be developed in an open hearings process in which all interested parties can have input. Regulations used by insurance companies today are developed by the companies as those companies see fit.

ARTICLE: *"Escaping the system and paying out-of-pocket to see a specialist for the tests and treatment you think you need will be almost impossible."*

FACT: **That is wrong. Under the Act, you can pay "out-of-pocket" for anything you want at any time, to any physician or hospital willing to treat you.**

However, we should stress that, under reform, it is very unlikely that individuals will have to pay for such treatment. Every plan, even the most structured HMO, must offer at the very least a point-of-service option which enables you to go see a physician of your choice at any time. In some plans you may have to pay somewhat more to do this, but it is always an option, unlike today and unlike the alternative plan (Cooper) endorsed by The New Republic.

ARTICLE: *"If you walk into a doctor's office and ask for treatment for an illness you must show proof that you are enrolled in one of the health plans offered by the government. The doctor can be paid only by the plan, not by you."*

FACT: False. You do **not** have to be enrolled in a plan to be treated. If you go to a doctor and are not enrolled in a plan, the doctor will treat you. You will then be given information on available plans and you may choose any plan you want. The plan you choose then pays the physician. The purpose of this provision is to assist all individuals in enrolling in a plan.

However, as noted above, an individual may pay any doctor any price for any service outside the comprehensive package of services offered as part of a plan. So if an individual wants to go to a doctor and pay the doctor they can.

ARTICLE: *"The bill requires the doctor to report your visit to a national data bank containing the medical histories of all Americans."*

FACT: Not true. The very first provision of this section of the Act states: *"The information system must be consistent with privacy security standards in the Act."* Physicians may be required to submit data on outcomes, treatments, etc. for the purpose of improving quality and assessing treatments and outcomes. **But the Act very specifically prevents against tying this data to specific individuals.**

Sections 5101 and 5102 spell out detailed protections that assure that patient records and individual health data are strictly protected. Therefore, the implication that an individual's medical records will be in a national data bank and that those records can be accessed by all kinds of other agencies, individuals, etc., is patently untrue.

ARTICLE: *If you work for a company with fewer than 5000 workers you "must enroll in one of the limited number of health plans offered by the regional alliance where you live."*

FACT: Misleading. These individuals choose a health plan from the regional alliance bargaining on their behalf. **But it is clearly misleading to assume there will be a "limited" number of plans offered by the alliances.** In contrast, the alliance is obliged to offer **all** plans certified by the state, including at least one traditional "fee-for-service" plan. The only exception is that an alliance may decide not to offer a plan than charges 120% or more of the average premium cost in the region.

For example, one of the real world models of an alliance -- the California Public Employees Retirement System -- offers its members a choice of 24 different plans and individuals choose a personal physician in the plan. And more than two-thirds of the members are so satisfied with their plan that they would recommend it to a friend. This is a big difference from today's system in which the great majority of Americans face a very limited choice of health plans. About 50% of Americans insured through their employer have only one or two options of health plans. The great majority of Americans will have more choice in the alliance system.

ARTICLE: *"Under the bill, a National Health Board . . . will decide how much the nation can spend on health care beginning in 1996."*

FACT: This is untrue. The Health Security Act makes no attempt to "decide how much the nation can spend on health care" and specifically rejected the idea of global budgets or arbitrary price controls. The National Board is only authorized to set the initial premium targets -- the rates at which *health insurance premiums* (for the comprehensive benefits package) not *national health expenditures* may increase from year to year. These premium targets are important guarantee to American taxpayers and businesses who are being asked to contribute to their health care that their premiums will not continue to spiral out of control, as they have done for years. **There are no restrictions in the Act on the amount of money that may be spent by people with their own funds for additional services or supplemental insurance policies.**

ARTICLE: *"The bill outlaws plans that would cause a region to exceed its budget or that cost 20 percent more than the average plan."*

FACT: Wrong again. **No plan is "outlawed."** The premium limit does not preclude any plan from participating. The alliance has the option (not the requirement) to refuse to contract with a plan charging more than 20% over the average premium (so that people have a safeguard against insurance company price inflation).

ARTICLE: *"Even the bill's authors anticipate that restricting the dollars available for health care in the teeth of these trends will produce grave shortages; the bill provides that when medical needs outpace the budget and premium money runs low, state governments and insurers must make `automatic, mandatory, nondiscretionary' reductions in payments to doctors nurses and hospitals to assure that expenditures will not exceed budget."*

FACT: This is misleading. **The author here is clearly implying that such a mechanism exists in the main proposal – it does not.** The section the author is quoting from here refers to states that choose to form single payer systems, not from the description of the primary system advocated in the plan. Virtually all single payer systems work in this manner, adjusting payments to providers to make certain budgets are met.

Even with regard to single payer systems, there is absolutely no indication in the plan that the bill's authors are anticipating "grave shortages." This is responsible legislation; the plan merely spells out, in this special case, the mechanism by which a single payer system would meet targets if expenditures were running ahead of anticipated costs. To spell out such a mechanism is hardly an admission that "grave shortages" are expected.

ARTICLE: *"Above a threshold level of quality, alliance officials will approve health plans based on lowest cost, not highest quality."*

FACT: Not true. In contrast, the alliance is obliged to offer **all** plans certified by the state, including at least one traditional "fee-for-service" plan. The only exception is that an alliance may decide not to offer a plan than charges 120% or more of the average premium cost in the region. They are not <u>required</u> to do this however.

ARTICLE: *"What most of us call fee-for-service (choose your own doctor) will be difficult to buy."*

FACT: That is wrong. To the contrary, the Health Security Act preserves fee-for-service arrangements by requiring all alliances to offer at least one fee-for-service plan. Today, more and more Americans cannot choose a fee for service plan because their employers have chosen not to offer that option. Recent reports have shown that ". . . *a growing number of employers have abandoned traditional indemnity [fee-for-service] plans entirely. In fact, more employers now offer managed care plans than offer traditional indemnity plans.*" In fact, in 1988 , 89% of employers offered fee-for-service plans but, by 1993, this number had dropped to 65%. [*"1992 Health Care Benefits Survey"*, Foster Higgins, 1992; *"Health Benefits in 1993"*, KPMG Peat Marwick]

ARTICLE: *"Price controls on doctors' fees and other regulations will push doctors.."*

FACT: That is wrong. There are no price controls in the President's plan. Price controls -- calling for government micro-management of every health care service, doctor's fee, drug technology, and product -- were considered and specifically rejected. The Health Security Act does have -- as a backup mechanism for cost control -- a limit on how much insurance premiums can increase every year. This is an important guarantee. If employers are to be told they have the responsibility to contribute to coverage -- and if the federal government is going to provide discounts to small businesses and low-income individuals -- then American businesses and families deserve the guarantee that their premiums, and government spending, won't continue to rise unchecked.

Since, the federal government won't make market decisions on specific prices; health plans will have to decide themselves how to become more efficient in a way that won't drive consumers to another plan. As Stephen Zuckerman and Jack Hadley, two leading health policy analysts, wrote in support of the plan's premium limits, *"it seems far preferable that insurance companies that are responsible to their subscribers make these decisions than having the federal government involved in detailed price negotiations and review procedures with individual hospitals and physicians."* [*"Clinton's Cost Controls Can Work"*, Washington Post, 11/7/93]

ARTICLE: *"The bill limits what health plans can pay physicians and prohibits patients from paying their doctors directly."*

FACT: False. Any health plan that pays physicians according to their own contracts may pay those physicians anything they like. The bill only tells most health plans what to pay physicians with whom it has no contract. These fees apply to fee-for-service plans and for charges when individuals go out of the plans' network of doctors.

It is not clear why a patient would want to pay a doctor "directly," for services that their insurance company is obligated to pay. **If the implication is that individuals cannot go to any doctor and pay for whatever they want, that is false. Their right to do so is expressly protected.**

ARTICLE: *"The Clinton bill calls utilization review a `reasonable restriction' on patient care and expressly includes it as a requirement for doctors treating patients with fee for service insurance as well."*

FACT: That is wrong. The plan does **not** "require" fee for service insurers to use utilization review. It says they **may** do so. The purpose is to define what fee for service insurers -- who have no contracts with the physicians they are paying -- may do in assessing charges. **Utilization review is one option they are expressly *permitted*, not required, to do.** [more]

In reality, the bill is just following common practice here, acknowledging the typical practice of utilization review in fee for service plans. If the author is implying that many Americans are enrolled in plans where there is no review by the insurer, she is being deliberately misleading. As Michael Kinsley said, "*It so happens that the New Republic's own health care plan (of which I am a member) has extensive `utilization review.' . . . Utilization review is one of the developments rapidly spreading -- for good or ill -- under our current health care system. It is one reason health cost inflation has abated so dramatically . . .*" ["*Health Care Nonsense*", The Washington Post, 1/27/94]

ARTICLE: *"Some states recently have enacted laws to safeguard choices patients want to make for themselves, such as which hospital or pharmacy to use. HMOs protest that these laws hobble cost containment, and the Clinton administration apparently agrees. The Clinton bill pre-empts state laws protecting patient choice."*

FACT: Deliberately inaccurate. The Act guarantees all individuals full choice by giving everyone the option many don't have today -- access to a fee for service plan in which they can choose any provider. The Act also mandates that all HMO's and other managed care plans offer a point-of-service option in which individuals have a right to see any doctor outside of their plan or its network. This, again, is far greater choice than many individuals have today. In fact, current trends are towards declining numbers of individuals in fee for service plans and therefore fewer choice of doctors.

Most of the relevant laws that are being "pre-empted" are not geared to protecting patient choice -- which is fully protected and expanded in the Act -- but to protect providers from price competition and other pressures of managed care organizations. The state laws the Act overrides are those that bar managed care organizations from creating their own networks -- for example, not allowing a managed care network to refuse to admit a qualified physician into its network.

ARTICLE: *"Doctors in training will be assigned to the coveted specialty programs based partially on race and ethnicity...."*

FACT: This is ridiculous. **No physician or medical student is "assigned" to any specialty or told what type of medicine they can practice.** The Act does make clear that funding of medical education will put more emphasis on the widely-acknowledged need to train primary, as opposed to specialty care physicians, and that attention will be paid to the potential under-representation of minority groups.

ARTICLE: *"Under the Clinton bill you are entitled to a package of basic benefits, but you can have them only when the are `medically necessary' and `appropriate.' That decision will be made by the National Quality Management Council, not be you or your doctor. The Council ... will establish `practice guidelines' to control `utilization' of health services."*

FACT: That is wrong. You and your doctor will decide the type of care that you need. The National Board has the authority to issue guidelines on what may be necessary or appropriate. Its process of issuing any guidelines will entail the fullest participation of all concerned.

Today, virtually all insurance plans can refuse to pay for services deemed unnecessary and inappropriate, and it is the insurance company -- not the patient and physician -- with the ultimate authority. The decision-making process of insurers are not subject to any public input or scrutiny. To imply that the new system will have restrictions on what is necessary and appropriate, when the current system does not, is anything but truthful.

There is nothing in the Act to suggest that the "practice guidelines" referred to here will be mandatory or will control anything. They are to assist plans, providers and others in providing higher quality care. As the Act says, they "may *be used by health care providers to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately by prevented, diagnosed, treated and managed clinically.*"

ARTICLE: *"The Secretary of Health and Human Services has the power to set a controlled price for every new drug, and to require the drug manufacturer to pay a rebate to the federal government . . . If a producer balks at paying the rebate, the Secretary can `blacklist' the drug, striking it from the list of medications eligible for Medicare reimbursement."*

FACT: Very misleading. **The word "blacklist," with quotation marks around it in the statement, does not appear in the bill.** Putting quotation marks around it implies it is directly lifted from the text. In this case, however, it obviously applies to the author's interpretation of the text.

The Secretary can, in some circumstances, request a rebate on a drug as a cost containment tool. This will apply only to those drugs purchased in bulk by the federal government for the millions of Medicare beneficiaries. Manufacturers are given process rights in these negotiations as well. **There is no "blacklist".**

ARTICLE: *"Under the bill, the Secretary weighs the development costs and profit margin for the single new drug, rather than the overall profitability of investing in new cures."*

FACT: The statement refers to page 373 of the bill. The bottom of that page and the next page list **no less than 8 factors** that must be considered by the Secretary in negotiating a rebate in the Medicare drug program. Clearly, there is no effort to exclude the consideration that many efforts to produce new drugs cost a great deal and produce no profit to drug manufacturers. Drug companies would certainly be given the opportunity to raise these considerations and there is absolutely nothing in the proposal would prevent the Secretary from considering that reality.

Nat Hunter

civil or criminal

- Balanced Billing - Penalties

HW
coverage

Supplemental -

outside of system → reinsurance supplemental

Idea -

Charts for costs connected to private sector

Medicare G 7%

2095

Briefing

320

Laundry List

$250 →
$160 →

Budget Resolution
to base

- Pediatric research
- Area not covered care

Medicare

Medicaid per capita

CBO
Medicaid

5

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Re: Meeting with Senator Moynihan (3 pages)	1/24/94	P5

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.

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23745

FOLDER TITLE:
January 1994 HSA [1]

gf114

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]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo	Chris Jennings to Hillary Clinton Re: Moynihan Meeting (1 page)	1/24/94	P5

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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