DRAFT

Proposals	1994	1995	1996	1997	1998	1994-1998
Part A:						
Extenders						
10% Capital Reduction, Inpatient	0	0	300	380	420	1,100
Other						
Reduce Hospital Update by MB Minus 1% in FY 94 & FY 95 ✓	550	1,170	1,550	1,690	1,840	6,800
Put Hospitals on CY Update •	1,000	1,140	1,180	1,290	1,420	6,030
Reduce IME *	0	0	560	1,330	1,560	3,450
Direct Medical Education	350	340	340	330	320	1,680
Eliminate Add-On for Hospital-Based HHAs	160	200	230	290	280	1,120
Eliminate SNF ROE Payments	110	140	150	160	170	730
HI Interaction	-190	-20	-30	-30	-40	-310
Part B:						
Extenders						
Maintain SMI Premium at 1995 Percent ✓	0	0	1,450	4,340	7,120	12,910
10% Capital Reduction, OPD	0	0	110	150	170	430
Continue 5.8% Hospital Outpatient Cut	0	0	425	525	600	1,550
2% Lab Fee Update	30	110	220	380	570	1,310
Other						
Reduce Doctor Fees in 1994 Except Primary Care	200	300	350	400	425	1,675
Resource-Based Practice Expense Phase-in	100	350	700	875	950	2,975
Reduce Default MVPS & Update	0	0	200	650	1,225	2,075
Bundle RAP Payments	0	80	150	160	180	570
Single Fee for Surgery	50	100	110	120	130	510
Ban Physician Referrals	0	50	100	100	100	350
Electronic Billing Initiative	0	0	90	175	175	440
OPD Cut at 10% (above 5.8% cut)	0	0	315	375	425	1,115
Set Lab Rates at Market Levels	390	690	890	1,120	1,390	4,480
DME Options	75	125	150	160	175	685
Set EPO at Non-U.S. Market Rates ($10 per 1000 units)	30	40	40	50	50	210
Interaction of Premium Proposal	0	0	-420	-700	-980	-2,100
SMI Interaction	0	-40	-70	-80	-90	-280
Parts A & B:						
Extenders						
IRS/SSA/HCFA Data Match	0	0	45	120	205	370
MSP for Disabled	0	0	850	980	1,085	2,895
MSP for ESRD for 18 Months	0	0	35	35	35	105
Other						
MSP Reforms	127	240	275	305	345	1,292
Medicaid:						
Eliminate Mandatory Medicaid Personal Care	0	1,190	1,355	1,540	1,760	5,845
Reduce Medicaid Match to 50% ✓	310	380	410	450	495	2,025
Remove Prohibition on Drug Formularies	10	15	20	25	30	100
Tighten Estate/Asset Rules *liens + recoveries*	25	80	135	155	170	565
Medicaid Offset	30	70	60	-90	-240	-170
Medicare/Medicaid:						
Third Party Liability *– clearing house*	—	—	—	400	—	400
TOTAL, ALL PROPOSALS	3,357	6,730	12,075	18,100	22,470	62,732

5

(62.7) 34 $55.7

D. **States.** Assumes a $2 billion cut in the Federal match for States' administrative expenses. This represents approximately 3.4 percent of the total proposed Medicare/Medicaid cut.

3. Expected Reaction

* **Providers.** Health care providers will strenuously object to these cuts because (1) the public programs will be, once again, cost shifting to the private sector, and (2) because cuts will not be offset by any increase in health insurance coverage.

* **Governors.** State Executives will be displeased because of the proposed shifting of administrative costs under Medicaid to the States.

* **Congress and Consumers.** Advocates for health reform can be expected to become disgruntled because this round of cuts in Medicare are going to deficit reduction rather than to expand coverage. As a result, they will focus on the need to raise additional revenue through increased taxes, making it more politically problematic to pass national health insurance reform this year. In other words, they fear they will be asked twice to vote for cuts and tax increases.

  In addition, many of these cuts are extremely similar to those proposed and opposed by Democratically controlled Congresses. Many Democrats will feel extremely uncomfortable about defending. Lastly, a number of Members particularly sympathetic to health reform will (and do) feel that such an approach is inconsistent with previous statements made by the President with regard to this issue. Moreover, they feel that they have not been adaquately consulted in switching directions.

D. **States.** Assumes a $2 billion cut in the Federal match for States' administrative expenses. This represents approximately 3.4 percent of the total proposed Medicare/Medicaid cut.

E. **Other.** Assumes $12.982 billion in cuts for the programs and services that concurrently crossovers into Part A and Part B areas. This represents 22 percent of the Medicare/Medicaid cut.

3. Expected Reaction

* **Providers.** Health care providers will strenuously object to these cuts because (1) the public programs will be, once again, cost shifting to the private sector, and (2) because cuts will not be offset by any increase in health insurance coverage.

* **Governors.** State Executives will be displeased because of the proposed shifting of administrative costs under Medicaid to the States.

* **Congress and Consumers.** Advocates for health reform can be expected to become disgruntled because this round of cuts in Medicare are going to deficit reduction rather than to expand coverage. As a result, they will focus on the need to raise additional revenue through increased taxes, making it more politically problematic to pass national health insurance reform this year. In other words, they fear they will be asked twice to vote for cuts and tax increases.

  In addition, many of these cuts are extremely similar to those proposed and opposed by Democratically controlled Congresses. Many Democrats will feel extremely uncomfortable about defending. Lastly, a number of Members particularly sympathetic to health reform will (and do) feel that such an approach is inconsistent with previous statements made by the President with regard to this issue. Moreover, they feel that they have not been adaquately consulted in switching directions.

Chris Jennings

CONGRESSIONAL REQUESTS

TO	FROM	NAME	REQUEST	DATE
HRC		RICHARD LAMM	I TALKED TO HIM AND REFERRED HIS PLAN TO THE WORKING GROUPS.	4/19
MM		YALE BERRY	SENT IN PLAN. FORWARDED TO THE WORKING GROUP ON COST CONTROL.	4/15
MM		JOHN MAGUIRE	SENT IN PLAN. FORWARDED TO THE WORKING GROUPS.	4/15
MM		JIM BEAL	SENT IN IDEAS. GAVE TO WALTER'S GROUP	4/15
MM		JOHN LEVINGSTON	SENT IN PLAN. FINANCE WORKING GROUP POLICY ASSISTANT MARGE GEHAN TALKED TO HIM.	4/16
HRC	CONG. KREIDLER		SENT IN HIS IDEAS. GAVE TO RICHETTI AND TO THE WORKING GROUP ON COVERAGE. SHOWED TO CHRIS JENNINGS	4/16
IM	CAROL RASCOE	LARRY JINDRA ARNOLD RELMAN LAWRENCE GOLUB D. OF EDUCATION REPRESENTATIVES	HRC WANTED TO KNOW WHETHER THESE PEOPLE HAD BEEN PULLED INTO OUR EFFORT. ALL HAVE.	4/16
HRC	SEN. SASSER	DR. FRANK CHUCKER	WANTS HIM INVOLVED. HE WAS ASKED TO JOIN A BRIEFING TEAM ALREADY. I TOLD SASSER'S OFFICE.	4/16
HRC	SEN. SIMON	BILL DRUCKER	I'LL TRY TO ADD HIM TO A BRIEFING TEAM. I GAVE HIM TO DR. GLEASON.	4/27

HRC	CONG. BARRETT	RICHARD BOXER	HE IS ALREADY INVOLVED AS LEADER OF THE BRIEFING TEAM. I CALLED BARRETT.	4/16
HRC	CONG. COSTELLO	RICHARD MARK	JENNIFER WILL USE HIM IN AN AUDIT GROUP	4/19
HRC	SEN. HELMS	LINDA SPROAT	WANTS HER TO BE INVOLVED. i GAVE HER TO THE HPRG GROUP TO USE INTHEIR NURSE'S PANEL	4/19
HRC	CONG. REYNOLDS		SENT IN HIS IDEAS. COPY TO RICHETTI, ADN CHRIS JENNINGS. REFERRED TO THE WORKING GROUPS	4/15
HRC	SEN. BIDEN	HOWARD PALLEY	BRIEFING TEAM?? GAVE TO REDLENER	4/19
HRC	GOVERNOR SULLIVAN-WYOMING	JERRY SAUNDERS	REFERRED TO WORKING GROUPS. COPIED TO JOHN HART. ALAN WILL USE HIM FOR HIS DR.S GROUP	4/19
HRC	JOHN BALDACCI - MAINE SENATE		WANTS TO BE SMALL BUSINESS ADVISOR TO THE TASK FORCE. JENNIFER KLEIN MIGHT BE ABLE TO USE HIM.	
HRC	MIKE LOWRY-GOVERNOR OF WASHINGTON	LUANA REYES	SHE IS ALREADY A WORKING GROUP MEMBER. I'LL CALL THE GOVERNOR AND LET HIM KNOW.	4/16
HRC	CONG. PAT SCHROEDER	DR. PATRICIA GABOW	CALLED HER 4/14. I GAVE HER CV TO JENNIFER KLEIN TO INCLUDE IN THE ADMIN. SIMPLIFICATION AUDIT.	4/15

HRC		ROBERT FIELD	PERSONAL FRIEND OF HRC'S. GAVE TO BILL SAGE'S GROUP TO CALL.	4/16
HRC	*	VIRGINIA KUTAIT	MUST ADD TO BRIEFING TEAM. HRC PERSONAL REQUEST. GAVE TO REDLENER.	****
HRC	*	PAT RILEY	NEEDS TO BE CALLED BY WORKING GROUP MEMBER. GAVE TO ROBYN STONE.	4/15
HRC	*	MARK SHIELDS	WORKING GROUP MEMBER WILL CALL	4/15
HRC	*	BRIAN CASEY	BERNIE ARONS WILL CALL HIM.	4/15
HRC	* ELISE DONNELLEY	DR. WENTZ		**** *
HRC	* PHIL CORBOY	CLIFFORD STROMBERG	I WILL GET SOMEONE FROM BILL SAGE'S GROUP TO CALL BOTH CLIFFORD AND CORBOY	4/15
HRC	CAROLYN HUBER	JAMES WILKINS	HE WANTS A MEETING/CONFERENCE CALL ABOUT INFORMATION SYSTEMS. THIS IS BILL SAGE'S GROUP. ALAN CALLED HIM.	4/15

Budget Reconciliation

MEDICARE SAVINGS PROPOSALS - $21 BILLION

(millions of $, by FY)

PROPOSAL	Proposal Source	1994	1995	1996	1997	1998	TOTAL	Pricing Source
Ways & Means Plus Energy & Commerce	House	771	1,351	2,144	2,852	3,856	10,974	CBO
		This represents the non-duplicated total savings of House Ways and Means, and Energy and Commerce-adopted proposals, interactively priced.						
Limit Physician MVPS Adjustment to 50%	Staff	600	950	1,100	1,200	1,350	5,200	CBO
		Physician fees in calendar year 1994 would be updated by half of the proposed volume bonus that physicians are slated to receive. The transition in relative weights supporting primary care would continue.						
1% Productivity Adjustment for All Hospitals	ProPAC/ Staff	0	0	600	1,700	3,250	5,550	CBO
		With the return to annual indexation of hospital reimbursements, this proposal would introduce a 1% productivity adjustment to the hospital inpatient payment amount. The adjustment would begin in 1996. For hospitals not in the prospective payment system, the per-diem amount would be adjusted by the same percentage. Most hospitals achieve annual productivity gains, and this adjustment allows Medicare to benefit from hospitals' increased productivity. ProPAC has endorsed a 1% productivity adjustment.						
Total		1,371	2,301	3,844	5,752	8,456	21,724	

These new proposals have been priced independently of each other, and do not take into account interactions with other entitlement savings proposals. Final savings estimates may vary by 15% to 25%, depending upon interactions with each other and with other savings proposals in the final reconciliation package.

Chris

SUBJECT: Talking Points regarding change to Byrd Rule to make it possible to include health care reform in reconciliation bill.

Senator Byrd was the author of the Byrd rule to prevent repetition of the abuses of the budget process carried out by the Reagan Administration.

The Reagan Administration used the reconciliation bill--particularly its first reconciliation bill, in 1981--to enact the bulk of its legislative program into law, including parts of the program that had nothing to do with deficit reduction. The main procedural advantage of using reconciliation in this way is that debate on a reconciliation bill is limited. A reconciliation bill cannot be filibustered, and only 51 votes are required to pass it. In addition, the special rules of germaneness that apply to reconciliation bills make substantive amendments difficult: essentially, only amendments to narrow the scope of a provision or to change a number are in order.

In Senator Byrd's view, the use of a reconciliation bill to enact substantive programs and program changes that have nothing to do with deficit reduction bypasses the Senate's tradition of extended debate and protection of the rights of the minority.

Under the Byrd rule as interpreted by the Parliamentarian, it would be impossible to enact health care reform on a reconciliation bill, because the scope of the program would go well beyond the narrow germaneness rules imposed by the Byrd rule. In particular:

--a cost control program affecting both private payers and the public sector would violate the Byrd rule, because the part affecting the private sector would be considered non-germane;

--Coverage expansion would be considered non-germane because they would not directly affect the deficit, regardless of the impact of the program, taken as a whole.

In addition, several Committees with jurisdiction over matters included in comprehensive health reform would have special problems under reconciliation, because <u>any</u> legislation in the jurisdiction of another committee makes a provision non-germane. This is a much tighter standard than the rule of preponderance. The change in the Byrd rule needs to be specifically designed to accommodate these Committees.

Senator Sasser has prepared language to be included in the budget resolution to narrowly adapt the Byrd Rule to accommodate health care reform on reconciliation.

Senator Byrd is reported to be leaning against a change in the Byrd rule to allow inclusion of health care reform in reconciliation because he feels it might bring back the abuses of the Reagan era and that, if we did it for health reform this year, why not do it again next year for something else?

TALKING POINTS REGARDING CHANGE TO BYRD RULE

--It is very important to use the reconciliation bill as the vehicle for enactment of health care reform. The one big bill approach gives us the best possible opportunity to enact the program, since it maximizes the Clinton Administration's leverage and minimizes the number of tough votes the Democrats have to take.

--If health reform is deferred to the fall or into next year, chances of enactment will go down as a President's popularity has historically decreased after Labor Day of the first year, and members begin to worry about their own re-election.

--It is appropriate to use the reconciliation process to enact health care reform. This is a truly special case where the normal and appropriate Byrd rule protections should be modified.

--Reconciliation is the process by which the Senate achieves deficit reduction. We all know that control of health care entitlement spending is the key to long-term deficit reduction, but health care entitlement spending cannot be controlled unless private health care spending growth is also reduced. If the two do not go together, there will be massive cost-shifting to private payers and Medicare beneficiaries will become second-class citizens, because the gap between what private insurance pays for services and what Medicare pays will become too great.

--Universal insurance coverage must also be part of the package, because enactment of cost control separately from universal coverage would doom passage of universal coverage. It would be perceived as a pure add-on to the budget. Health care reform needs to be one comprehensive program to guarantee coverage and control costs.

--According to the Parliamentarian, unless a special modification to the rule is made for health care reform, both private sector cost-containment and universal coverage would be deemed extraneous if a point of order is raised, even if they are integral parts of a comprehensive health reform program that reduces the deficit overall.

--Other provisions relating to extraneousness, unless modified for the purpose of this bill, make it difficult for the several Committees with reconciliation to participate in health care reform on a reconciliation bill.

--This proposal is different than the abuses of the Reagan Administration, the Byrd rule was designed to curtail, because it would be narrowly tailored to allow passage of comprehensive health care reform--a program clearly vital to deficit reduction. Future proposals to modify the rule would be unlikely to meet the criterion of being essential to long-term deficit reduction.

--Senator Sasser has prepared appropriate language to add to the Budget Resolution to accommodate health care reform.

690-6351

Budget Reconciliation H.C.R

- Blum
- Nuckles
- Vedrinsky

Budgetary Treatment of the President's Health Reform Proposal

The case for including the transactions of the proposed health alliances in the federal budget:

1. The proposed alliances would exercise sovereign power through the assessment of compulsory premiums, which must be paid by all employers and individuals except for individuals with very low incomes.

If premiums are not paid, the alliances could levy a special premium surcharge on all employers and individuals. Premium contributions owed to alliances would be privileged compared to other corporate or personal obligations in bankruptcy proceedings.

The Secretary of Labor ensures that all employers fulfill the obligation to pay premiums or provide coverage through a qualified health plan.

Although illegal immigrants would not be eligible for guaranteed health benefits, employers would be required to pay premiums for all their employees, regardless of immigration status.

The level of premiums would be set by federal statute and regulation.

2. The premiums would be used to finance a comprehensive package of health care services which would be determined by the federal government.

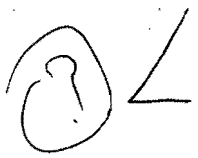
The medical services covered by health plans and any necessary cost sharing would be specified by federal legislation and regulations.

3. The operations of the alliances essentially would be controlled by the federal government.

The National Health Board, a new federal government agency, would establish requirements for state plans, and would control alliance budgets.

Corporate alliances would be supervised by the Department of Labor. Large employers whose health plans do not meet national spending goals would be required to purchase coverage through regional alliances.

The Department of Labor would oversee the financial operations of alliances, conduct audits of management and financial systems, and could recommend remedial actions to the National Board if required to adhere to federal requirements.



The National Board could rule that a state is not in compliance with federal requirements; in this case, the federal government would provide health coverage to all individuals in the state, financed by a payroll tax imposed by the Secretary of the Treasury on all employers in the state.

4. The proposed health reform plan is very similar to the joint federal-state unemployment insurance system, the finances for which are included in the federal budget.

The states are effectively compelled by federal law to create and operate a federally approved UI program. Federal law imposes a payroll tax on all employers; if a state operates a federally approved plan, the employers pay only a fraction of the federal tax. However, if a state fails to operate an approved plan, the full federal tax is imposed but no benefits are provided.

State UI systems must meet various criteria set by federal law (minimum benefits, eligibility criteria, etc) and by the Department of Labor.

The UI taxes collected and benefits paid by each state are maintained in separate state accounts in the U.S. Treasury and are reported as federal receipts and outlays in the budget.

The case for not including the transactions of the proposed health alliances in the federal budget:

1. The regional alliances would be established by the states and would operate as non-profit corporations, an independent state agency or an agency of the state executive branch. Large employers could establish and operate corporate alliances.

2. States would be responsible for administering covered health care services.

States would certify health care plans; administer subsidies for low-income individuals, families and employers; provide financial regulation of health plans; provide for the governance of health alliances; administer data collection; and operate a guaranty fund to provide financial protection to health care providers and others if a health plan becomes insolvent.

States would be able to establish a single-payer health care system rather than an alliance system offering multiple plans.

3. Regional alliance operating funds would be handled by private banks.

Regional alliances would collect health premiums from employers and individuals and make payments to health plans and providers. The transactions would not go through the U.S. Treasury.

4. The federal role is designed to be regulatory in nature. Except for federal administrative costs, the cost to employers of complying with federal regulations are not normally included in the federal budget.

Except when states fail to comply with federal requirements, the federal government would not directly operate the health insurance program. The health alliances would operate under state law.

Members of the health care reform/abortion working group

1. Nita Lowey
2. Rosa DeLauro
3. Karen Sheperd.
4. Eleanor Holmes Norton
5. Dan Glickman
6. Dick Durbin
7. David Obey
8. Vic Fazio
9. David Price
10. Barbara Kennelly
11. Carrie Meek
12. Dick Gephardt

Flannigan Alg. 30

Business response

GROUPS, BUSINESSES AND PROMINENT INDIVIDUALS THAT ARE SUPPORTING THE ADMINISTRATION'S OVERALL DIRECTION AND SIX PRINCIPLES FOR HEALTH REFORM

The ADS Group; Alan Solomont, President
AFL-CIO
Aging 2000
AIDS Action Council
Airline Suppliers Association
Alliance for Health Reform
Alzheimer's Association
Amalgamated Clothing and Textile Workers Union
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Physicians Assistants
American Association of Children's Residential Centers
American Association of Homes for the Aging
American Association for Marriage and Family Therapy
American Association for Partial Hospitalization
American Association for Retired Persons
American Association of Nurse Anesthetists
American Association of Pastoral Counselors
American Association of Physicians from India
American Association of Preferred Provider Organizations
American Association of University Women
American Cancer Association
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American Council of the Blind
American Counseling Association
American Dental Association
American Ex-POWs
American Federation of Government Employees
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Federation of the Blind
American Forest and Paper Association
American Gold Star Mothers
American Group Practice Association
American Health Care Association
American Heart Association
American Hospital Association
American Iron and Steel Institute

American Jewish Committee
American Jewish Congress
American Legion
American Lung Association
American Managed Care Review Association
American Medical Association
American Nurses Association
American Occupational Therapy Association
American Physical Therapy Association
American Postal Workers Union
American Psychiatric Association
American Public Health Association
American Society of Internal Medicine
American Speech-Language-Hearing Association
Amtrak; W. Graham Claytor, Jr., President and Chairman of the Board
AMVETS
Anti-Defamation League
Anxiety Disorders Association of America
The ARC
Asian American Health Forum
ASPIRA Association
Association of Academic Health Centers
Association of American Medical Colleges
Association of Schools of Public Health
Autumn Harp; Kevin Harper, CEO
B'nai B'rith International
Bakery, Confectionery & Tobacco Workers International Union
Baltimore Minority Business Development Center
Bario & Associates
Baumgarten's Print Shop, Washington D.C.
Bazelon Center for Mental Health Law
Ben & Jerry's - Old Town/Adam's Morgan
Beth Israel Hospital; Mitchell Rabkin, MD, President
Bethlehem Steele Corporation; Curtis "Hank" Barnette, Chairman and CEO
Black Women's Agenda
Blinded Veterans Association
Blue Cross Blue Shield Association
Blue Cross Blue Shield of Iowa
Blue Cross Blue Shield of Western Pennsylvania
Boston University Medical Hospital
Brandeis University; Dr. Samuel Thier, President
Thomas Berry Brazelton, MD; Professor of Pediatrics Emeritus at Harvard Medical School and Children's Hospital
Brigham and Women's Hospital
Building and Construction Trades Department
Business and Professional Women

Businesses for Social Responsibility
Robert Butler, MD; Chairman of Gerontology at Mt. Sinai Hospital Medical School
Bynex Corporation, Pennsylvania
California Health Care Institute
Campaign for Women's Health
Catholic Charities USA
Catholic Health Association
Catholic War Veterans
Center on Policy Alternatives
Charles R Drew University of Medicine and Science; Reed Tuckson, MD, President
Children's Defense Fund
Children's Health Fund
Columbia School of Public Health; Allan Rosenfield, Dean
Chrysler Corporation; Robert Eaton, Chairman and CEO
Church Women United
Circuit City Stores Inc.; Alan Wurtzel, Chairman of the Board
Citizen Action
Coalition for Consumer Protection and Quality in Health Care Reform
Communications Workers of America
Community Retail Pharmacy Coalition
Consortium for Citizens with Disabilities
Consultech Communications, Inc.
Consumer Federation of America
Consumer Power Corporation
Consumers Union
Continental Health Affiliates
Louis Cooper, MD; Director of Pediatrics at St. Luke's Roosevelt Hospital Center
Council of Jewish Federations
Dartmouth Medical Center; Jack Wennberg, M.D., Director of Center for the Evaluative Clinical Sciences
John Delfs, MD; Director of Geriatric Medicine and ElderCare Program at New England Deconess Hospital
Diario Los Americas
Disabled American Veterans
Diversified Management, California
The Drummond Company; Gary Drummond, Chairman and CEO
Duke University School of Medicine; Dr. Ralph Snyderman, Chancellor for Health Affairs
EER Systems Corp., Virginia
Earl Graves Publishing; Earl Graves, CEO
Ecoprint
Ecumenical Ministries of Oregon
Electronic Data Systems; Alice Lusk, Corporate Vice President
Enron Corp; Terry Thorn, Senior Vice President
Epilepsy Foundation of America
Exclusive Temporaries of Virginia, Incorporated
Families USA

Family Services America, Inc.
Federation of Families for Children's Mental Health
Federation of Professional Athletes
Fidelity Investments; Peter Lynch, Vice Chairman
Fleet Reserve Association
Food 4 Less Supermarkets; Ronald Burkle, Chairman and CEO
Ford Motor Company; Harold Poling, Chairman and CEO
Fourth Presbyterian Church
Frieda's Inc., California
Gaylord's Originals
The Gerontological Society of America
GI Forum
Giant Food, Incorporated; Peter Manos, CEO
Glass, Pottery, Plastics & Allied Workers International Union
Gold Star Wives
Graphic Communications International Union
Grayboyes Commercial Window, Pennsylvania
Greenbrier Development Corporation
Grimes Oil
Group Health Cooperative of Puget Sound; Phil Nudelman, President and CEO
Gulf Atlantic Life, New York
Harvard School of Medicine; Daniel Tosteson, MD; Dean
Harvard School of Public Health; Harvey V. Fineberg, MD, Dean
Harvard Community Health of Rhode Island
Health Care Reform Project
Health Insurance Plan of Greater New York HMO
Hechinger Company; John Hechinger, Sr., Chairman of the Board
Hispanic Association of Colleges and Universities
Hispanic Council on Aging
Homeland Ministries
Hotel and Restaurant Employees International Union
Hubbard & Revo-Cohen, Inc., Virginia
Human Rights Campaign Fund
I Care of Arkansas Medical Center
Institute for Health Policy Solutions
Institute of Medicine
Interfaith IMPACT
International Association of Machinists and Aerospace Workers
International Association of Psychosocial Rehabilitation Services
International Brotherhood of Electrical Workers
International Brotherhood of Teamsters
International Lady Garment Workers Union
Interreligious Health Care Access Campaign
International Union of Bricklayers and Allied Craftsmen
International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers
International Union of Operating Engineers

Invacare; Mal Mixon, Chairman of the Board, President and CEO
JMH Realty Concepts, Inc., Pennsylvania
James River Corporation; Robert Williams, Chairman and CEO
Jewish War Veterans
John A. Clark Company
John Alden Insurance Company; Bill Mauk, CEO
Johns Hopkins Health System, Johns Hopkins University; James Block, MD, President and CEO
Johns Hopkins University School of Medicine; Michael M.E. Johns,MD; Vice President for Medicine and Dean of the Medical Faculty
Joint Center on Political and Economic Studies
Julander Energy Co.; Fred Julander, President
Kell Enterprises, Inc., New York
Kemrodco Development & Construction Co., Inc., Pennsylvania
Keystone Outdoor Advertising Co., Pennsylvania
Kirson Medical Equipment
Kohn, Wast, Graf, P.C., Pennsylvania
C. Everett Koop, MD; Former Surgeon General
Laborers International Union of North America
Leadership Conference on Civil Rights
League of Women Voters
Legion of Valor
Lisboa Associates; Elizabeth Lisboa-Farrow, CEO
Long Term Care Campaign
Louisiana State University Medical Center; Perry G. Rigby, MD, Chancellor
Malibu Family Medical Center
Marine Corps League
Massachusetts Federation of Nursing Homes
Massachusetts General Hospital
Massachusetts Assistive Technology Partnership Center
Meharry College School of Medicine; Henry W. Foster, MD, Dean of the School of Medicine and President of Health Services
Memorial Sloan-Kettering Cancer Center; Paul Marks, MD, President and CEO
Mental Health Policy Resource Center
MEVATEC Corporation, Alabama
Mexican American Legal Defense and Education Fund
Mexican American Women's National Association
Midwest/Northeast Voter Registration Project
Military Order of the Purple Heart
National Abortion Rights Action League
National Association of Chain Drug Stores
National Association of Children's Hospitals and Related Institutions
National Association of the Deaf
National Association of Hispanic Publications
National Association for Home Care
National Association of Letter Carriers

National Association of People With AIDS
National Association of Public Hospitals
National Association of Retail Druggists
National Association of Social Workers
National Association of State Directors of Developmental Disabilities Services
National Association of State Mental Health Program Directors
National Association of State Units on Aging
National Black Nurses Association
National Black Women's Health Project
National Caucus and Center on the Black Aged
National Council of Community Mental Healthcare Centers
National Conference on Soviet Jewry
National Consumers League
National Council of Negro Women, Inc.
National Council of Senior Citizens
National Council of the Churches of Christ in the USA
National Council on Independent Living
National Council of Jewish Women
National Council on the Aging
National Easter Seal Society
National Education Association
National Farmers Union
National Federation of Black Women Business Owners
National Gay and Lesbian Task Force
National Health Policy Council
National Hispanic Council on Aging
National Hospice Organization
National Jewish Community Relations Advisory Council
National Jewish Democratic Council
National Leadership Coalition for Health Care Reform
National Medical Association
National Minority AIDS Council
National Organization for Rare Diseases
National Organization on Disability
National Medical Association
National Mental Health Consumer Self Help Clearing House
National Puerto Rican Coalition
National Urban League
National Women's Health Network
National Women's Law Center
Neighbor-Care Pharmacies, Maryland
The New Hampshire Health Care Coalition
Northwestern Memorial Hospital
Older Women's League
Omni Cable, Pennsylvania
Palarco Inc., Pennsylvania

Paralyzed Veterans of America
Parkland Memorial Hospital; Ron Anderson, MD, President and CEO
Perman Asset Mangement, Illinois
Planned Parenthood Federation of America
Polish Legion of American Veterans USA
President's Committee on Employment of People with Disabilities
Prospect Associates, Maryland
Purdue University; Steven Beering, MD, President
Ralph's Grocery Store; George Allumbaugh, Chairman and CEO
Religious Action Center
Research Management Consultants, Inc., Virginia
Retail, Wholesale and Department Store Workers
Retired Enlisted Association
Rhodes Enterprise, Louisiana
Rite Aid; Alex Grass, Chairman and CEO
Rittenhouse Management, Pennsylvania
Santa Fe Cafe, Virginia
Save Our Security
Scripps Clinic & Research Foundation; Dr. Charles Edwards, President
Seafarers International Union of North America
Service Employees International Union
Soapbox Trading Company and the Mills Group; Helen Mills, CEO
Soft-Sheen Products; Edward Gardner, Chairman of the Board and CEO
Spanish Broadcasting System, New York
Stanford University Medical Center; David Korn, MD, Vice President and Dean
State University of New York at Stoneybrook School of Medicine; Jordan Cohen, MD, Dean
Struever Associates, Maryland
S.W. Morris & Company
Louis Sullivan, MD; Former Secretary of Health and Human Services
Systems, Maintenance and Technology, Maryland
Tangent Corporation
TEI Industries
United Association of Plumbing & Pipe Fitting Industry
United Automobile, Aerospace & Agricultural Implement Workers of America International Union
United Brotherhood of Carpenters and Joiners of America
United Church of Christ
United Food & Commercial Workers International Union
United Mine Workers of America
United Paperworkers International Union
United Seniors Health Cooperative
United States Students Association
United Steelworkers of America
The University Hospital
The University of California; Cornelius Hopper, MD, Vice President of Health Services
The University of Chicago Hospitals

University of Florida J. Hillis Miller Health Center; David R. Challoner, MD, Vice President for Health Affairs
University of Kansas; David K. Clawson, MD, Executive Vice Chancellor
University of Medicine and Dentistry of New Jersey; Stanley Bergen, MD, President
University of Missouri - Kansas School of Medicine; James Mongan, MD, Dean
University of Notre Dame, Reverend Theodore Hesbergh, C.S.C., President Emeritus
University of Pennsylvania School of Medicine; William Kelley, MD, Dean
University of Tennessee Medical Center at Knoxville
University of Washington School of Medicine; Philip Fialkow, Vice President for Medical Affairs and Dean
U.S. Assist
Vermont Teddy Bear Company
Veterans of Foreign Wars of the United States
Vietnam Veterans of America
VITAS Healthcare Corporation
Watts Health Foundation
White Dog Cafe
Women's Health Research
Women's Legal Defense Fund

COMPARISON OF ALTERNATIVE APPROACHES*

Crisis vs. No Crisis

Our approach is based on the fact that American families and businesses are facing a health care crisis.

Others have adopted the insurance company/Republican line that a crisis does not exist. They don't understand how Americans live.

Guaranteed Private Insurance vs. Continued Insecurity

Our approach guarantees private insurance for every American that can never be taken away.

Other approaches don't protect families from the threat of losing their insurance or solve the problem of rising costs.

People In Charge vs. Insurance Companies In Charge

Our approach puts individuals and small businesses in control of their health care choices.

Other approaches allow insurance companies to continue picking and choosing whom to cover, how much to raise your rates, and when to drop you.

Comprehensive Benefits vs. Bare Bones Benefits

Our approach guarantees a comprehensive benefit package, including preventive care and prescription drugs, with low deductibles.

Other approaches provide for a bare bones package with high deductibles.

Benefits Spelled Out in Law vs. Benefits To Be Determined Later

Our approach sets down in law the comprehensive health benefits that must be provided to every American.

Other approaches leave it to a government board to decide what benefits people should get; they want you to buy a pig in a poke.

Good For Seniors vs. Threatening To Seniors

Our approach preserves Medicare, adding new coverage for prescription drugs and more long-term care options.

Alternatives threaten Medicare, cutting its growth but providing no new benefits; they see Medicare as a bank to pay other bills.

---

* This does not apply to the single-payer proposal.

THE FIVE BIGGEST LIES
ABOUT THE PRESIDENT'S HEALTH CARE APPROACH

Lie #1: The President wants a government takeover of the health care system.

Truth: The President specifically rejected a government-run system. His approach builds on the current system, preserving what's right and fixing what's wrong. It's the least disruptive approach, building on today's system, where 9 out of 10 people get their insurance through their employer.

He wants guaranteed private insurance for every American. And his approach would make two critical changes. First, it would guarantee comprehensive benefits that can never be taken away. And second, it would provide greater power for consumers and small businesses to choose quality health insurance at lower cost.

Lie #2: The President wants the government to choose your doctor and health plan.

Truth: You will be able to choose your own doctor and health plan. In fact, our approach actually increases the choices most consumers will have. Under the Clinton approach, all Americans will be able to choose from several kinds of health plans, no matter where they work. And everyone will have the option of a traditional fee-for-service plan, where you go to any doctor you want and pay individually for each test or procedure. And people will be able to switch plans every year if they're not satisfied with their care or service.

In fact, it's today's health care system that is limiting people's choices. 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]

Lie # 3: The price controls in the President's approach will cause rationing.

Truth: The President specifically rejected price controls. His approach does include a limit on how much insurance companies can raise premiums year to year. And the insurance companies are trying to scare you because that would limit their freedom to jack up rates. Rationing is a classic scare tactic; but experience shows that you can control health care costs and provide quality care.

This debate is about insurance companies that want to keep picking and choosing whom to cover or drop, and when to increase rates. The Clinton approach puts people in charge. It will be illegal for insurance companies to drop you, refuse you, or jack up rates because of your medical history or age.

Lie #4: The new system will be a bureaucratic nightmare.

Truth: Nothing could be more complex than what we have now. Today's patchwork system is the result of insurance companies competing to cover only the healthiest people.
The important thing is what happens to the consumer and the Clinton approach will make life easier for people. You'll know what you're getting without having to read insurance company fine print. And you'll have a Health Security Card and fill out one standard claims form -- without all the insurance company red tape -- when you go to the doctor's office. The Washington Post says the Clinton approach will create a "surprisingly simple" world for consumers.

Lie #5: Reform will be a job-killer.

Truth: High health costs today are killing businesses, large and small. The Clinton approach will help businesses compete by bringing costs under control. *The Wall Street Journal* called the Clinton approach "an unexpected windfall" for small businesses that currently provide insurance. And all small businesses will get increased bargaining power and discounts on the price of insurance.

In fact, analysts predict job gains as a result of our approach. An Economic Policy Institute predicts that 258,000 manufacturing jobs will be created over the next decade as high health costs drop. There will also be health care jobs created, as we guarantee coverage for everyone, with one Brookings Institution analyst predicting 750,000 jobs created in home health care alone. Some people will certainly be doing different things -- there'll be less people processing paper and more people giving care.

POSSIBLE QUESTIONS FOR LEON PANETTA

1. To me, scoring a private health insurance premium for private insurance as on budget flies in the face of common sense. To the best of your knowledge, has the CBO or any other Government budget estimator scored as on budget any one of the following?

   - **Car Insurance.** Many states require that all drivers have car insurance in order to be legally permitted to drive.
   - **The Minumum Wage.** The requirement that all employers -- not specifically exempted -- pay a minimum wage to their employees.
   - **The Occupational Health and Safety Act.** The requirment that employers conform to Federally defined health and safety standards in the workplace.
   - **Family and Medical Leave Act.** The requirement that employers provide job protection for employees who must leave work in order to take care of a sick family member.
   - **The Americans with Disability Act.** The requirement that employers comply with access standards for customers and employees.

2. Although I doubt that I would understand or agree with it, I am certain that the CBO Director does have some defensible rationale for coming to the conclusion he did. The next obvious question, though, is whether there should be much fuss about it. Isn't the real question how CBO's on "on budget" decision affects:

The Guarantee of Every American Citizen Always Having Comprehensive Private Health Insurance.

The Scorable Projected Reduction in the Rate of Health Inflation.

The Expansion of Prescription Drug Coverage Under Medicare.

The Phasing in of a Substantive Long-Term Care Benefit for All Americans.

The Fact that this Plan Reduces the Deficit.

DIRECTOR PANETTA: Are any of these provisions of the President's approach threatened in any way by CBO's "on budget" conclusion?

QUESTIONS FOR CBO

1. Will the budget show any more information based on the CBO change in accounting for premiums?

According to the President's FY 1995 budget, when the Health Security Act is fully implemented, the budget will include information each year showing total premiums estimated to be paid by employers and consumers. In addition to premiums, the budget will show accounts receivable and cash flow.

Under CBO's "on-budget" treatment, will the budget be required to provide any additional information?

QUESTIONS FOR CBO

2. Does the CBO change in accounting alter the flow of dollars into the Federal Treasury?

Under H.R. 3600, premiums flow into regional alliances and not the Federal government. By classifying the premiums as "on-budget" for CBO accounting purposes, do you mean to imply that alliance premium dollars will come into the Federal Treasury and be mixed together with Federal government revenues?

Would the Federal government have any more access to the premiums paid into alliances than they would to other private insurance premiums?

For example, if there were a surplus nationwide in health alliances, could health care premiums be used to pay other Federal bills?

QUESTIONS FOR CBO

3. The President's FY 1995 budget shows the sources and uses of Federal funds associated with the Health Security Act. Would you agree that these revenues --- from the cigarette tax, for example --- are different from alliance premiums?

I've studied the tables (on pages 189-190) in the President's budget that reflect the Administration's cost estimates for various components of the Health Security Act. They show the costs to the Federal government --- from the subsidies, to the expenditures for public health, etc. --- and the receipts to the Federal government --- from the cigarette tax, etc. So isn't this debate just about the premiums paid to alliances, which you say should be "on budget"?

QUESTIONS FOR CBO

4. I'm trying to understand the real significance of your opinion that the premiums paid to alliances should be placed "on budget." Does the fact that CBO accounts for premiums differently mean that any businesses or individuals will pay more than they would if the premiums paid by alliances were accounted for off-budget?

QUESTIONS FOR CBO

5. What is the real impact of CBO's decision to account for alliance premiums as a miscellaneous Federal receipt?

If as a result of CBO's accounting decision there is no more information in the Federal budget, the alliance premiums cannot be used for any Federal purposes, and there is no cost to businesses or individuals, is it fair to conclude that the CBO scorekeeping decision does not seriously change either the impact or the cost of H.R. 3600?

QUESTIONS FOR CBO

6. You have indicated that in your opinion, the premiums paid to alliances for private health insurance should be classified as "on budget." But help me understand why this is so. Isn't it true that the Health Security Act is just a federally directed reorganization of an existing health insurance system in which most firms and individuals participate now, and would continue to participate absent this proposal? In fact, for many employers who now provide insurance, premium payments will actually go down as a result of the Health Security Act. What changes does the Health Security Act make to bring these private premiums into the Federal budget?

QUESTIONS FOR CBO

7. I have trouble understanding why you have reached the conclusion that these private transactions should be "on budget." You have indicated that one of the bases for your opinion is that the Health Security Act mandates that employers and individuals contribute to their private insurance coverage. But Federal mandates on private sector behavior generally are not included in the budget. For example, the Federal minimum wage law and Superfund regulations requiring firms to clean up hazardous waste sites have a significant private sector impact, but the costs borne by the firms are not included in the budget. Can you explain the difference?

QUESTIONS FOR CBO

8. You have indicated that one of the reasons you have determined that the premiums paid to alliances should be "on budget" is that the alliances are subject to a Federal authority. But as I read the Health Security Act, the alliances will be subject to considerable State regulation and control, such as determining the number of alliances and their geographic coverage, etc. In other cases where the responsibility is now shared by the States and the Federal Government, such as the Medicaid program, only the Federal share of the total costs is shown in the Federal budget. Can you explain why this is different?

QUESTIONS FOR CBO

9. You say that one of the reasons why you have determined that the premiums paid to the alliances should be "on budget" is that the Federal government would determine the amount of the premiums. But in most Federal programs, the types of goods and services offered and the prices are set by the Federal Government. For example, the coverage and the premium for the Medicare Part B program are established in law. In the case of the regional alliances, the types of insurance plans purchased and the premiums will be determined largely by private firms and individuals, insurance companies, and health care providers.

   Can you help me understand why these private decisions all add up to your conclusion that premiums should be "on budget"?

QUESTIONS FOR CBO

10. Some have mentioned the United Mine Workers' Health Fund legislation that the Congress passed to provide health benefits to retired coal miners as being analogous to the Health Security Act. It seems to me that there are some distinctions between the United Mine Workers' Health Fund and the premiums paid to the health alliances created by the Health Security Act. Isn't it true that in the case of the United Mine Workers' Health Fund, the entire legislation was an amendment to the Internal Revenue Code?

Under the United Mine Workers' Health Fund, the failure to pay premiums was enforced through the Internal Revenue Code as a failure to pay tax. In the Health Security Act, the legislation is not a part of the Internal Revenue Code, and the failure to pay premiums is not enforced through the Internal Revenue Code.

Is CBO's rationale for treating health premiums under H.R. 3600 as miscellaneous receipts the same as or different than the treatment of the United Mine Workers' Health Fund legislation?

QUESTIONS FOR CBO

11. The CBO has also assessed the Federal fiscal impact of two other comprehensive health reform proposals in the past few years. In particular, I recall that the CBO priced S.1265, the "Minimum Benefits for All Workers Act" (100th Congress) and S.768, the "Basic Health Benefits for All Workers Act" (101st Congress).

Both of these proposed bills included an employer and employee mandate to purchase insurance coverage, and required employers to contribute 80% of the cost of the premiums.

I have looked at your official cost estimates of these bills and cannot find that you classified the mandatory premiums as "on-budget" expenditures. I would appreciate your commenting on why you have reached a different conclusion with respect to the Health Security Act.

QUESTIONS FOR CBO

12. I wonder if you could comment on what you see as the differences between the health alliances and government-sponsored enterprises such as the Student Loan Marketing Association and the Farm Credit System Financial Assistance Corporation. These government-sponsored enterprises are Federally chartered and regulated. It seems to me that it could be argued that these are more directly Federal activities than the health alliances, which are State chartered and partially State regulated. I assume you agree with the fact that the expenditures of these government-sponsored enterprises should not be shown as "on budget." I would appreciate your comments as to why you think the premiums paid to health alliances are somehow different.

QUESTIONS FOR CBO

13. I am confused about how this mandate is different from other federally mandated employee benefits, such as the minimum wage.

Federal law specifies that all employers must comply with the minimum wage and other fair labor standards regarding wages and hours. The Department of Labor and federal prosecutors even enforce our wages and hours laws. Yet I have never heard it argued, even by opponents of the minimum wage, that wages should be considered "on-budget" simply because a federal mandate specifies that they must be paid.

The employer mandate looks to me a lot like an increase in the minimum wage. It says that in addition to a minimum wage, all employers must also provide a minimum health benefit, though they are free to provide a larger health benefit, just like they are free to provide a higher than minimum wage.

Help me understand the difference.

QUESTIONS FOR CBO

14. I understand that H.R. 3600 requires that employers help pay for health insurance premiums of their employees. I don't understand how this insurance requirement is different from other private insurance which various federal and state laws now require.

In most states, for example, all cars must be insured with at least a minimum level of insurance. While you could choose not to drive a car, you cannot choose not to ride in a car and still function in society, which means that directly or indirectly we all pay required auto insurance premiums.

When we buy auto insurance, we call insurance agents who are licensed by the government and buy insurance policies which are regulated by the government. Yet I don't think any of us think of our car insurance payments as a tax or as a payment to the government of any kind.

Can you help me understand the difference between requiring health insurance as opposed to auto insurance?

QUESTIONS FOR CBO

15. In thinking about your opinion that the premiums paid to the alliances should be categorized as "on budget," I thought of a precedent in the environmental area in Title I of the Clean Air Act. I wondered if you could help me understand what the difference is between that statute and the Health Security Act.

Title I of the Clean Air Act requires State or local governments to take an extremely detailed series of actions to improve the quality of air. For example, in some cases, the State or local government may not license the opening of a new plant that will emit pollutants unless it closes an existing plant. As I understand it, the cost of these measures is not scored as being "on budget." And yet the Clean Air Act also includes a provision that allows the Federal government to assume the functions of the State or local government necessary to carry out the provisions of the Clean Air Act if the State fails to do so, which is similar to the provision for the failure of States to establish alliances under the Health Security Act. Can you help me understand the distinction?

QUESTIONS FOR CBO

16. I understand that your opinion is that the premiums paid to the alliances should be categorized as miscellaneous receipts. Some have suggested that this is tantamount to a tax. But it seems to me that these premium payments lack key characteristics of a tax:

- The premiums will not be paid to the government and will not go through the Federal Treasury;

- The premiums are not a standardized amount; rather, they are based on the average price of health plans in an alliance area as negotiated by a private entity and represent the actual cost of covering people enrolled in the alliance;

- Even within a particular alliance, the mandated premium is a minimum rather than an actual contribution level (the employer contribution may be higher than the minimum);

- The employee and individual responsibility is a general requirement to enroll in a plan rather than a specific financial obligation. The financial obligation of the employee is a function of the difference between the

employer contribution and the plan chosen, and is neither a fixed dollar amount nor a fixed percentage.

Do you agree with my description of the premiums paid to the alliances? If not, can you explain how you disagree?

QUESTIONS FOR CBO

17. I am confused by this characterization of premiums paid to the alliances as being receipts that should be classified as "on budget." It seems to me that we regulate businesses and individuals in many ways that have never been included in the Federal budget.

I can cite a few examples that come to mind, including:

- The employer requirement to abide by the Occupational Safety and Health Act;

- The employer requirement to comply with the Americans With Disabilities Act;

- The requirement on automobile manufacturers to install seat belts.

All of these kinds of government regulation have undeniable costs to the entities that are regulated, but we do not categorize them as "miscellaneous receipts" that must be detailed in the Federal budget. Can you explain why these situations are different than the premiums paid for private insurance in the alliances?