MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris J.
RE: FYI on Conversation with Senator Wofford
cc: Melanne

April 10, 1995

During your trip in India, Senator Wofford asked me to meet with him following a discussion we both had with the board of Families USA. He mentioned how upset he was at himself for not calling you prior to your departure. (He wanted to share his experiences in India and give you some advice.) He said he would love to talk to you about the trip once you returned; I told him I was certain you would enjoy such a discussion. (Just a heads up that he may call -- if he has not done so already.)

The Senator seems to be having problems deciding exactly how he wants to frame his writings on health care. However, he is giving a number of speeches on the history and current status of health reform. I gave him some new budget and polling numbers, and he seemed quite appreciative.

Lastly, as you may know, Senator Wofford is writing and giving NPR commentaries on a wide range of issues. Attached for your information are copies of some of his latest comments that he gave to me.

NATIONAL PUBLIC RADIO - Morning Edition - 3/28/95

"The secret heart of America."

Comments by Harris Wofford

Why do we make it so hard for our politicians to strike a common sense balance on complicated issues like affirmative action?

That's the "wedge" issue now being used by those who see America divided into two warring camps on matters of race and poverty, and hope to win by the formula of divide and conquer.

Race is the oldest, most dangerous wedge in American politics -- a time-tested way to split the nation apart. Once it led to civil war. For years afterwards, especially in the South, it was the way for demagogues to win elections.

Knowing the damage racial discrimination was doing to his region and to the country, Lyndon Johnson, the president who gave the strongest original push to policies of affirmative action, warned that this issue of securing "the full blessings of American life" to those who had been left out and left behind lays "bare the secret heart of America."

It still does. As Pat Buchanan and Phil Gramm hammer on this wedge with glee, Jesse Jackson threatens to run for president himself if President Clinton proposes any changes in those policies.

So off we go to another political war, this time on a matter that brings out not the better angels of our nature, but the worst in us.

Have we forgotten what we learned from the years of civil rights struggle in the South and then from the riots in the cities of the North and West?

Three decades ago, when affirmative action became national law and policy, most Americans -- and both parties -- agreed that remedial action to open the doors of education and economic opportunity was necessary and proper. Most of us understood that overcoming a century of discrimination

would be far more complicated than striking down segregation laws or enforcing the right to vote. We also recognized that when goals are turned into quotas a price is paid -- both by those who consider themselves victims of reverse discrimination, and by those who benefit but suffer a psychological wound from doubt that they have advanced on their own merits. So we hoped that the time would come when these remedies were no longer necessary.

Take one example. In the 1950s there were only a handful of women students in my law school classes. Women suffrage leaders went to historically black Howard Law School at the turn of the century because neither they nor black students could break the white male monopoly at other schools. Today women law students, who may soon outnumber men, no longer need help in law school admissions. But can anyone deny that there are many other areas where special efforts are still needed, especially in tapping the talents of African-American or Latino men and women?

So it is time to review the various kinds of affirmative action to see which are still needed and which may do more harm than good. But let's do it knowing this still is an issue that lays bare the secret heart of America. Let's do it not in the spirit of political warfare, not with partisan hammers, and not with the kind of broad-brush denunciation coming from those whose real goal is to sew division and reap votes.

National Public Radio - 3/4/95

"The political football of the Balanced Budget Amendment."

Comments by Harris Wofford

The political football of the Balanced Budget Amendment has been kicked off the field -- for the time being. But Senator Dole promises to bring it back before the presidential election, when the heat under the feet of Democratic senators will be hottest. That's the kind of game they love to play in Washington. And its the kind of low political gamesmanship that makes people hate politics.

Maybe some Member of Congress with a sense of humor will throw onto the field an ultimate political football: a constitutional amendment that rolls into one the two most controversial pending proposals, the amendment, just blocked, for a balanced budget, and the one still to come, for prayer in schools. That would be a constitutional amendment requiring that public schools begin each day with a prayer for a balanced budget.

Joking aside, Republican leaders better reconsider their course because they're on a hot seat, too. With straight faces they promise that cuts in Social Security will not go on the budget-balancing table yet they let the amendment go down to defeat rather than put that promise in the proposed amendment. Who do they think they're fooling? The people, of course.

They know politicians are trying to fool them about Social Security and about a balanced budget, and probably about prayer in schools. As everyone is at last discovering, the surplus in the Social Security fund is being counted as an asset in balancing the budget and not treated as a debt owed to people who reach the qualifying age. For the sake of honest budgeting, it's time we faced up to the fact that our national debt is larger than we're told. That's because these social security funds are a trust held for those who paid for some security in their older years.

Let's put this challenge to those in Congress who say they consider Social Security a sacred contract with the American people: If you mean what you say, then come together, across party lines, and take the steps necessary to stop counting the trust fund surplus in budget-balancing. And then move on to some practical health care reform that would enable the growth of medicare costs to be cut, fairly -- that would do more to reduce the deficit than any other action Congress can take, since health care costs are the only major budget item that keeps increasing beyond the rate of inflation.

This is what President Clinton has been asking. Instead of lip service about reducing the deficit or playing politics with the issue, the President has already taken the country, in just over two years, further toward a balanced budget than any administration since John Kennedy's. Let's keep on that track.

NATIONAL PUBLIC RADIO #1 - 2/27/95// broadcast 3/1/95

". . . give governing a chance"

Comments by Harris Wofford

In the midst of the fanfare over the launching of the presidential campaigns of Senator Phil Gramm and Lamar Alexander, and the visits of a dozen would-be Republican candidates to New Hampshire, did you notice the obvious relish with which Washington political reporters welcomed the early start of the 1996 race?

It was as if they were at last relieved of the heavy duty of trying to make sense of Washington's real -- and complicated -- problems of governing -- released to travel again the Road to the White House.

The trouble with that is there already **is** someone in the White House, beginning the second half of his term. This is 1995, not '96, and a lot of us were hoping that at least this year, the year before the big quadrennial battle, Washington might get some governing done.

The dialogue of Newt and Bill, and now the dialogue between the House and the Senate, is just beginning to get interesting. There is agreement on some major goals -- the reduction of government bureaucracy, welfare and health care reform, progress toward a balanced budget. In the clash of ideas about how to reach those goals, there is the possibility that 1995 could see some hard-fought but practical and perhaps historic compromises.

There's little chance of that happening in the midst of election warfare. An American national election is a kind of war, with aerial bombardment, simplistic promises, thirty-second negative ads, charges and counter-charges -- everything but governing. Last year as the election tactics of slash and burn took over, Congress became a killing field for legislation -- even for legislation members on both sides of the aisle favored.

When an old woman was once asked why she took pride in never voting, she said, "I don't want to encourage them!"

Maybe one reason so many Americans are now saying the same thing is that the election seems to never end. We can't discourage the candidates, but let's ask news editors assigning reporters not to forsake Washington for the campaign trail -- not yet. Let's have some balance in the selection of stories and give governing a chance.

MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Health Care Polling Data
cc: Melanne, Jen

March 14, 1995

Stan Greenberg's shop has been pulled a host of public polling data on a wide variety of issues. I thought that you might be interested in reviewing those questions that have health care as their central focus.

A brief review of the information documents that health care reform remains at or near the top of the public's legislative priorities. Americans also consistently report that they not only lose their appetite for deficit reduction when Medicare is thrown on the table for consideration, but that cuts in the Medicaid program -- defined as the "health program for the poor" -- produces a similar result. More specifically, at least two thirds of those surveyed respond negatively to Medicare and Medicaid cuts being used for deficit reduction.

The polling data clearly points out the problem the Republicans will have when they formally propose the level of Medicare and Medicaid cuts (over $200 billion over 5 years to be roughly divided between the programs) that they are reportedly considering. If we choose to criticize their proposals, they will be extremely vulnerable to charges that they are undermining the programs and the people they serve. (This will particularly be the case when the aging advocacy groups join in -- or start -- their own chorus of criticism.)

The likely fig leaf the Republicans hope to stand on is the public's growing familiarity and comfort with managed care (HMOs/PPOs/etc). If the Republicans can sell their approach as providing greater choice, with the ability to retain the option of fee for service, they may have some chance of capturing the media elite and at least some of the public. The fact is, however, that the only way that managed care can produce the level of savings the Republicans are discussing is through limiting choice of affordable options.

The many issues and options surrounding managed care, particularly Medicare managed care, need to be fully discussed and evaluated. Attached for your review is a current draft of a memo we wrote for the President on this issue. By next week, we plan on completing our review of the possible managed care options that are likely to be on the table. We will of course get this information to you as soon as it is available.

January 27, 1995

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: CHRIS JENNINGS
SUBJECT: Health Care/Budget Briefing
cc: Melanne V.

The following information was prepared as back-up for an oral briefing for the President on the implications of a Medicaid block grant or cap. Because of time constraints, the briefing was cancelled

Since the Medicaid subject is not likely to be raised at NGA this weekend, Carol decided it would not be wise to overwhelm him with paper at this time. I thought, however, that you would be interested in the enclosed. The Medicaid capping issue will be at the heart of the upcoming budget discussion and I believe this information may be quite helpful to you decide how we can best evaluate how to respond to the inevitable Republican initiatives in this area.

Attached you will find a 2-page document that provides a brief summary of the budget and political status of this proposal and an advantage/disadvantage summary. Behind this document is a much more detailed background memo which illustrates the serious implications of the block grant/capping idea and the reason why many of the Democratic Governors (and particularly the advocates) are nervous.

On an unrelated matter, I want you to know that I have started meeting with Drug Company reps on the regulatory review issue. Just last night, I had a productive discussion with Merck and Bill Schultz (the new FDA Deputy to David Kessler and a friend of mine). They had a number of ideas that sounded quite reasonable to both Bill and myself. Their particular gripe is with the section of FDA that reviews biotech drugs and their slow and unresponsive review process.

We are going to meet with at least two or three others companies (I will include American Home Products on that list) in the very near future to add to our now growing list of regulatory changes that will please the industry and that can be implemented without compromising safety. I would be happy to go over them if you have any desire to do so.

Lastly, I talked with Harkin's staff. They are sending me over everything they have been doing in their oversight work on HCFA. Their staff is very interested in working with us. I'll talk to you the moment I have some follow-up that comes close to being worthwhile.

MEDICAID: BUDGET AND POLITICAL ENVIRONMENT

- **Congressional Republicans need hundreds of billions of dollars** to finance tax cut and deficit reduction pledges.

- **Medicaid is seen as major cash cow** because it is vulnerable as it serves the poor and because many Governors may be willing to negotiate over a cap. (In addition, Republicans growing increasingly nervous about excessively large Medicare cuts.)

- **Speaker Gingrich discussing a 5% cap on Medicaid program growth,** which would yield $130 billion ($193 billion using CBO numbers) in Federal savings through 2002 and $375 billion ($500 billion using CBO) in Federal savings through 2005.

- **Republican Governors either supportive or staying quiet for now** because they philosophically support. Moderate Republicans from states with high growth rates are evaluating just how they could live with these reductions in Federal dollars.

- **Governor Dean sending signals he might be open to a cap, although most Democratic Governors appear to be extremely nervous about it.** Governor Chiles, for example, is very opposed to eliminating individual entitlement. Having said this, some low growth rate states think it might not be a bad deal for them and others are nervous about defending a program for the poor. The fear that unifies almost all of the Democrats, however, is the size of potential reductions in Federal support.

- **Not on NGA agenda for this weekend, although DGA meeting may discuss** to plan out a more unified Democratic Governors' strategy. Medicaid capping may also come up in context of balanced budget disucssions that may be raised at NGA meeting.

- **Any block grant deal on welfare reform will serve as precedence** and political cover for Republicans who need the Medicaid money.

- **Weak but vocal advocates are opposed and scared:** many of these are considered our traditional Democratic base.

ADVANTAGES AND DISADVANTAGES OF MEDICAID CAP

Advantages

- Allows Federal Government to achieve savings by lowering or capping growth rate.
- Increases flexibility for States to design and administer Medicaid programs to reflect their priorities.
- Avoids requiring Congress or the Administration to specify cuts.
- Provides greater predictability in future Federal Medicaid funding.

Disadvantages

- Impact on States
    - Leaves States at risk during recessions.
    - Places States at risk for cost of aging population.
    - Makes States less able to expand coverage.
    - Forces Governors -- not the Congress -- to specify cuts.
- Impact on health reform
    - Increases number of uninsured.
    - Exacerbates cost shifting.

MEDICAID CAP/BLOCK GRANT BACKROUND INFORMATION

PURPOSE:

To review the implications for states and for coverage under the Medicaid program of NGA and likely Republican proposals to cap Medicaid spending.

BACKGROUND:

Although not on the formal agenda, it is possible that the topic of capping the Medicaid program may be raised at the upcoming meeting with the Governors. (In all likelihood, if it is raised, it would come up in the context of the balanced budget amendment discussion.)

NGA's proposed policy would give states the choice between continuing Medicaid as an individual entitlement or accepting a capped federal payment. The NGA staff recognize this "choice" is a political and not a practical policy response to a desire by many Republican Governors to assure that a Medicaid cap/block grant proposal is on the table for consideration. Democratic Governors, like Governor Chiles, have made the point that such a choice would not work in the Congress or in the budget world since states could choose what is best for them financially; as a result, the primary incentive for enacting a cap -- saving Federal dollars -- would likely not be achieved in any significant way.

A number of Governors have been discussing a Medicaid block grant with the Republicans in Congress. Both Governor Dean and Governor Thompson have indicated that they might be able to "live with" a Medicaid block grant that caps the growth in federal contribution at a 5% growth rate (the projected baseline growth rate is 9.3%). Under a 5% growth rate scenario, the reduction in federal spending would be very large -- about $375 billion over ten years (over $500 billion under the CBO baseline). In recent days, however, Governor Dean and his office have made clear he has made no deal and does have concerns.

It is worth pointing out that a 5% cap means that the states (in aggregate) must reduce total program costs by the $375 billion before they can begin reducing their own spending levels. While there are some low growth with fairly large base levels who could save money in the short-term, it is unlikely they could do so over the long term without cut-backs in services or programs.

Obviously, the Governors are interested in block grants because they free states from federal requirements and oversight. Many Governors appear to be willing to consider reductions in federal payments in exchange for greater flexibility that results from eliminating the individual entitlement. However, if the Administration can come up with proposals that are responsive to the flexibility requests of the States that do not include Federal caps, such an approach could well be more attractive. (Such approaches are discussed at end of the memo).

Proposals to convert Medicaid to a block grant raise a number of serious concerns. Some relate to converting Medicaid from an individual entitlement to a block grant. Others relate to the effect that significant reductions in federal payments would have on coverage. The following outlines these concerns.

Converting from Individual Entitlement to a Block Grant Raises State Concerns:

- **States At Risk from Inflation and Recession.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the level of need. For example, when a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, the federal government shares the additional costs. Under a block grant, states must address the increased need on their own, either by increasing state spending or reducing services and coverage.

- **Block Grants Do Not Recognize Differences Among State Programs.** A block grant that fixes the growth in federal payments at a set percentage would benefit some states and penalize others. State growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns or service mix. States also have very different opportunities to achieve savings through managed care (e.g., some states already have achieved savings; rural states have less capacity to implement capitated payment arrangements). An individual entitlement adjusts federal payments to these changing circumstances; a block grant does not. The variation in state growth rates for the 1990 to 1993 period is shown in Attachment 1.

- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services as the population ages.

- **Tough Choices Are Devolved To States.** Under a block grant approach, the federal government can achieve substantial federal budget savings without taking responsibility for identifying specific cuts in payments, services or eligibility. The tough choices about where to cut are left to the states. This problem is likely to get worse over time, since reducing the rate of growth of a block grant payment is much easier than making specific program cuts.

Effects of Capping Federal Payments

Given the magnitude of cuts necessary to fulfill Republican promises, a block grant would inevitably result in a significant reduction in federal Medicaid payments to states. For example, the 5% growth proposal that Speaker Gingrich has discussed with the Governors would reduce federal payments to states by $130 billion between 1996 and 2002, and by about $375 billion between 1996 and 2006. (Under the slightly higher CBO baseline, the reduction is over $500 billion over the ten-year period). In 1997, projected federal payments would be reduced by about 7% to 10%; in 2006, the reduction rises to 35% (40% under CBO baseline). This is due to the cumulative effect of annual reductions in federal payments. This is shown graphically in Attachment 2.

You may hear from some Republican Governors (and particularly Republicans from the Hill) that large reductions in the growth of federal payments are acceptable because managed care can produce enormous savings. Although managed care can improve efficiency and thereby produce meaningful savings , the savings are not nearly enough to compensate for the very large reductions being discussed with the block grant proposals.

Given the rapid expansion of managed care that already is occurring in states, a significant portion of the potential savings are already being realized. Also, managed care is applied almost exclusively to the nonelderly, nondisabled population, who account for only about one third of Medicaid expenditures. Preliminary OMB estimates show that if all nondisabled, nonelderly recipients were enrolled in managed care by the year 1999, any additional savings through 2005 would be less than $5 billion. However, some states may use managed care as a mechanism simply to make large cuts in provider payments. In reality, this is a cost shifting strategy rather than cost containment.

Under the current baseline, Medicaid enrollment is projected to grow at about 4% annually. Medicaid per capita spending actually is projected to grow at approximately the same rate as per capita private health spending. Therefore, capping federal Medicaid payments substantially below baseline would appear to assume either that states can contain costs much better than the private sector or that substantial reductions in the scope of the program (including cuts in eligibility) are acceptable. While some states may be able to adapt to such a large reduction in federal support for a few years, most probably cannot. Over a longer period, few states could respond to this level of reduction without significant program cuts.

Illustration of State Responses to Capping Federal Payments

The following discussion illustrates the impact on states of a block grant that caps the federal payments at a 5% rate of growth. For ease of presentation, the information is presented under the assumption that states would respond to reduced federal payments entirely through one of the following: (1) higher state spending, (2) lower provider payments, (3) benefit cut backs, or (4) eligibility cutbacks. Although a few states might increase spending in response to federal payment reductions, most would likely reduce eligibility, benefits or payment levels.

The following scenarios assume that states maintain (or in the first case, increase) the level of spending projected in the baseline. The state responses shown below merely offset the reductions in federal spending -- they do not produce any savings to states. If states were to reduce their spending below the projected levels in order to achieve savings in their own budgets, additional reductions would be needed.

- **Increase State Medicaid Spending**
  If states chose to increase their own spending in response to the reduction in federal payments, between 1996 and 2002, state spending would need to increase by over 20% over baseline projections. However, because the size of the federal payment reduction would grow each year, the percentage increase in state spending would also need to grow:

  - In 2002, the increase in state spending would be 32% over baseline projections;
  - In 2005, the increase in state spending would be 43% over baseline projections.

- **Reduction in Provider Payments**

  If states chose to reduce provider payments in response to the reduction in federal payments, between 1996 and 2002, payments to hospitals, physicians and nursing homes would be reduced on average by 13.7%. And because the size of the federal payment reduction would grow each year, the percentage reduction in provider payments (relative to baseline projections) would also need to grow. For example:

  - In 1997, a 6% reduction in hospital payments would be needed;
  - In 2002, a 22.9% reduction in hospital payments would be needed;;
  - In 2005, a 32.8% reduction in hospital payments would be needed.

  These reductions are on top of Medicaid's already low payment rates. This level of provider cuts will disproportionately harm public hospitals and clinics, for whom Medicaid is a significant payment source.

- **Reductions in Benefits**

  States also could choose to reduce benefit levels in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular categories of benefits is shown in Attachment 3. For example, eliminating all dental benefits could achieve about 28% of the necessary savings from baseline in 1997. Eliminating personal care services would achieve about 55% of the necessary savings.

These reductions, however, would not be sufficient over time, because the size of the federal reduction would increase each year. For example, in 2002, eliminating dental benefits would produce only 8% of the necessary savings, and in 2005, only 6%. In 2005, eliminating all benefits for dental, prescription drugs, EPSDT, home health care, hospice, personal care services and payments for Medicare premiums and cost-sharing still would not be sufficient to compensate for the lost federal funding.

- **Reductions in Program Eligibility**

  States also could choose to reduce coverage eligibility in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular eligibility categories is shown in Attachment 3. For example, eliminating eligibility for non-cash children (the OBRA expansions) would achieve about 62% of the necessary savings in 1997, but only about 14% in 2005. Again, because of size of the federal reduction would grow each year, the reductions in eligibility also need to grow.

In reality, states would respond through a combination of these approaches. However, given the magnitude of the reduction in federal payments, even when states spread the cuts over several of these categories, the reductions in each category would still be quite large. For example, a 5% cap would reduce federal payments to states in 2005 by about $66.3 billion below baseline projections. If a state chose not to increase spending and were to allocate their portion of this reduction roughly equally to reductions in provider payments, benefits and eligibility, it could achieve approximately the necessary savings through:

- Reducing provider payments by 12 to 13%.
- Eliminating coverage for prescription drugs and EPSDT, and
- Eliminating coverage for noncash children and qualified and special Medicare beneficiaries (QMBs).

And, because federal payments would continue to decline, further reductions would be needed in each future year. Other options are, of course, possible. Chart 3 gives you a partial menu of how much the elimination of particular populations and services (on a nantional level) would save. Some would argue that states would be more likely to choose eliminate AFDC adults rather than noncash kids and QMBs.

Even under less extreme proposals, federal payment reductions can be significant over time. For example, a 2 percentage point reduction in baseline rate of growth would result in a large reduction in federal payments -- $ 66 billion-- between 1996 and 2002. In 2006, projected federal payments to states would be reduced by nearly 20%.

CONCLUSION

Medicaid block grant proposals under discussion would dramatically reduce federal Medicaid payments to states over time. Increased use of managed care cannot generate the savings necessary to make up for these reductions and there is little room in state budgets to increase state Medicaid spending to compensate for the reduced federal commitment.

Unless states choose to offset federal reductions with increases in state spending, they would be forced to respond by reducing provider payments, services, and/or coverage. Given the inflexibility of a block grant to respond to the needs of individual states and differences in state political environments, the level and nature of the reductions in the scope of the program would vary significantly from state to state.

Reducing the scope of the Medicaid program to such a large extent would not only put those served by Medicaid at some risk, but also set back movement towards more comprehensive health reform in a number of ways, including:

- **Increasing the number of uninsured.** Recipient growth currently accounts for two-fifths of overall Medicaid program growth. In fact, spending per person under Medicaid is increasing at about the same rate as in the private sector.

  During the early 1990s, Medicaid increased coverage as employers decreased coverage. This trend would be reversed under a block grant, increasing the number of people who are uninsured. The changes in employer-based coverage and Medicaid are shown in Attachment 4.

- **Exacerbating cost shifting**. One of the central problems in our health system is the shifting of uncompensated care costs and Medicaid underpayments to business and families who purchase insurance. Reductions in Medicaid provider payments or increases in the number of people uninsured would exacerbate this problem.

Alternative To Capping Federal Payments that States May Find Attractive.

The obvious question is how to be responsive to States' legitimate need and desire for more flexibility without imposing significant reductions in Federal support. We have reviewed the NGA's health policy position paper's recommendations and have conducted our own internal analyis, which included discussions with OMB and HHS, and have come up with some interesting possibilities -- there may be even more -- that Iwe believe would be welcomed by the Governors. (Since Medicaid is not scheduled to come up before the NGA meetings, we probably should discuss when would be the most strategic and opportune time to begin discussions with the Governors on this issue.)

Specific and preliminary options to Medicaid cap now include:

- **Agree to NGA's request to eliminate the 1915(b) waiver approval process for states implementing managed care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.

- **Consistent with NGA request, agree to eliminate the waiver approval process for states implementing home and community-based care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.

- **Enable states to target programs and services to specific populations and communities.** Requirements that programs and services be uniform statewide would be removed for Medicaid managed care, home and community based programs, and optional services.

- **Agree to NGA's request to establish safe harbors under the Boren amendment for state hospital payments.**

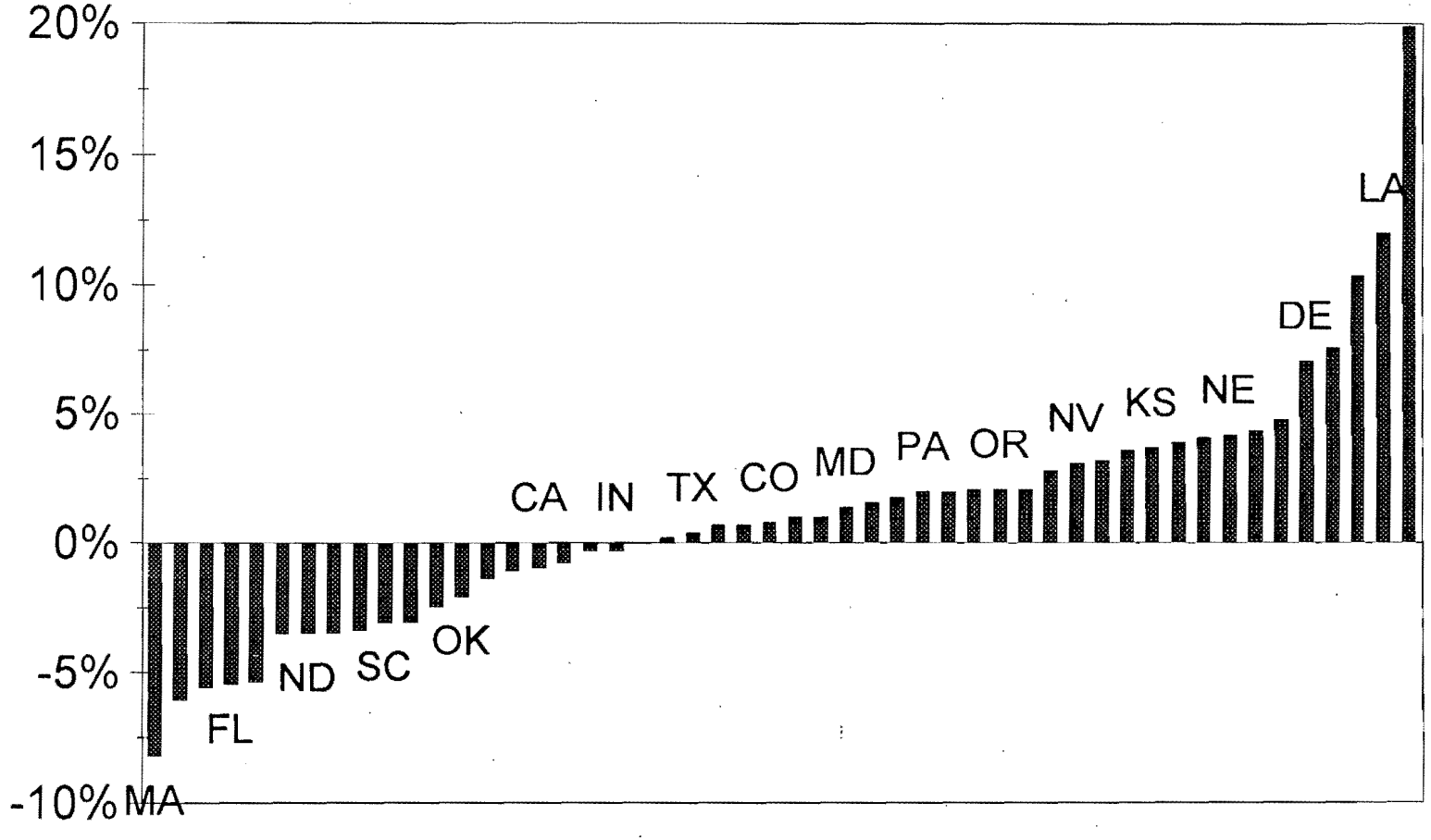
- **Agree with NGA that Boren amendment requirements do not apply to managed care arrangements.**

- **Agree to NGA's request for substantial modifications to the PASARR provisions under nursing home reform.** For example, agree that the annual resident review should be repealed.

- **Agree to NGA's request for the development of more demonstration programs that investigate the integration acute and long-term care services.**

Variation in State Medicaid Growth

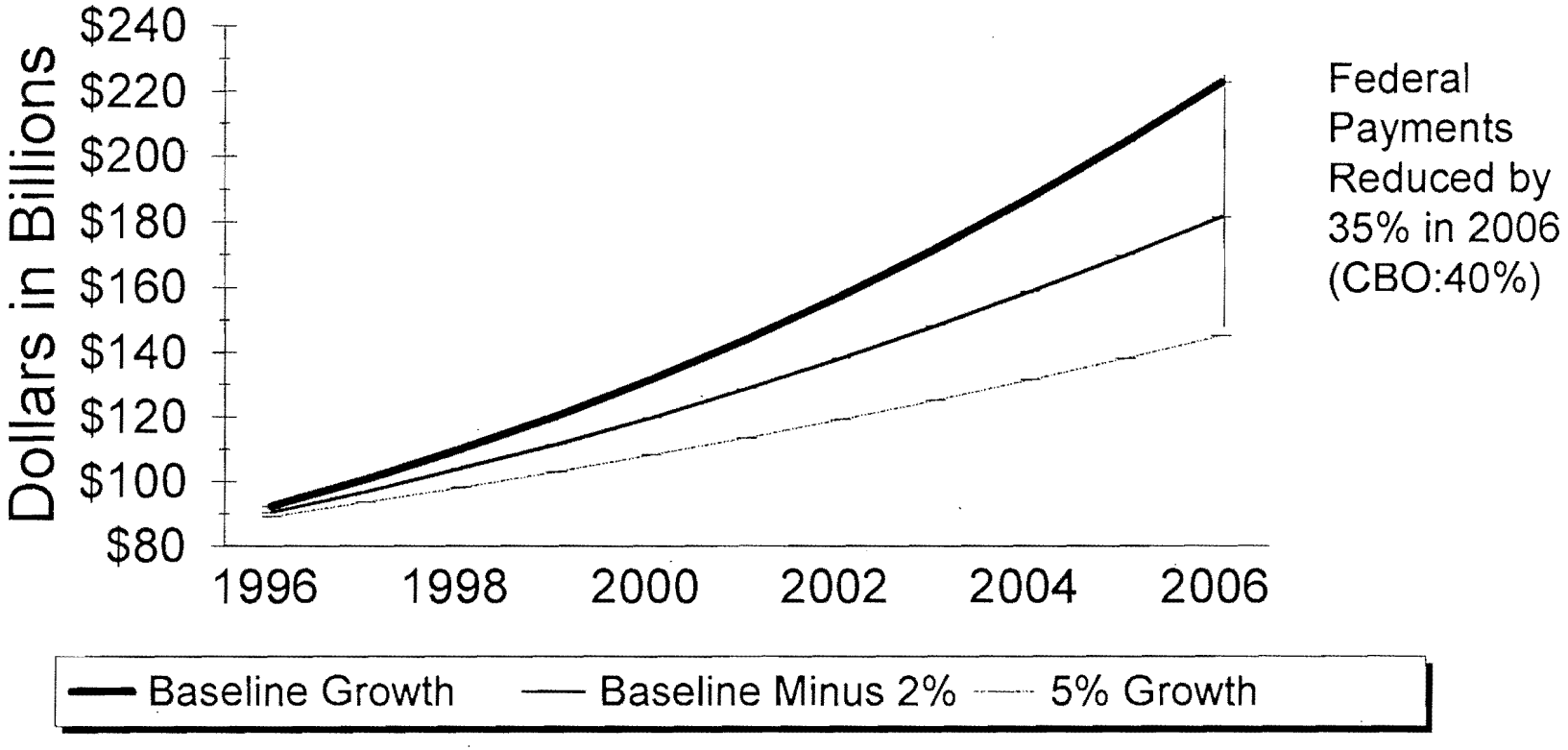
Difference from Average, 1990-1993



* Note: Average annual per capita growth rates, excluding Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

Federal Medicaid Payments 1996-2006

Baseline & Capped Federal Payments



This wedge Illustrates the cumulative effect of capped expenditures. Over time, the size of the federal payment reduction grows.

Potential Savings From Eliminating Selected Services or Recipient Categories

	1997 $ in billions	2005 $ in billions
Reduction in Federal Payments with Growth at 5%	-7.0	-66.3
Cost of Services		
Dental	1.9	3.9
Drugs	9.3	17.6
EPSDT	1.1	4.0
Home Health & Hospice	2.5	5.8
Medicare Premiums & Cost Sharing	4.7	10.8
Personal Care Services	3.8	7.1
Cost of Services for Recipients		
AFDC Adults	12.0	24.4
NonCash Kids (OBRA Expansion)	4.3	9.5
QMBs/SLMBs (1)	4.7	10.8
Medically Needy	22.1	38.8

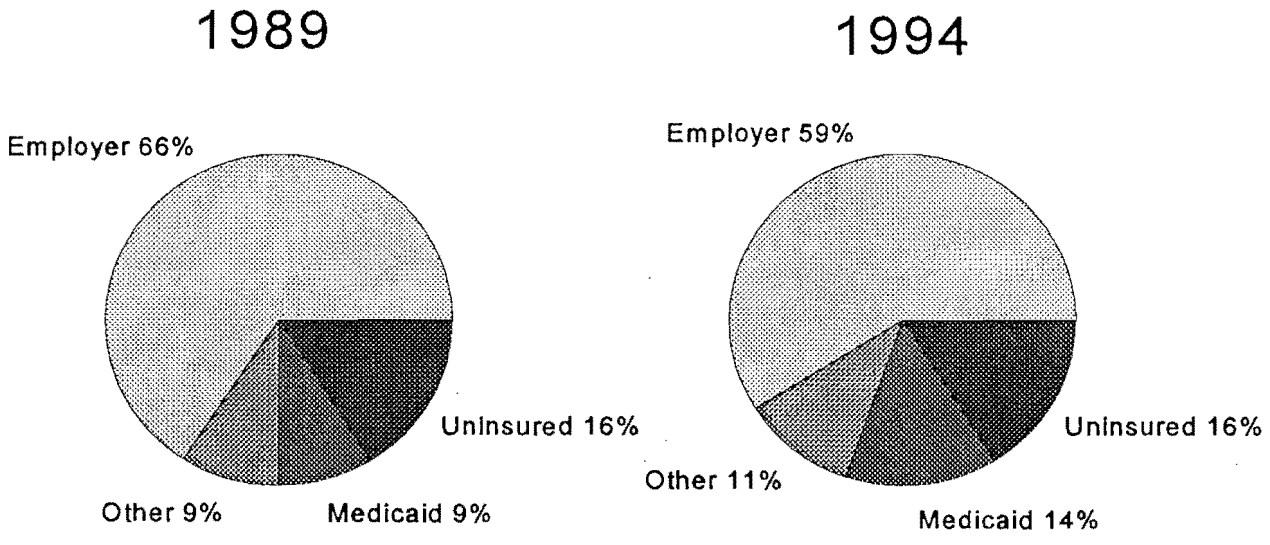
- The 1997 reductions will not be sufficient over time, because the size of the federal reduction would increase each year. For example, while eliminating dental benefits could achieve 28% of the required savings in 1997, in 2005 this service reduction would produce only 6% of the necessary savings.

(1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost of Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states, and overstate savings, because of interactions in the expenditure categories.

Changes in Insurance Coverage

1989 to 1994



SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

The 1989 data represent an average of three years, 1988-1990, with 1989 data having a weight of .50 and 1988 and 1990 data having weights of .25. The 1994 estimates are based on 1993 CPS data on insurance coverage as adjusted by The Urban Institute's TRIM2 microsimulation model and 1993 HCFA data on Medicaid enrollment. Estimates for 1994 were derived using CBO projections of changes in insurance coverage.

SMALL BUSINESS, HEALTH CARE COSTS, AND THE CLINTON REFORM PLAN*

Small businesses face higher costs and more unstable insurance premiums. The Clinton plan will reduce these burdensome costs.

TODAY	THE CLINTON REFORM PROPOSAL
High Administrative Costs: Higher administrative costs kill small businesses. These costs account for as much as 40% of the policy costs compared to about 5% for large companies.	**Cuts Administrative Costs:** Administrative costs will be dramatically reduced by the formation of health alliances which will streamline and simplify administrative functions.
Faster Rising Costs: Premiums for small employers rise at a faster rate than for other employers -- as much as 50% in any given year. [NAM]	**Aggressively Controls Costs:** Health reform will aggressively control costs through market based competition backed up by an enforceable budget.
Inequitable Self-Employed Tax Policy: Today, unlike big businesses, small, self-employed businesses cannot deduct 100 percent of their health care expenses. This has the practical effect of further increasing the cost of insurance that is already priced higher than that available to larger firms.	**Increases Deduction to 100% for Self-Employed:** The Administration proposal will ensure that the self-employed are treated equally under our nation's tax policy, allowing them to deduct the full value of their health insurance coverage.
Workers' Compensation Costs: In today's system, high health care costs are surpassed only by the skyrocketing costs of workers' compensation insurance. Between 1980 and 1985, workers' compensation medical cost grew more than one and a half times as fast as medical costs and now accounts for $24 billion a year in health care expenditures.	**Reform Workers' Compensation:** The Administration's proposal reforms the health component of workers' compensation insurance, making it more efficient and reducing costs by covering work related injuries through health plans in the same manner as non work related injuries -- eliminating duplication and improving quality for workers who receive services.
Small Employers Have No Control: Small businesses and their employees have little or no ability to determine the level of premiums they pay or the information they receive about the services the plans provide.	**Assures Employers a Place on Alliance:** Business owners will sit on alliances to ensure sensitivity and responsiveness to needs of employers in terms of costs, administrative simplification and quality.
Volatile Costs: Small businesses face large variations in the costs of similar plans. Nearly identical benefits packages can range in price by as much as 350%. [Blue Cross/Blue Shield, Survey of Six Sample Plans, January 1992]	**Stabilize Costs:** The Administration proposal will stop the wild fluctuation of premiums in the small group market through community ratings and insurance reform. We will outlaw discriminatory pricing and ensure smaller predictable cost with aggressive cost controls.

SMALL BUSINESS, INSURANCE ABUSES, AND THE CLINTON REFORM PLAN *

Many insurers discriminate against small businesses, often charging more for similar policies or refusing to provide coverage at all. Abuses within the insurance industry hit small businesses particularly hard.

TODAY	THE CLINTON REFORM PROPOSAL
Hassle Factor: Small business owners who cover their employees spend inordinate amounts of time trying to figure out a maze of insurance policies, forms, and requirements. What's worse is that the rules of the game are changed all the time; unfortunately, they are changed by the seller and not the buyer.	**Eliminates Hassle:** The employer no longer has to worry about the headaches of selecting insurance for his/her employees. The employer/employee-run health alliance negotiates rates, provides information on plans, increases ease of enrollment and absorbs the manpower drain. Then, the employee, not the employer, chooses the plan. Regardless of the choice, however, the employer pays the same fixed amount.
Small Risk Pool: Fewer employees mean a smaller pool to share the risk. Insurers frequently charge more for these policies.	**Spreads Risk Evenly:** The proposal consolidates small businesses in purchasing pools to give them the same bargaining power as large firms.
Underwriting and Experience Rating: Medical underwriting is the practice of basing premiums on perceived risk and medical history. Experience rating is when insurers jack up costs after an employee falls ill or gets injured.	**Prevents insurers from raising rates or dropping coverage after illness strikes:** The Administration's proposal will reform practices such as underwriting and experience rating. Under the Clinton plan, you can drop your insurance plan, but they can't drop you.
Price Baiting and Gouging: Many insurers engage in "price baiting and gouging" offering "discount" rates for the first year of coverage only to charge much higher prices in the next year when pre-existing condition exclusions expire.	**Outlaws Price Baiting and Gouging:** The plan will end the days when insurers can raise and lower premiums at their whim. We will bring predictability and fairness to the cost of insuring families and workers.
Occupational Redlining: Some insurers simply refuse to cover entire industries perceived to be high risk.	**Covers Everyone:** Under the Clinton plan, there is an end to occupational redlining.
Refusal to Renew Policy: After a first year of reasonable rates, small businesses often face higher costs and difficulty obtaining renewal.	**Guarantees Renewal**: The Clinton plan guarantees insurance renewal and stabilizes premiums.

* All reform scenarios are based on assumptions of policies which have yet to be finalized or released.

HOUSE SMALL BUSINESS COMMITTEE
July 28, 1993

DEMOCRATS:

CONGRESSMAN JOHN LAFALCE (D-NY): The Chairman of the Small Business Committee, Congressman LaFalce can be a key player on health care reform and invaluable if it supports the Administration package. His support of Family and Medical Leave was crucial. LaFalce is on the Rural Health Care Coalition and close to labor.

Because his upper New York district borders Canada, both LaFalce and his constituents are familiar with and supportive of a single payer system. His role with the small business community and closeness to the National Federation of Independent Business make him skeptical of employer mandates. On the other hand, he understands why breaking the employer-employee link would be difficult. He wrote to the First Lady in February opposing employer mandates and offering to serve as liaison to the small business community. In May he discussed with Chris Jennings his excellent relationship with the NFIB and his regular meetings with their executive director.

He is supportive of universal coverage. The Task Force has been working closely with LaFalce, including Ira with whom he has worked in the past, and is hopeful that he will be helpful. While LaFalce does not have legislative jurisdiction on health care, he wants to hold hearings on its impact. His position may be influenced by his strong anti-choice views.

Recent Developments: In a June 23 meeting with the First Lady and McDermott cosponsors, LaFalce praised the Canadian system for being totally hassle-free. He would prefer no co-payments in the reform bill. He believes the biggest problems are for small businesses who operate on a very small margin. He said anything other than a payroll tax would be more progressive. He asked how to overcome doctor opposition.

The First Lady also met with Chairman LaFalce on the 29th of June. He stated that he "feels passionately" about health care and thought that it was especially important to sever the link between health coverage and jobs. He senses that people don't want to pay more for what they are getting now. He recognizes that a single payer system would mean unacceptable taxes. LaFalce believes that a good argument to make to single payer advocates is the dislocation of people under a complete restructuring of health care. LaFalce prefers a premium to a payroll approach. He asked how contract employees would be covered - by the employee, the service utilizing them, or the contract service. There was discussion of a $1500 deductible premium for the self-employed. He suggested a phase in over three or four years for low-wage workers and those under 25.

Regarding the NFIB, LaFalce wants to try for them to be simply opposed rather than undertaking a high mobilization opposition. He thinks their only concern is the financing mechanism. He would try to convince them to oppose that mechanism in a floor vote but not the whole package.

He recommends that the President release a set of health care principles and say that approach is best but that he will look at alternatives – including financing mechanisms. That would be a challenge to Congress and employers to put up or shut up.

In a personal note, he invited the First Lady to visit his Niagara Falls district and stated his interest in helping in whatever way possible. If used, he will be helpful.

CONGRESSMAN NEAL SMITH (D-IA): Congressman Smith has served in the House since 1959 and spends most of his time working on the Appropriations Subcommittee on Commerce, Justice, State and the Judiciary which he chairs. He is hopeful of someday chairing the full committee. Popular in his Des Moines district, Smith is a skilled parliamentarian who has never excelled at internal politics. His work on Appropriations has kept him from a prominent role on Small Business.

While Smith's general health care views are not known he should be supportive of the health care package. He is a liberal who cannot understand why other members, particularly Democrats, put deficit reduction ahead of social needs. He has voted pro-choice. In March, He flew with the First Lady to Iowa.

CONGRESSMAN IKE SKELTON (D-MO): A pro-defense, but not necessarily pro-Pentagon, Democrat, Congressman Skelton is in his ninth term in the House. He is a member of the Armed Services and Small Business Committees, Rural Health Care Coalition and Mainstream Forum. Skelton also served on the Select Committee on Aging. He has two sons pursuing military careers, one of whom served in the Persian Gulf. Congressmen Clay and Volkmer can be influential with him, and he and Secretary of Defense Aspin worked closely together when serving together in the House.

While Skelton's health care views are not know, he can be predicted to be sensitive to the concerns for rural areas and small business. He has said he does not believe the reform package should be voted on in 1993 but that he is worried about the runaway costs of health care. He is anti-choice.

CONGRESSMAN ROMANO MAZZOLI (D-KY): Congressman Mazzoli is best known for his role in the landmark immigration legislation of the late 1980's. Judiciary Committee Democrats, who felt that as Subcommittee Chairman he had sided with the Republicans too often, ousted him from his chairmanship. He did not defect to the GOP, as some speculated, and has since been returned to his chairmanship. Mazzoli represents Louisville and its suburbs and won with 53% of the vote in 1992. He has been less active on the Small Business Committee and tends to be a conservative vote on budget issues.

His general health care views are not known but he is expected to support the reform package. A Roman Catholic, Mazzoli is a strong opponent of abortion.

CONGRESSMAN RON WYDEN (D-OR): The former executive director of Oregon's Gray Panthers, Congressman Wyden is an ardent advocate for the interests of the elderly. An aggressive and tenacious Member, Wyden is a committed liberal who was first elected in 1980. He represents Portland and some of its suburbs, as well as a small rural area. Wyden won in 1992 with 77% of the vote. He serves on both Small Business and Energy and Commerce where he is a close ally of Chairman Dingell. Wyden is a team player who will be willing to broker a deal between liberals and conservatives. He serves on Congressman Waxman's Health Subcommittee and is close to him as well.

Congressman Wyden is an enthusiastic supporter of Oregon's health care reform demonstration program. He is a strong proponent of abortion rights, and sponsored a bill for NIH research on RU-486. Wyden was a major sponsor of legislation to constrain the costs of drugs sold to Medicaid patients, and recently backed a bill to establish a process to provide reasonable prices for drugs, devices and other products receiving NIH funding. In the 103rd Congress, he reintroduced a bill to establish Federal standards for long-term care insurance policies. His staffer participated in Global Budget and the Quality Measurement Working Groups.

CONGRESSMAN NORMAN SISISKY (D-VA): Congressman Sisisky is a World War II veteran and successful businessman whose aim in Congress is to make the Pentagon more fiscally responsible. He serves on the Armed Services Committee as well as Small Business and is a member of the Rural Health Care Coalition. Sisisky serves on the Select Committee on Aging. He is protective of both Portsmouth and the rural interests of his district, including tobacco and peanut farmers.

Sisisky's views on health care reform are not known. He signed the March 30 letter regarding tobacco excise taxes and has been against abortion rights. Sisisky voted against Family and Medical Leave and is not expected to support the Administration on health care.

CONGRESSMAN JOHN CONYERS, JR. (D-MI): The Chairman of the Government Operations Committee was instrumental in establishing the Congressional Black Caucus and is a long-time fighter for civil rights and minority concerns. Conyers, who is also on the Judiciary Committee, surprised many by dropping his sometimes abrasive style and skillfully, albeit sometimes painfully, investigating the charges against black judge Alcee Hastings. Ironically, Hastings is now a freshman Member of Congress.

Conyers favored putting the health care package into reconciliation. He believes health care reform is the most important program since Roosevelt but may be difficult because he strongly supports a single payer approach. Along with Congressman McDermott, Conyers is a leading sponsor of the House Single Payer bill and fights for recognition of that fact. He attended two early meetings with the First Lady. His district is overwhelmingly black and has all the problems one anticipates for a poor urban area. He will fight for those concerns and, while often still a loner, is very adept at press. One of Conyers' staff members served on the Working Group.

CONGRESSMAN JAMES BILBRAY (D-NV): A lawyer from a well-connected Law Vegas family, Congressman Bilbray is a moderate who serves on both Armed Services and Small Business. Despite some missteps when he first came to the House, he is known to be highly intelligent and a successful fighter for his state. White House lobbyists counted him as a "real trooper" on the economic package.

On health care, Bilbray's views are not known. However, he has shown concern for both the elderly and veterans and supports home care. A Roman Catholic, he has stated that after discussion with his family, he now supports reproductive rights.

CONGRESSMAN KWEISI MFUME (D-MD): Congressman Kweisi Mfume (pronounced Kway-see Em-fume-ay) represents most of metropolitan Baltimore. He has been able to turn personal disappointments in his early life into positive life experiences. He was elected in 1986, after serving on the Baltimore City Council. He was first assigned to the Banking, Finance and Urban Affairs Committee and currently serves on the Small Business, Ethics, and Joint Economic Committees. He has spent most of his time on the Banking Committee working on housing issues.

Congressman Mfume is the current Chairman of the Congressional Black Caucus. The caucus has raised two main concerns regarding health care reform. The first is how to address the needs of underserved populations. The Administration's plan must incorporate and reach out to those who are currently underserved by the health care system. Secondly, the caucus is concerned that doctors, who are the primary providers in many African-American communities, are not unfairly treated by the Administration's reforms, and that in developing networks accommodations are made for community providers. Similarly, the CBC is interested in ensuring that traditionally black colleges are not disproportionately effected by health care reform. Congressman Stokes has taken the lead on health care reform for the caucus, and will be extremely influential in getting their support. Congressman Mfume has suggested that if Stokes is happy with the Administration's proposal, they will be happy.

CONGRESSMAN FLOYD FLAKE (D-NY): Congressman Flake is considered one of the new generation of black House members who are willing to work for change through the power structure rather than from the outside. There has been some controversy around Flake, a charismatic AME Minister. In 1991 the government dismissed a case against him in which he was accused of diverting federal housing funds from his church for his own use. In 1988 a church panel rejected claims of sexual harassment by a woman parishioner. Flake is a member of the Small Business and Banking Committees. He is a McDermott co-sponsor but is expected to be supportive of the Administration's health care reform efforts. Flake believes that VA hospitals are underutilized. He attended the First Lady's March meeting with the CBC.

CONGRESSMAN BILL SARPALIUS (D-TX): This is Congressman Sarpalius' third term in Congress, representing the eastern panhandle of Texas. He is a conservative Democrat who voted as often with President Bush as with the Democrats. Sarpalius has a compelling personal history – he was a victim of polio as a child, abandoned by his father at 10, and sent by his alcoholic mother to a home for wayward boys. He served in the State Senate. Sarpalius is now a member of the Agriculture and Small Business Committees. On the latter, he chairs the Health Subcommittee. He is also a member of the Mainstream Forum and the Rural Health Care Coalition. He voted against the budget package in May.

Sarpalius's health care views are not known, but he is said to want to play a major role through his Health Subcommittee. He opposes abortion.

CONGRESSMAN GLENN POSHARD (D-IL): Congressman Poshard treads a difficult line between his conservative outlook and a rural constituency which presses him to vote as a traditional labor Democrat. He serves on the Small Business Committee and is a member of both the Rural Health Care Coalition and the Mainstream Forum.

In December he wrote to the President-Elect about health care reform, in particular the need for access for those living in rural areas. Rural health care was one of Poshard's specialties in the state legislature. He also asked that reform focus on: preventive health care; technology sharing; increased usage of mid-level health care providers, including nurse-midwives, nurse practitioners and physician assistants; conversion of unused hospital beds into paying entities; and improved incentives to recruit health care professionals to rural areas. In March Poshard held three district hearings on health care reform. He forwarded that testimony to the First Lady stating that the result "confirms that major reform of our health care system is necessary and that your efforts in this process are indeed appreciated."

CONGRESSWOMAN EVA CLAYTON (D-NC): Congresswoman Eva Clayton has been elected Chairwoman of the Democratic Freshman class. She represents a tobacco-producing district and was one of the 30 co-signers of the March 30 letter urging caution on tobacco excise taxes. Clayton sits on the Agriculture and Small Business Committees. She is a member of the Congressional Black Caucus, and attended the March 2 meeting with the First Lady.

At that time she was concerned about the role of the Jackson Hole Group in formulating the health care package. In a February letter to the First Lady, she outlined her experience as a County Commissioner faced with the possibility of the only hospital in their rural community being closed. They were not only able to save the hospital but also create a primary preventive care system as well. Based on that letter, her health care focus will be on underserved populations – both rural and urban poor – and on preventive health care. She will be in a delicate position, balancing the conflicting tobacco and health care interests of her district.

CONGRESSMAN MARTIN MEEHAN (D-MA): Freshman Congressman Meehan made his reputation as a crime fighter when, as an assistant district attorney, he dealt with white collar and violent crime, and hate crimes against gays. Meehan comes to Congress with a liberal agenda which fits his Lowell constituency. He may also feel the need, however, to be independent. He serves on the Small Business and Armed Services Committees.

During his campaign, Meehan advocated a "play or pay" health care plan. He supports universal access and has proposed a cost-containment program to bring down doctor and hospital bills. A Roman Catholic, he supports abortion rights. He also supports sin taxes.

CONGRESSWOMAN PAT DANNER (D-MO): Freshman Congresswoman Danner represents a largely agricultural area of Missouri - an area she served in the state senate as well. She sits on the Small Business Committee, and is a member of the Mainstream Forum.

On health care issues, Danner opposes a national system and supports tax breaks for small businesses which offer health insurance. She would like to see costs cut by standardizing medical forms. She also advocates drug coverage for those under 65 and is opposed to rationing. Danner attended the Mainstream Forum meeting with Ira and the First Lady's meeting with the Caucus for Women's Issues. Danner's family is very involved with the medical profession: one daughter-in-law is a nurse; one son-in-law is a surgeon; and one daughter is an anesthesiologist.

CONGRESSMAN TED STRICKLAND (OH): Freshman Congressman Strickland won his first term by 51% and represents an industrial area. He is considered a liberal Democrat. A former professor who ran three times before capturing the seat, Strickland serves on both Small Business and Education and Labor.

He believes in a community based and employment-based approach with small business paying into a public insurance pool. He favors inclusion of mental health benefits in the Administration's plan. He also favors stronger emphasis on preventive care, immunizations and prenatal care. He has pledged not to accept the health care coverage offered to members until all Americans have coverage. He attended a briefing for Congressional members on mental health issues by Mrs. Gore, which he spoke eloquently about the need for reform.

CONGRESSWOMAN NYDIA VELAZQUEZ (D-NY): The first Puerto Rican woman to serve in Congress, Freshman Velazquez (pronounced NYD-ee-uh veh-LASS-kez) has, through a monthly column in the nation's largest Spanish-speaking newspaper and her work for the Government of Puerto Rico, focused her career on the needs of Hispanics, women and the poor. After a fierce primary, she won overwhelmingly in this district which includes lower Manhattan, and parts of Brooklyn and Queens. In addition to the Small Business Committee, she sits on the Banking Committee.

In a March letter inviting the First Lady to discuss health care and tour her district, Velazquez outlined some of the specific health problems of her Latino community: high uninsurance rates; population most likely to receive Medicaid benefits; infant mortality; tuberculosis; HIV; and the need for basic primary care for women. Velazquez is a McDermott co-sponsor and sits on the Banking and Small Business Committees. She is also a member of the Caucus for Women's Issues and the Hispanic Caucus. She attended the latter's March 2 meeting with the First Lady. Velazquez is pro-choice and co-signed the May 13 letter urging inclusion of abortion services in the health care package.

CONGRESSMAN CLEO FIELDS (D-LA): Freshman Congressman Fields is a former state legislator who represents parts of Monroe, Shreveport, and Baton Rouge. Fields is a lawyer and was, at 24, the youngest member in the history of the Louisiana Senate. He won in 1992 with 74% of the vote in his newly drawn district. He now sits on the Small Business and Banking Committees.

On health care reform, he is expected to take his cues from the Congressional Black Caucus. His state has a large charitable hospital system. Fields attended the March 2 meeting with the First Lady.

CONGRESSWOMAN MARJORIE MARGOLIES-MEZVINSKY (D-PA):
Congresswoman Marjorie Margolies-Mezvinsky rode a wave of anti-incumbent, anti-politician sentiment in order to eke out a slim victory in her race for the House. At one time a reporter for WRC-TV in Washington, she is married to former Iowa Democratic Congressman Edward Mezvinsky. She is very skittish about her district which has a Republican edge in registration. However, her constituents are liberal on social issues and have voted Democratic in recent elections. She has voted against the President on economic issues, presumably out of fear of a backlash from her fiscally conservative constituents.

The Congresswoman's particular concerns are children and child welfare, education, and issues related to families. She is the first unmarried American to adopt a foreign child and at one time or another she has had 11 children growing up in her household. She sits on the Energy and Commerce and Small Business Committees.

On health care reform, she has said she wants to be involved but most people believe she will need serious work before she votes for the plan.

CONGRESSMAN WALTER TUCKER (D-CA): The former Mayor of Compton, freshman Congressman Tucker's ethnically diverse district has perhaps the highest unemployment rate in California. Tucker has a law degree from Georgetown University and comes to Washington with a decidedly liberal, urban agenda. He is a member of the Small Business Committee.

Tucker campaigned for health care reform and for federally financed inner-city health centers, including mobile clinics. He attended the First Lady's March meeting with the Congressional Black Caucus.

CONGRESSMAN RON KLINK (PA): Freshman Congressman Klink is a former television anchorman who beat an incumbent Democrat in a heavily Democratic district. The incumbent had lost key union support. Klink voted for the President's budget plan on May 27 after intense contact and negotiations with the White House. In addition to the Education and Labor Committee, he serves on the Small Business, Banking and Steering and Policy Committees.

Klink campaigned in support of reforming the nation's health care system. He was on the board of a health care institution in his district.

CONGRESSWOMAN LUCILLE ROYBAL-ALLARD (D-CA): Freshman Congresswoman Roybal-Allard represents the Congressional district with the nation's highest concentration of Hispanics. While serving in the California Assembly, Roybal-Allard chaired a subcommittee on health and human services. In the Congress, she is a member of the Small Business and Banking Committees, as well as the Caucus for Women's Issues and the Hispanic Caucus.

Roybal-Allard has taken a leadership role in the Congressional Hispanic Caucus and set up a meeting with the First Lady and a group of Hispanic women to discuss their particular health concerns. A Roman Catholic, Roybal-Allard is pro-choice and co-signed the May 13 letter urging inclusion of abortion coverage in the health care package. She is a McDermott co-sponsor and is particularly concerned about coverage for the uninsured.

CONGRESSMAN EARL HILLIARD (D-AL): A freshman Congressman from rural Alabama, Hilliard serves on both the Agriculture and Small Business Committees. He is a lawyer who served in both the Alabama House and Senate.

Hillard campaigned on a platform which included a national health care program. He met with Steve Edelstein to discuss health care and indicated his belief that the package should be comprehensive, including malpractice reform. His chief-of-staff formerly worked for Claude Pepper and could be helpful. Hilliard is a McDermott co-sponsor. He attended the Congressional Black Caucus's March 2 meeting with the First Lady.

CONGRESSMAN MARTIN LANCASTER (D-NC): Congressman Lancaster represents conservative East Carolina tobacco country as well as Camp Lejeune and the Seymour Johnson Air Force Base. Protective of his district's economic interests, Lancaster is considered a conservative Democrat but in the Jim Hunt tradition. Lancaster serves on the Armed Services and Small Business Committees and won with 54% of the vote in 1992.

In March Lancaster wrote a long letter to the First Lady outlining his health care reform concerns, including: rural access in a managed competition system; the need for more primary care and fewer specialty physicians; the benefits of home health care and hospice services; the need for preventive care; and how to address costs at the end of life. In addition, he wrote that his wife, Alice, had worked with Mrs. Gore on the Adolescent Mental Health Care Task Force, and that he supported inclusion of mental health services in the reform package. He also stated that while jogging with the President, he had brought up the issue of state flexibility which the President had assured him would be a feature in the final package. Lancaster was one of the 25 Members co-signing the letter to the President concerning tobacco excise taxes. He has voted for abortion services and attended Ira's meeting with the House Democratic Caucus on March 31.

CONGRESSMAN TOM ANDREWS (D-ME): Second-term Congressman Tom Andrews is a liberal activist turned legislator. Before being elected to Congress he worked on causes related to the poor and was executive director of the Maine Association of Handicapped Persons. As a teenager Andrews had a leg amputated because of cancer. He is popular in his district which encompasses Portland and former President Bush's Kennebunkport summer home. Andrews serves on the Small Business, Armed Services, and Merchant Marine Committees. Andrews is a McDermott co-sponsor but is expected to support the Administration's package.

CONGRESSWOMAN MAXINE WATERS (D-CA): A liberal activist who is outspoken about the problems of the inner-city urban area she represents, Congresswoman Waters focuses her energy on the needs of the minority poor. She received a great deal of attention when riots erupted in the Watts area of her Congressional District following the first Rodney King verdict. A Democratic National Committeewoman, Waters was an active supporter of Jesse Jackson's Presidential ambitions. She sits on the Small Business and Veterans' Affairs Committees and is a member of both the Congressional Black Caucus and the Caucus for Women's Issues. Waters attended the First Lady's meetings with the latter two groups.

She is a McDermott co-sponsor but is expected to vote for the health care package as long as it includes abortion services. She was very active in the Clinton/Gore campaign.

CONGRESSMAN BENNIE THOMPSON (D-MS): Congressman Thompson was elected to fill the seat of now Agriculture Secretary Espy. Thompson has had an active career in local politics and holds a Master of Science degree. In addition to being a member of the Congressional Black Caucus, Thompson is on the Small Business, Agriculture, and Merchant Marine Committees.

His district is the second poorest in the United States. Health care services for the large indigent population are either non-existent or woefully inadequate. Thompson would like to see not only adequate health care, but sufficient numbers of health care professionals, and appropriate and affordable insurance and/or funding programs for his district.

REPUBLICANS:

CONGRESSWOMAN JAN MEYERS (R-KS): Congresswoman Meyers is a moderate and pro-choice with possible aspirations for statewide office. The ranking Republican on the Small Business Committee, she has focused on extending the health insurance deduction for the self-employed - while maintaining the GOP line against federal mandates on employers.

While Meyers' general health care views are not know, her son is a physician. A member of the Caucus for Women's Issues, she attended their February meeting with the First Lady. She is a Bonior target.

CONGRESSMAN LARRY COMBEST (R-TX): A protege of the late Sen. John Tower and former Congressional staffer, Congressman Combest is known as a steady conservative with a talent for legislative deal-making. He is safe in his western panhandle district which includes parts of Lubbock and Amarillo. In addition to the Small Business Committee, he serves on Agriculture. He is an ally of Rep. Stenholm and in 1990 was one of four House members to vote 100 percent of the time with the "conservative coalition" of Republicans and Southern Democrats. He is not, however, an ally of Newt Gingrich, as Combest prefers a more pragmatic and behind-the-scenes role.

Combest's views on health care reform are not known. He will undoubtedly be sensitive to rural interests. He has voted against abortion.

CONGRESSMAN RICHARD H. BAKER (R-LA): Congressman Baker began his long career in Louisiana politics as a labor-oriented Democrat in the state House. He switched parties and in Congress is considered a low-key conservative party loyalist. His district is a mix of rural areas and most of Baton Rouge and its suburban areas. Baker serves on the Small Business, Banking, and Natural Resources Committees. He won in 1992 with 51% of the vote.

When Baker switched his total opposition to abortion to its being allowed in cases of rape and incest, some thought he was looking toward a statewide race. His general views on health care reform are not known.

CONGRESSMAN JOEL HEFLEY (R-CO): A former state legislator, Congressman Hefley is a pro-defense, business-oriented legislator. His district includes Colorado Springs and south central Colorado, and he won there with 74% in 1992. In addition to the Small Business Committee, Hefley sits on the Armed Services and Natural Resources Committees.

His health care positions, others than his opposition to abortion, are not known. The single piece of legislation with his name attached is the National Visiting Nurses Association Week.

CONGRESSMAN RONALD MACHTLEY (R-RI): Congressman Machtley (pronounced MAKE-lee) is one of the House's more liberal Republicans, a position supported by his constituents who returned him with 70% of the vote in 1992. He represents Providence and eastern parts of the state which include light manufacturing. Machtley serves on the Armed Services and Small Business Committees. He previously was a member of the Select Committee on Children. A lawyer, Machtley is a graduate of the Naval Academy and continues to serve in the Navy Reserves. His vote to override President Bush's veto of the "family leave" bill was one of many against his party.

Machtley's views on health care are not known. He has been a volunteer with the YMCA and that and his work on the Select Committee on Children clearly indicate an interest in the young. He will also presumably look out for small business interests. He is a supporter of reproductive rights. Congressman Bonior considers Machtley a top target.

CONGRESSMAN JIM RAMSTAD (R-MN): Congressman Ramstad is in his seond term and came to Congress as a former staffer in both the House and the Senate. He represents suburbs of Minneapolis. He now sits on the Small Business and Judiciary Committees. Ramstad replaced Bill Frenzel in the House. Frenzel was moderate but partisan and Ramstad considers him his mentor.

While Ramstad's general health care views are not known, he is pro-choice. He has been interested in emergency medical care for children. He worked on issues involving chemical dependency in young people, cocaine babies and the handicapped while in the State Senate. At that time he also dealt with a personal alcoholism problem.

CONGRESSMAN SAM JOHNSON (R-TX): Congressman Johnson is a former fighter-pilot who lost partial use of his right arm while held prisoner in North Vietnam. He met his future colleague, Senator John McCain, while there. Johnson represents north Dallas and won with 86% of the vote in 1992. He came to Congress in 1991 after winning the seat when the incumbent ran for mayor of Dallas.

Johnson's health care views are not known.

CONGRESSMAN BILL ZELIFF (R-NH): A protege of former Gov. John Sununu, Congressman Zeliff won in 1990 on his image as a successful businessman - and after spending $400,000 in the GOP primary. Zeliff's district includes Manchester and eastern New Hampshire. He retained it with 53% of the vote in 1992. Zeliff is a member of the Small Business, Government Operations and Public Works Committees.

While Zeliff's health care views are not known, one possible indicator of his views is that as the owner of a small resort, he has linked his business success to entrepreneurialism and frugality.

CONGRESSMAN MAC COLLINS (R-GA): Freshman Congressman Collins won his seat with 55% thanks to redistricting and a strong anti-Washington mood. His district includes parts of Newt Gingrich's old district and is a mixture of independents, Reagan Democrats and Republican suburbanites. It is a seat targeted by Democrats in 1994. Collins is ia truck company owner and seen as a down-home conservative with a knack for hard-nosed campaigning. In the state Senate, Collins is said to have used a "graceful negotiating style" to help enact bills to combat drug dealing and to help people get off welfare. His health care views are unknown.

CONGRESSMAN SCOTT MCINNIS (R-CO): Serving his first term in Congress after five in the state legislature, Congressman McInnis is a traditional conservative. He won with 56% on the western slope of Colorado, including Pueblo. He serves on both the Small Business and Natural Resources Committees.

While his specific views on health care are not known, he will be looking out for rural areas as well as small business. A Roman Catholic, McInnis is pro-abortion.

CONGRESSMAN MICHAEL HUFFINGTON (R-CA): Freshman Congressman Huffington won his seat with 53% of the vote after spending the record sum of $4.2 million. He is a former Reagan administration official and video production company owner who has never held elective office. He holds engineering and economics degrees from Stanford and an MBA from Harvard. Huffington serves on the Small Business and Banking Committees. He has said he wants to eliminate all Capitol Hill perks and significantly change the way Congress operates.

While Huffington's general health care views are not known, he campaigned against tobacco interests. He also supports abortion rights.

CONGRESSMAN JAMES M. TALENT (R-MO): Congressman Talent comes to Congress with substantial experience in the state legislature and a strong conservative agenda. Talent beat President Bush's cousin in the primary and first term Democrat Joan Kelly Horn in the general. He won this largely suburban district with 50% of the vote. He sits on Armed Services and wants to use his position on Small Business to guard against excessive government regulation.

While Talent supports health care reform along the lines of managed competition, he opposes universal health coverage. He supports malpractice reform and allowing employees to establish medical IRAs. However, he opposes government allocating health care resources. Talent supports abortion only in cases of rape, incest or to protect the woman's life.

CONGRESSMAN JOE KNOLLENBERG (R-MI): Freshman Congressman Knollenberg used his long-time party experience to win this open seat with 58% of the vote. The owner of an insurance agency, Knollenberg now represents an upscale Republican district in suburban Detroit. Abortion rights advocates thought they could win the seat given Knollenberg's hard line on abortion - he supports it only to save the life of the mother. Knollenberg now sits on the Banking as well as the Small Business Committee.

Other than his position on abortion, Knollenberg's views on health care are not know.

CONGRESSMAN JAY DICKEY (R-AR): Another Freshman who was once a Democrat, Congressman Dickey won by 52% and Democrats are looking to regain the seat in 1994. In addition to Small Business, he sits on the Agriculture and Natural Resources Committees.

Congressman Dickey requested a meeting with the First Lady which was held on June 7. He brought in his district working group which includes over 15 physicians and the President of the Arkansas Medical Society. Dickey and his group met later with the President in the Oval Office as well as having a separate meeting with Chris Jennings and Phil Lee. Dickey indicated that he wanted to be either a Republican co-sponsor or the only Republican sponsor of health care reform but not if it includes abortion in any form. He is concerned about the effects of the package on small business, but that is not as important to him as malpractice reform or abortion. He received a lot of press in his district from the meetings and was most appreciative of the time he was given. One personal note, Dickey is a polio survivor.

CONGRESSMAN JAY KIM (R-CA): Congressman Kim is the first Korean-American to win a seat in Congress. His newly created seat includes parts of Orange, Los Angeles, and San Bernardino Counties. Kim is a small business conservative and strong opponent of unnecessary government spending. He sold his construction business to avoid any appearance of conflict of interest - it was one of five minority-owned companies hired following the Rodney King riots in LA. An LA grand jury has subpoenaed his campaign records and company documents in an investigation of his using corporate funds to finance his campaign. In addition to Small Business, Kim is on Public Works and Transportation.

His health care views are not known. His only child is a neurosurgeon. Kim is a libertarian on abortion - believing it not to be the government's business.

CONGRESSMAN DONALD MANZULLO (R-IL): A hard-line conservative, Freshman Congressman Manzullo beat a one-term Democrat with 56% of the vote - the first Democrat to hold this aging, rural district in northwest Illinois. There may be a rematch in 1994. Manzullo sits on Foreign Affairs as well as Small Business.

Manzullo has received a lot of support from fundamentalist Christians and has crusaded against abortion. His other health care views are not known, but he is apt to be concerned about rural coverage.

CONGRESSMAN PETER G. TORKILDSEN (R-MA): Freshman Congressman Torkildsen served in the state legislature and as Massachusetts Commissioner of Labor. He strongly resembles his former boss, Governor William Weld, with his fiscally conservative, pro-business stand and his support - as of April - of abortion rights. Torkildsen won his seat with 51% of the vote and Democrats hope to recapture it in 1994. He sits on the Armed Services as well as the Small Business Committee.

Health care reform is one of Torkildsen's priorities. He supports a pro-business plan of vouchers and tax credits. He is one of Congressman Bonior's targets.

CONGRESSMAN ROB PORTMAN (R-OH): The most junior member of this Congress, Representative Portman won the seat of Republican Bill Gradison, a man he once interned for when he was in college. Portman has extensive Washington experience, including practicing at Patton, Boggs and Blow and Director of President Bush's Office of Legislative Affairs. Portman won the seat with 70% of the vote.

His health care views are not known.

SMALL BUSINESS ASSOCIATIONS

OVERVIEW: Although the small business community may well be the greatest loser under the status quo, the roadblocks to their support may well be the greatest to overcome. Many small business owners have a strong anti-government ideology, which when balanced against the burdens of federal, state, and local taxes and regulations, coupled with workman's comp, unemployment tax, and health benefits, an anti-government ideology may be understandable. Even on the provisions where agreement can be reached, there is great skeptism about government commitments. However, philosophical issues aside, the following items will play large roles in nearly all discussions with the small business community and are in many cases the make or break issues for the following associations.

- **EMPLOYER MANDATES/COVERAGE OF PART TIME WORKERS.** The plan achieves universal coverage through requiring employer contribution for full and part time workers. Small business groups have traditionally opposed all types of employer mandates, with health insurance mandates at the top of the list.

- **COST OF COVERAGE/PHASE-IN FOR BUSINESSES WHO DON'T CURRENTLY PROVIDE.** For businesses who don't provide we are looking at an average increase in spending of about 7% of payroll, nor is there a "rainy day fund" for financially distressed businesses so as to avoid job loss. And, as the plan is currently structured, there is no provision for phasing in businesses who don't currently provide.

- **EXPENSIVE AND OVERLY COMPREHENSIVE BENEFIT PACKAGE.** Partly as a result of state mandates in benefit packages at the state level in recent years, small businesses continue to express concern about a benefit package which goes beyond 'basic' and in turn will increase their costs.

- **PROHIBITING ASSOCIATION PLANS.** Many associations provide low cost insurance to their members as one of their membership services (many also do bulk purchasing and other networking programs for their small business members). Association, which rely on underwriting, pre-existing condition exclusions, and other such things to keep costs low for their members -- such as the COSE plan in Cleveland -- will not be allowed to continue to operate under our plan. Association insurance plans also generate additional operating revenue for association budgets.

CHAMBER OF COMMERCE

The Chamber's represents approximately 215,000 businesses, of which over 90 percent have less than 100 employees (71% have less than 10 employees). The service and retail industries comprise 56% of their membership. They have a strong grassroots network and a significant presence on Capitol Hill.

Their approach to reform is managed competition and early in the debate they indicated their willingness to support employer mandates with sufficient subsidies for low-wage emloyees and their emloyers. However, they have paid a price for this position within their membership, where a growing number have cancelled their membership. NFIB has capitalized on the Chamber's employer mandate position, forcing the Chamber to take a much harder line in recent weeks.

The other key issue for the Chamber is limiting Alliance participation at no more than 100 employees. As recently as last week, they indicated that anything over 150 would guarantee their opposition.

It is critical that the Chamber remain neutral until our proposal is released, however, they are under increasing pressure to start an opposition campaign in August to help off-set the criticism they are taking on their right. This has been temporarily stalled, through a steady effort to show our changes in response to their proposals. ASSESSMENT: They will oppose in September, but may qualify their opposition.

NATIONAL FEDERAL OF INDEPENDENT BUSINESSES (NFIB)

The NFIB reprensents 600,000 small business owners. During the last decade the NFIB has become an extremely visible and vocal voice for small businesses on Capitol Hill, however very closely allied with Republicans. They strongly oppose employer mandates and tax increases of any type, and have opposed our efforts through out the task force process. Their opposition has been used as an effective marketing tool this year to increase their membership and in many cases siphon members from other small business groups.

The NFIB is trying to work out a program to program to provide health insurance to their members and want that flexibiliy on the association insurance issue. Another high priority is the self-employed tax deductibility, however this alone would not be sufficient to gain a positive reaction. Despite their strong opposition to government regulation, they have voiced support for strong cost containment provisions (price controls) on providers.

The NFIB yields an especially strong influence with House members from the Midwest and the South. We will need to be prepared to respond to their active opposition should we expect to have sufficient support in the House, and to provide cover for the other small business groups who may play a more constructive role. Although they do not yet support the Chafee bill, it is their intention to do so. ASSESSMENT: Active opposition.

NATIONAL SMALL BUSINESS LEGISLATIVE COUNCIL

The Small Business Legislative Council is a Coalition of 100 small business trade organizations, which represent at least 1.6 owners. Despite the fact that they, as an organization of other organizations, can claim more small business owners than NFIB, they have yet to wield much clout or deliver an effective grass roots campaign on any issue of importance to them. Having said that, they are well liked by those members of Congress who know them, i.e., Rostenkowski and Pryor. They have been an early participant in the health reform debate, introducing their own reform proposal two years ago.

Although they have been willing to consider employer mandates and have been largely supportive of our outline, they strongly support the inclusion of association insurance plans (MEWA's) and this to date may well be our greatest hurdle for their support. Although their impact is small, their support will be greatly needed to offset the otherwise broad small business opposition. ASSESSMENT: Unclear.

NATIONAL SMALL BUSINESS UNITED

Small Business United represents over 65,000 small business owners. Their bi-partisan approach has yielded limited congressional influence, but their public advocacy has played well in the media. Earlier this year they indicated a willingess to consider individual mandates, but their openness has become more qualified in recent months. They will oppose emloyer mandates, but may be willing to speak supportively of other provisions in the proposal. The association insurance issue will also be a concern for them. They need to be more actively wooed. ASSESSMENT: Qualified opposition.

NATIONAL RESTAURANT ASSOCIATION

The National Restaurant Association represents 15,000 foodservie operations, which covers nine million foodservice employees and part-time employees. They are a founding member of the Healthcare Equity Action League (HEAL), designed to find a market-based solution to reform. They are politically active on Capitol Hill and very conservative. Adamently opposed to employer mandates and global budgeting. ASSESSMENT: Oppose.

NATIONAL ASSOCIATION OF MINORITY CONTRACTORS

The Minority Contractors Association represents 3,500 black, hispanic, asian-pacific, and native American contruction contractors in over 45 states. Their membership is highly transient, largely uninsured, and most employ less than 10 employees. Their greatest influence is in the African-American community. They have opposed employer mandates (supported individual mandates), but are open to discussion about small business subsidies in conjunction with mandates. They are likley to respond to good data showing that our plan will be affordable for small businesses. They strongly support maintaining association insurance plans. They strongly support the 100% tax deductability for self-employed. ASSESSMENT: Unclear, likely to be modified opposition.

NATIONAL ASSOCIATION OF WOMEN BUSINESS OWNERS

The National Association of Women Business Owners represent about 4,000 women small business owners. Still a relatively new organization (formed in 1978), they have expanded their membership to 50 states. They oppose employer mandates, but have been open-minded to discussions of small business subsidies for small businesses within the mandate. They work closely with the Small Business United, and although they are likely to oppose the plan, may contructively do so by supporting individual provisions. They need to be wooed. ASSESSMENT: Unclear.

THE NATIONAL ASSOCIATION OF PRIVATE ENTERPRISES

The National Association of Private Enterprises (NAPE) represents 40,000 small business owners with 10 employees or less. Over 60 percent of their members are 40 years of age or younger. This relatively new organization (established in 1983) provides a network of bulk purchasing and insurance for their members. The NAPE offers a benefit plan that includes access to more than 48 products such as travel discounts, health insurance, and scholarships for NAPE members and their families. NAPE is new to the grass root advocacy process and their impact on Capitol Hill is still small.

NAPE strongly supports cost containment measures that include global budgets and malpractice reform, and the self-employed tax deduction is a strong issue with this group. However, employer mandates, prohibiting association insurance policies, and FUTA increases is very likely to result in their opposition. Their position will be simple: if small business labor costs increase under this plan, they will oppose. If we can quantify substantial small business assistance to offset what would otherwise be cost increases, their position may be qualified. ASSESSMENT: Opposition, may be qualified.

THE NATIONAL ASSOCIATION OF SELF-EMPLOYED

The National Association of Self-Employed represents 320,000 small business owners. The self-employed tax deduction is a very strong issue with this group, as well as association insurance coverage. However, additional costs of the reform proposal will weigh heavily in their reaction, if we are not able to quantify subsidies. ASSESSMENT; Unclear.

SMALL BUSINESS AND HEALTH REFORM:
Questions and Answers *

The following questions and answers address many of the most common concerns of small business owners.

COST-CONTAINMENT

Q. How is this reform plan going to keep the costs of health care down for small business owners?

A. The Administration's proposal controls costs by bringing **the force of the market place** to bear upon the health care system. Health alliances will band families, businesses, and individuals together to bargain for lower costs and better quality of services. Costs will be kept low by market forces and guaranteed by **a fail safe budget enforcement mechanism** should health expenditures rise too fast.

Administrative costs, which account for most of the higher costs paid by small businesses, will be reduced by the creation of health alliances, which will assume administrative functions, and simplification of the system -- standardization of forms and benefits packages.

Business representatives will serve on the board of the health alliances and will be involved in cost negotiations with health plans.

Insurance abuses, including underwriting and experience rating which lead to higher costs for small business -- **will be ended**, guaranteeing predictable, lower costs.

In addition, **increasing the deduction for self-employed to 100%** and **reforming the medical component of workers' compensation** will significantly reduce costs for many small business owners.

Q. How can I afford to provide the health benefits package to my employees and still remain profitable?

A. The Administration's proposal ensures that the cost to small business to provide health benefits does not exceed its ability to pay. We will cap the amount small businesses have to pay for premiums, keep premiums low for small, low-wage businesses and provide subsidies in accordance with need.

SELF-EMPLOYED -- 100% DEDUCTION

Q. Will health reform address the inequity in the tax law that forces the self-employed small business owner to pay higher taxes for their health benefits?

A. Yes. Health reform will expand and **make permanent** a 100% tax deduction for the cost of health benefits bought by self-employed workers and their families.

* All answers are based on assumptions of policies which have yet to be finalized or released.

WORKERS' COMPENSATION

Q. I already face astronomical workers' compensation costs. How can I be expected to pick up health insurance as well?

A. The cost of workers' compensation insurance is killing many small businesses. In fact, today's high health care costs are surpassed only by skyrocketing workers' compensation costs. Between 1982 and 1992 the average workers' compensation medical claim that included time lost from work rose from $2,584 to $8,900.

That's why our reform plan will reform the medical component of the workers' compensation system making it more efficient and reducing costs by covering work related injuries through health plans in the same manner as non-work related injuries -- eliminating duplication and improving quality for workers who receive services.

PART-TIME EMPLOYEES

Q. Will we have to cover everyone, or for example, will part-time employees be exempt?

A. Employers will pay an hourly pro-rated amount for part-time workers. So an employer would pay the same amount for two part-time workers, each of whom work 15 hours a week, as he would for one full time worker who works 30 hours.

THE EMPLOYER MANDATE

Q. What do we as small business owners possibly stand to gain by being forced to provide coverage to our employees?

A. As small business owners and as individuals you gain the **security of knowing that no member of your family will go without needed medical care because of lack of health insurance.** You gain the ability to compete with larger businesses for top employees. And you gain the security that you and your business will never be bankrupted by a serious illness or injury.

Just as everyone stands to gain, everyone has to contribute something. Small businesses that provide coverage should not have to compete against other businesses that don't cover their employees. Under today's high cost system, 62% of small businesses with less than 100 employees and 51% of those with less than 25 employees make the sacrifices necessary to cover their employees. They end up picking up the tab for the uncompensated care.

PRICE DISCRIMINATION IN THE SMALL GROUP MARKET

Q. One of my employees developed a serious illness. Because of this employee's illness, my insurance costs went through the roof. I can't afford to provide health insurance and stay in business.

A. Under our plan insurance companies will no longer be allowed to charge discriminatory rates to small businesses who have sick workers. Everyone in working and living in the same area will pay a similar amount for their health coverage -- a concept known as community rating. Other practices such as cherry picking (covering only the young and the healthy) and pre-existing condition exclusions (where an illness or an entire person is excluded from coverage) will be outlawed. We will require all insurers to play by the same rules in order to participate in the reformed health insurance market.

REFORM GIVES SMALL BUSINESS THE CLOUT OF BIG BUSINESS

Q. Why should we as small business owners support any government sponsored plan when in the past the government has favored big businesses?

A. This plan has been written with the specific concerns of small businesses in mind. The President and I are committed to putting forth a health reform plan that works for small business. We know that small business generated 90% of all job growth in 1990. No Governor from Arkansas, a state in which over 90% of the businesses have fewer than 20 employees, gets elected five times without being sensitive to the concerns of small business.

Q. Won't this reform simply increase the economic gap between large and small businesses?

A. Health reform will help small businesses bridge the economic gap by allowing small businesses to band together to obtain the bargaining power of large corporations. Small businesses will combine their purchasing power to negotiate with insurance companies for high quality care at affordable prices. Insurance reform will end the practice of charging higher rates to small businesses than they charge Exxon or General Electric.

JOB LOSS AND BUSINESS FAILURE

Q. I'm scared that this plan will drive me out of business. How can you assure me that health reform will not produce massive job loss and business failure among small businesses?

A. Some special interests are trying to scare small employers into thinking that this plan will kill small business. The truth is everyone will benefit from cost containment, insurance reform and universal coverage. The U.S. Chamber of Commerce would not have endorsed the concept of a required employer contribution if such a requirement would hurt small business.

Although a full 95% of businesses in Hawaii have less than 100 employees, the states employer requirement has not had an adverse impact on the state's economy. The number of businesses in Hawaii has increased steadily from about 17,000 in 1974, the year the mandate was enacted, to nearly 27,000 in 1991 -- a 59% increase.

PAPERWORK AND ADMINISTRATIVE BURDEN

Q. Will my work-load increase as a result of this reform (i.e. more paperwork etc.)?

A. No, the Administration's plan will decrease the work-load. Today, lacking a benefits department like larger firms, most small business owners must perform all the functions of such a department by themselves. Negotiating health coverage in today's health care system is a process often fraught with frustration and obstacles.

We will take the burden off the small business with health alliances which will deal with the insurance companies and bargain for competitive prices. The alliance will take over the paperwork and the negotiations; provide information on plans and increase ease of enrollment. Higher administrative costs will be reduced and the hassle of the current system will be eliminated.

ECONOMIC IMPACT

Leading economists refute the notion that health care reform will cause significant economic pain -- even in the short term. A senior Labor economist criticizes NFIB's study in particular citing its failure to incorporate "key analytical processes" and called the study "essentially meaningless." "Many economists say they are skeptical of the federation's [NFIB] projections." says an L.A. Times article. Uwe Reinhardt estimates at most 100,000 small business jobs lost. John Sheils of Lewin VHI says the number is no higher than 60,000. In a U.S. News and World Report article entitled "Sparing the Knife, Clinton's Health Care Plan Won't Rip Into America's Weak Job Growth," David Brailer, professor at the University of Pennsylvania says "Reforming the health care system is not going to have a major impact on employment."

Clearly, critics of the plan will cite high figures to make their case. However these figures (such as the NFIB study) are misleading, largely because they estimate "jobs at risk" -- defined as any new employer contribution that results in reduced worker wages as opposed to actual lost jobs. They are easily refuted based on other published studies. The lower range of estimates use a relatively small employer contribution (such as a catastrophic plan) to calculate its numbers. The lower estimates are very small especially in the context of the labor market, where hundreds of thousands of job losses and gains occur each month.

Several other previously published estimates of job loss associated with a mandate have been produced. They range from a low of 50,000 per year to well over 1 million. The following studies illustrate the range:

- John Sheils, Vice President of Lewin-ICF, estimated that under The Health America Act, a pay-or-play plan which included a payroll tax of about 8 percent, loss of employment would be between 23,000 and 63,000 jobs. Dr. Kenneth Thorpe, Dr. Karen Davis, and the Congressional Budget Office had consistent estimates.[1]

- The Employee Benefit Research Institute (EBRI) estimated that, between 200,000 and 1.2 million workers could become unemployed as a result of a mandate that employers provide health benefits. These estimates assume that wages and other benefits do not change as health benefits are added.[2] EBRI estimated that, under a play-or pay plan with a 9% percent payroll tax, between 130,000 and 965,000 jobs could be lost, if wages and other components of total compensation do not adjust.

- The recent NFIB study prepared by CONSAD Research found the Jackson Hole Group proposal, which has an employer contribution of 50% to 100% of premiums as well as @8% of payroll, would result in the loss of 899,530 jobs and 18.2 million (almost a quarter of total) "jobs at risk." [In news reports, NFIB spokespeople took

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[1] Testimony to the United States Senate Committee on Finance, June 9, 1992.

[2] William S. Custer, Director of Research, EBRI. Testimony to Senate Committee on Finance, June 9, 1992

pains to point out that this proposal resembles what the Administration is working on.] The study also found that the Garamendi plan, which is funded by a 7.65% payroll tax and a 1.4% wage tax on workers, would result in 6.6 million jobs at risk. HealthAmerica, Senator Mitchell's "pay or play" legislation, would result in 12.1 million workers in jobs-at-risk. The Jackson Hole proposal does not include subsidies for small businesses while HealthAmerica does. Researchers defined "at risk" as an increase in compensation costs of at least 6% because of health care spending. The study looked only at those firms with less than 500 workers.

The Heritage Foundation proposal, which would replace the current tax exclusion on employer-provided health insurance with a tax credit to all taxpayers who would be required to purchase health insurance either privately or through their employer and Congressman Cooper's proposal, neither of which includes a mandate, would result in a "negligible number of jobs at risk."[3]

- An earlier CONSAD study prepared in April 1992 for The Partnership on Health Care and Employment found that under a federal pay or play health insurance plan, about 9.1 million jobs would be "at risk."[4]

- A study presented by Richard A. Armey in April 1992 for the Joint Economic Committee found that under a pay or play mandate with a 7% tax, 712,742 workers would lose their jobs in the first year of implementation, with 43% of this job loss falling on workers in businesses with under 20 employees. The four states of California, Texas, New York, and Florida would account for 42% of these job losses. A 9% payroll tax would result in the loss of 807,516 jobs.[5]

- Karen Davis, Professor of Economics and Chairman of the Department of Health Policy at Johns Hopkins, predicted that under The Minimum Heath Benefits For All Workers Act of 1987, there would be a loss of about 100,000 to 120,000 jobs from mandating insurance coverage on employers (adding about .1 percentage points to the unemployment rate.[6]

It is difficult to estimate what the effects of our health care plan will be without final financing or subsidy decisions. However it is probable that any requirement, because of the way these studies are conducted, will result in a some job loss estimate. For this reason, it is important to keep the debate focused on health care coverage and costs of today's system. We will be hard pressed to win an all out war centered around job loss estimates.

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[3] "Employment Impact Of Proposed Health Care Reform on Small Businesses." Prepared by CONSAD Research Corporation for The NFIB Foundation, May 6, 1993.

[4] "Jobs-At-Risk and Their Demographic Characteristics Associated With Mandated Employer Health Insurance." Prepared by CONSAD Research Corporation for The Partnership on Health Care and Employment, April 1992.

[5] "Run From Coverage: Job Destruction from a Play or Play Health Care Mandate." Richard Armey, Testimony for the Joint Economic Committee (1992), April 9, 1992.

[6] Testimony before the United States Senate Committee on Labor and Human Resources, 100th Congress, November 4, 1987

Additional costs – whether they arise from an employer requirement or a continued failure to bring the system under control are, in the long run, paid for by the worker. Economists, (and more importantly CBO) believe that the cost of the mandate are fully borne by workers. John Sheils said in the L.A. Times article "The only thing Karl Marx managed to get right is that in the end the worker pays all the bills."

For the past 26 years, the worker has in fact been paying the bill and the bill has been high. Health care costs per worker have increased **451%** since 1965 – **65 times** the rate of real wages and salaries. And health spending is eating up business profits. Health spending now consumes 97.5% of business after tax profits. In 1986, health care spending actually exceeded (113%) corporate after tax profits.[7]

The impact of reform will be markedly different for those who do currently provide health care insurance than for those who do not. Approximately 62% of businesses with less than 100 employees provide health care coverage. And 51% of those with less than 25 employees provide insurance. All of these employers contribute to the cost of coverage in some way. Most small businesses who provide insurance provide roughly the same package of benefits that large employers offer. The next section will look at what small businesses pay today and will pay under reform under two financing scenario under consideration.

Note: There is considerable skepticism among members of Congress especially those who come from Southern states on the percentage of small firms provide coverage to their employees. As is clear from the above referenced numbers the smaller the firm is the less likely it is to provide and contribute towards coverage. The widely cited two-thirds figure is slightly off base. Only if one uses firms under 100 workers does one approach the two thirds figure. Many view "small businesses" to be less than 25 workers instead of less than 100. Only 51% of businesses with less than 25 workers provide coverage to employees. And the smaller the firm is the less likely it is to provide.

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[7] Source: HCFA, Office of the Actuary

FINANCING SECTION

The following charts were prepared using distribution tables provided by Ken Thorpe and prepared by the Urban Institute using the 12.2% premium cap.* Because many financing decisions have not been made, these numbers are subject to change and are for your eyes only. Although the numbers can't be used yet, we thought they would be useful background for your meeting with the Congressional small business committee members.

What does seem clear from the data, however, is that those employers and employees who currently pay for health care coverage will pay less on average than they do under the current system -- which is very good news.

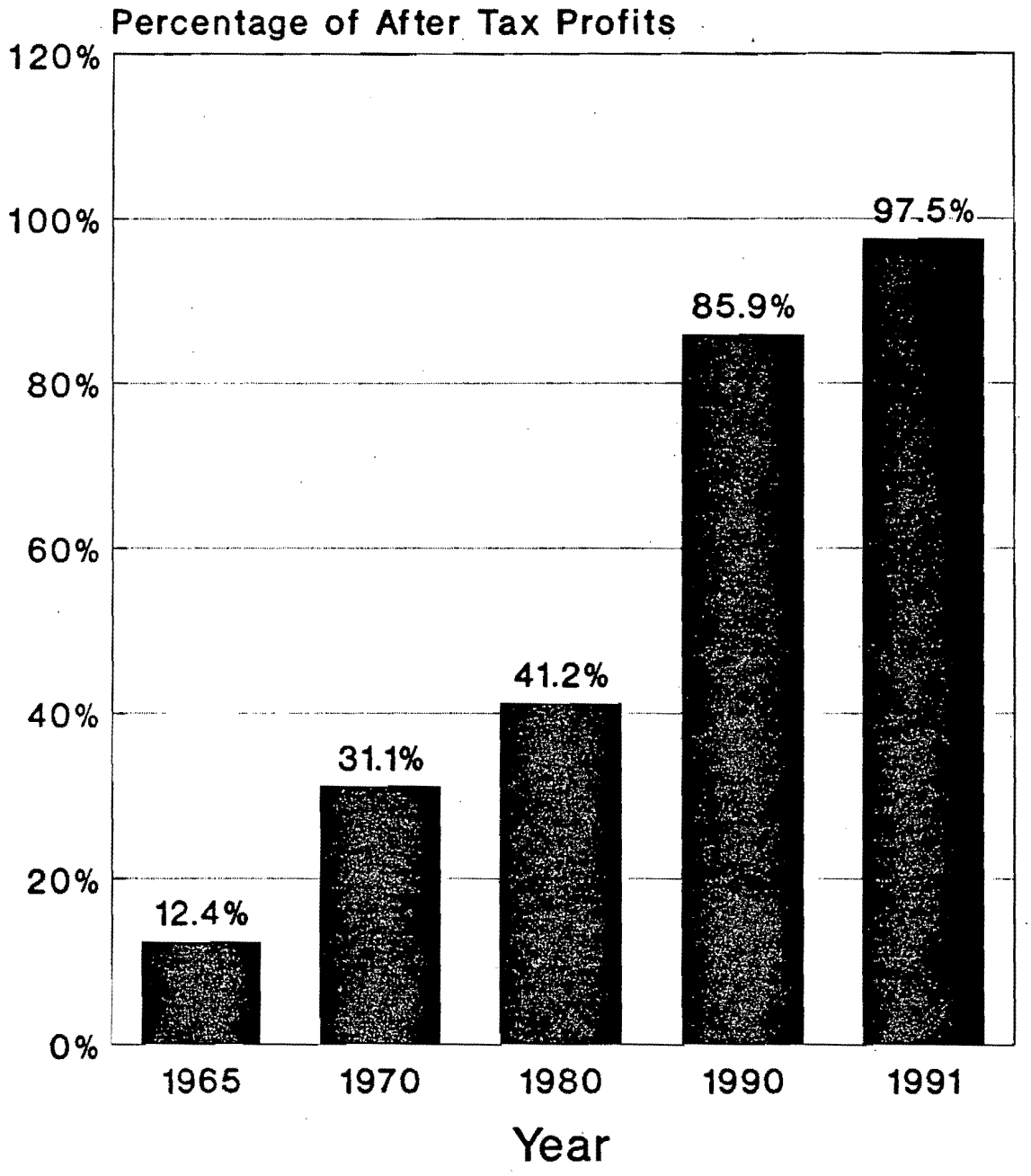
The graphs look at only at small businesses -- those with less than 25 workers or those with between 25-99 workers.

They show averages -- average worker contribution, average employer contribution -- today and under reform. As is the case with averages, they are not necessarily representative of what the "average American," pays or will pay, (because the very high costs plans and the very low cost plans are averaged in together).

Workers who do not currently receive health care coverage from their employer will pay, on average less, than those who do currently pay for coverage. We believe that this is due to the fact that today's uninsured are made up of more low-income or part-time workers. Also, smaller businesses (those with less than 25 workers) pay somewhat less on average under the reform plan because they are more likely to be eligible for subsidies.

* As you know, there are other financing scenario's under consideration. HCFA, Treasury, and the Agency for Health Care Policy Research are also preparing runs using the same data. Their numbers may differ from those used to prepare this data.

Health Spending Is Eating Up Business Profits



Source: HCFA, Office of the Actuary

ESTIMATED IMPACT OF ENACTMENT OF
DISCRIMINATORY PRICE PROVISIONS
ON FEDERAL PHARMACEUTICAL PRICES --

IMPACT OF F.S.S. PRODUCT DELETIONS:

Background.

VA expended $858 million on pharmaceuticals in FY 1992. Of this amount $500 million were procured through the Federal Supply Schedule (FSS), $280 million through depot and shared procurements, and $70 million in open-market or other procurements. Dollars expended through FSS procurements may increase (by $280 million) and dollars expended through depot procurements will decrease or be eliminated during the next year due to increased use of prime vendors and a proposed phase out of the depot system.

FSS contracts are generally not based on volume procurements. Any discounts, which may be achieved, are provided primarily based on **anticipated** volumes of purchase.

VA believes that if the discriminatory pricing provision, as proposed by the National Association of Retail Druggists and the National Association of Chain Drug Stores, becomes law, manufacturers will be forced to eliminate (non-volume-based) FSS discounts to the federal government on all products by deleting those products from the FSS. We also think these drug products would not be re-introduced to FSS in the 1995 contract cycle. If this scenario occurs, VA estimates that prices paid for pharmaceuticals would increase by 63% (See attachment A). These higher prices would result in greater total Departmental expenditures for drugs.

Impact.

For VA alone, this budgetary impact would be $ 413 million annually based on Fiscal Year 1992 data. Other Federal Agencies (DoD and PHS) would experience similar proportionate impacts.

The Drug & Pharmaceutical Product Management Section, VACO Pharmacy Service, Hines, IL., reviewed Prime Vendor purchases from McKesson in Region 4 for the 2nd quarter FY 93 and obtained the following information.

McKesson reports their product cost along with the VA's billed amount. 2769 line items were reported at a total cost of $ 2,555,712.25 for 132,918 units. (One unit is a tube of cream or a bottle of tablets or a case of dropper bottles). If the same number of units were purchased at the Prime Vendors cost, these 2769 line items would have resulted in a cost of $ 4,170,501.50.

The difference noted between the cost to the Prime Vendor (PV Cost) and amount billed to the VA facilities (FSS Cost) is an increase of $ 1,614789.30 or 63.18%.

($1,614,789.30/$2,555,712.50)*100%) = + 63.18%

It should be noted that this increase is based on the Prime Vendor's cost, not the Average Wholesale Price (AWP) which would include a wholesale mark-up. It is anticipated that the VA could obtain products at approximately the same cost as Prime Vendors or wholesale companies if Federal Supply Schedules contracts were not available.

Examples of the above costs include:

	FSS Cost	PV Cost	AWP
Tegretol	4.17	15.31	18.38
Procardia XL	188.66	269.15	321.95

The above FSS Cost and PV Cost were obtained from Prime Vendor sales reports while the AWP price was obtained from the 1993 Red Book.

Prescription drug

Chris —
Please review.
Thanks.
—Jason

PRESCRIPTION DRUGS
The Health Security plan

"Responsibility...means that drug companies should no longer charge three times more per prescription drugs made in America here in the United States than they charge for the same drug overseas." President Clinton, speech to a Joint Session of Congress, September 22, 1993

Top insert about the good element of Rx drugs. Loan Ar HRC's comments

PRESCRIPTION DRUG COST

Today, prescription drug prices continue to skyrocket. Between 1980 and 1992, while the general inflation rate increased by 22 percent, drug prices increased 128 percent. And according to a Families USA report entitled, "*Prescription Cost: America's Other Drug Crisis*," drug manufacturers are raising prices fastest on those medications which Americans need most.

Paying for prescription drugs is an incredible burden on many Americans, particularly the elderly. For 3 out of 4 older Americans, prescription drugs are the highest out of pocket health care cost. And over eight million older Americans choose between food and medicine every day. Expensive, frequently taken medications (i.e. antibiotics for children) become such a financial burden that many people go without.

The largest part of the price of a prescription goes to drug company marketing, advertising and profits. Approximately 35.5 % went to marketing, advertising and profits for the drug company, while just 16 percent went to pay for research and development expenses.

Drug companies charge U.S. citizens much higher prices than the citizens of other industrialized nations. If the average prescription product cost $1 in the United States, that product would cost only $0.67 in Canada (or 33 percent less), and only $0.60 in the European market (or 40 percent less).

Under the Health Security plan, prescription drug prices will be ~~controlled~~ contained. Many managed care programs have successfully used market-oriented incentives to contain prescription drug costs. Health plans will be able to negotiate with drug companies for a discount on the price of prescription drugs.

Under the Health Security plan, Medicare will get a discount on prescription drugs. The Medicare program will become the world's largest purchaser of medications and will receive a discount for prescription drugs currently on the market. The Secretary of Health and Human Services will be given authority to negotiate the price of new drugs for the Medicare program.

PRESCRIPTION DRUG BENEFIT

Many Americans have no prescription drug coverage in today's system. Almost 25 percent of Americans under age 65 do not have any type of public or private prescription drug insurance coverage -- leaving those Americans alone to face the financial burden of prescription drugs.

Today, older Americans -- those most in need of prescription drug coverage -- are often those without coverage. Since Medicare does not cover outpatient prescription drugs, less than half of all drug costs for seniors are covered by insurance.

The Health Security plan offers all Americans guaranteed prescription drug coverage for the first time. All health plans covering those under 65 will be required to cover outpatient prescription drugs. Under the low-cost sharing option plan, the beneficiary will pay $5 per prescription. Under the high-cost sharing option plan, the beneficiary will be covered for 80 percent of his or her prescriptions after meeting a $250 annual deductible. The insured person's copayments will count towards the overall out-of-pocket annual cap.

The Health Security plan offers Medicare beneficiaries a prescription drug benefit for the first time. Medicare beneficiaries will have 80 percent coverage for their medications after a $250 deductible is reached. A $1,000 annual cap will be placed on out-of-pocket prescription drug costs, with costs above this amount fully covered.

Because of the cost-effectiveness of prescription drugs, guaranteed coverage will reduce overall health care costs in the long-run. Many older Americans and others are hospitalized because their lack of prescription drug coverage means that they ~~can't afford to get the~~ medication they need. (get stat from Jennings) As Ron Ziegler, the President and CEO of the National Association of Chain Drug Stores pointed out, "When they say, 'well, the pharmacy benefit for Medicare, isn't that going to add tremendous cost to the Medicare program?' They are simply overlooking and not even giving any thought to the reality that good drug therapy and access on the part of the elderly to consistent drug therapy reduces and will reduce the overall societal contribution and commitment to health care."

* Drug 3's
* Cord Rosco to list

— Jason

2879

Prescription drugs

To: Patti Solis, Avis LaVelle, Charlotte Hayes, Skila Harris
Fr: Christine Heenan
Re: Possible "Message of the Week" events related to prescription drugs

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One possible event we could design to illustrate the problems seniors face with prescription drugs would be a "brown bag" session with seniors from the community and their local pharmacists. These brown bag sessions are basically informational/educational-- elderly people empty their medicine chests into "brown bags" and bring them to the pharmacist for the pharmacist to catch problems and/or answer questions.

Problems often uncovered in this type of event:

1) Elderly people have saved prescriptions that have expired, in case they ever need that drug again. This can be very dangerous as characteristics of the drug change and can get more potent or otherwise dangerous. The main reason people save unused prescriptions is to save the cost of buying them again at a later time, because they are so expensive.

2) Seniors also take drugs in combination with other drugs, or take drugs differently than prescribed. These combinations can have "contraindications", or dangerous side effects. These risky drug combinations happen for two basic reasons: 1) there is no coordination in the system, and one doctor doesn't know what another doctor has prescribed 2) seniors don't understand their drug regimen 3) in an effort to save money, people take drugs prescribed for others, or take drugs they have left over but should no longer be taking. These problems again relate directly to the high cost of drugs and the lack of coordination among health care providers.

A high percentage of elderly hospitalizations are caused by prescription drug problems--costing Medicare billions each year and causing life-threatening health problems that were avoidable.

We envision an event in which the seniors bring their drugs in, go over them with the pharmacist(s). The principal arrives at the event and hears from the pharmacist some of the examples he/she found that were dangerous, and talks with seniors about their problems with prescriptions, focusing on cost.

In response, we have very good things to say on these fronts:

1) Coverage of prescriptions through the Medicare program

2) Containment of drug prices

prescription drugs

Concerns of Dr. Arthur Flemming

Dr. Flemming is a Republican who served as President Eisenhower's Secretary of Health, Education, and Welfare and has advised subsequent Republican administrations. He has worked on health care since the Roosevelt administration

He was Chair of the White House Conference on Aging in 1971 and U.S. Commissioner on Aging at HEW from 1973 to 1978. Currently, he is Chair of the National Citizens' Board of Inquiry into Health in America, and the Co-Chair of the Save our Security Coalition. Last year, he was a member of the Families USA panel that supported then-Governor Clinton's plan as being the most cost-effective option.

Most recently, he has publicly supported President Clinton's reform proposal as "comprehensive, thoughtful, workable and fair."

Concerns about structure of prescription drug benefit

Dr. Flemming was concerned that seniors were being asked to pay more than everyone else for this benefit. He emphasized that this could be a problem with particular interest groups.

UNDER MEDICARE PART B:

Medicare Part B is expanded to include prescription drugs. The co-insurance level is 25%, the same as for all other Part B benefits.

UNDER LOW COST SHARING PLAN:

Prescription drug benefits are included with a $5 per prescription co-pay.

UNDER HIGH COST SHARING PLAN:

Prescription drug benefits are included with a 20% co-insurance.

Chris, as I mentioned on Monday night, I spoke with Dr. Flemming at the Doctors event.

He once again mentioned his concern about differences in Rx drug benefits, which I verified in the Planbook.

He said he'd be calling you at some point. I placed a copy of the reverse side in the folder of suggestions which Ira is reviewing / will review

FYI,

Ken

NEW DRUG PRICES AND
THE FEDERAL PHARMACEUTICAL REVIEW COMMISSION (PRC)

Even after reform, new drugs will be permitted to be priced at whatever level the pharmaceutical manufacturer chooses. No price regulation of these new products' launch prices was deemed appropriate for fear of excessively harming the environment and incentives to invest in pharmaceutical research and development. Since the new system will require all public and private plans to cover virtually all FDA approved drugs, payers will have no alternative other than to pay the cost of these medications. An unfettered pricing environment for these drugs can be expected to raise concerns to the government, businesses, employees, HMOs, health plans and other purchasers of prescription drugs. To address these concerns, provide needed information to public and private purchasers, and to assure that there will be continued public pressure for manufacturers to be price sensitive, a Pharmaceutical Review Commission will be established as a separate, but structural component of the National Health Care Board.

The Pharmaceutical Review Commission (PRC) will be established in conjuction with the National Health Care Board. It will work closely with the Department of Health and Human Services and be responsible for providing prescription drug pricing information to both publicly and privately administered insurance (or health plans) that provide drug coverage.

The Commission will be made up of 11 members composed of physicians, pharmacists, pharmaceutical economists, and industrial economists. PRC will also have a consumer, business, and pharmaceutical manufacturer representative.

The Commission will investigate the launch prices of (1) all new drugs that come on the market during the period that voluntary short-term price containment measures are in place (approximately 20 to 30 a year are approved by FDA); (2) all new breakthrough drugs for the lifetime of the Commission -- usually about 8 to 20 breakthrough drugs a year are expected to be approved; and (3) all drugs that are subject to a "reasonable price" clauses in contracts with the National Institutes of Health. (The latter category represents drugs in which the federal government has made a financial and research contribution to the development of a particular pharmaceutical.)

The Commission will investigate drug prices only in those cases where available evidence suggests that the price may be unreasonable. PRC has no authority to set or control drug prices.

The Commission is empowered to make an initial judgment as to reasonableness of price based on a comparison of therapeutically similar drugs in the U.S. and/or prices charged for the same drug in other industrialized nations. If the price of the drug exceeds these comparison variables, OR if the data available is inadequate to determine if a launch price is reasonable, the Commission is authorized to require the manufacturer to provide such cost information as the Commission finds is necessary to make a determination regarding the reasonableness of the price. Such information may include:

- Research and development costs for the drug;
- Allocation costs of research and development for "dry hole" investment (development costs for drugs that did not yield a marketable product);
- Research and development paid for by the federal government;
- Manufacturing costs of the product;
- Marketing and advertising expenses;
- Benefits of the drug as measured against other medical interventions; and
- Any other information relevant to pricing as identified by the Commission.

The Commission will have the authority to examine manufacturer records containing data outlined above. However, PRC is required to keep all price information on a strictly confidential basis. If the Commission concludes that the launch price of a product is unreasonably high, it will issue a public report documenting this conclusion. (The comparisons any such report makes will not list specific prices; rather it will discuss percentage variations.)

The Commission has a number of additional responsibilities that are critical to the effective implementation of health reform. They include, but are not limited to:

- Monitor and enforce any and all short-term pharmaceutical pricing agreements resulting from health care reform initiatives;
- Monitor the extent to which the pharmaceutical market is operating under a managed competition/care marketplace. (This is key because the current specifications link the elimination of the voluntary price constraints agreement to a percentage level (70 percent) that the market is operating under a managed care/competition environment.);

- Monitor and enforce the prices of pharmaceuticals in non-managed competition areas, and determine the extent to which pharmaceutical services are available in these areas;

- Oversee the pricing of all new drug products during the short term, and for breakthrough drug products throughout the Commission's lifetime;

- Working closely with the Department of Health and Human Services, the Department of Veterans Affairs, and the Department of Defense, help provide oversight over the federally-funded prescription drug programs, including Medicare, Medicaid, and DVA, and make programmatic recommendations for improvement to the appropriate Departments and the Congress;

- Collect and disseminate information about domestic prices to the Administration, the Congress, consumers and their representatives, physicians, pharmacists, and other health professionals;

- Collect information about international pharmaceutical prices and report, on a regular basis, to the Administration and the Congress;

- Publish lists of drugs that have high quality generic alternatives, and monitor generic substitution rates in various geographic areas, as well in different federal programs; and

- Provide studies and reports to the Administration and the Congress on other pertinent aspects of the pharmacy and pharmaceutical marketplace.

RATIONALE: THE PRESCRIPTION DRUG REVIEW COMMISSION

The growing use of formularies and large volume purchasing techniques has appeared to increase competition and moderate price increases for pharmaceuticals that have competition within the same therapeutic class. It is not absolutely certain that this price moderation is solely the result of this very recent trend or whether it is also in response to growing public pressure and criticism and drug pricing practices of the past. Regardless, the combination of the growing movement towards managed care and managed care bargaining principles, along with the recommendation of a voluntary price constraint provision (with fall back authority) for drugs currently on the market, provides an adequate degree of security that these drug prices will not be unduly inflationary.

The potential for the price of new drugs, particularly those that have no therapeutic competitors, to be an exreme financial burden continues to be great. In a new voluntary price increase constraint environment, even those new drugs that have therapeutic competition causes some concern. (This is because it is possible that a company may choose to price a new product high and opt for an expensive marketing strategy aimed at the non-managed care marketplace -- an environment that will be still quite large.)

New drugs with therapeutic competitors will, assuming managed competition works and is universally implemented, be subjected to market forces that should moderate their prices. However, prices of new drugs without theerapeutic competitors (breakthrough drugs) may be launched at extremely high prices; this is likely to be especially true with biotechnology products. A few examples of the prices of new drugs that have come to market in the past include:

* TPA: $3,000 a dose (clot-busting for heart attacks)
* EPO: $10,000 a year (used to treat anemia)
* Foscavir: $21,000 a year (used for AIDS)
* Ceredase: $140,000 a year (for Gaucher disease)

There may be as many as 15-20 of these "breakthrough" drugs a year coming to the market; the prices of which could literally break the backs of health care plans or the treasury (in the case of the Medicare program). Because most of these drugs represent significant medical advances and a universal system will require coverage of all FDA approved drugs, health plans will have no other choice than to pay whatever price the manufacturer chooses to charge.

Likewise, the Medicare program will need technical and economic expertise in making coverage and administrative decisions about its new multi-billion dollar prescription drug benefit. The last time the Medicare program was about to implement an outpatient prescription drug program (mandated by the Medicare Catastrophic Coverage Act), the Administration and the Congress saw the wisdom of having such a body when it enacted the Prescription Drug Payment Review Commision (RxPRC). It would make little sense to not have the benefit of such a similar body envisioned in the Pharmaceutical Review Commission. This is particularly the case when one considers the very real possibility of an example of an extremely expensive new treatment (not cure) for Alzheimer's patients. Medicare will be statuorily and morally required to cover such a medication that would prolong the life of an already expensive to treat patient. If, on top of that expense, the drug is also cost prohibitive, the Treasury would be at severe financial risk.

In direct conflict with these concerns is the drug industry's adamant position that price controls for new drugs represent a direct assault on their ability to attract capital for investment in research and development. The challenge for policy makers is to craft a recommendation that provides adequate incentives for price sensitivity as well as investment in research and development. Hence, the proposal to establish an informational board with no power to directly control prices.

The Pharmaceutical Review Commission will provide desperately needed and unbiased information on the cost and therapeutic effectiveness of new drugs coming to the market to both public and private purchasers of pharmaceuticals. This information will be critical to purchasers of both new breakthrough pharmaceuticals and new drugs that have therapeutic alternatives:

(1) Purchasers of new, breakthrough pharmaceuticals (that, by definition, have no therapeutic competition) will have little to no financial leverage in negotiating affordable prices with pharmaceutical manufacturers. Information on these drugs will provide the basis for appropriate usage suggestions to plan-sponsored physicians and have that added benefit of placing at least some public pressure on companies to be consumer/purchaser cost sensitive.

(2) Purchasers of drugs that have therapeutic alternatives who fear a manufacturer may pick a high price/heavy marketing strategy and target the part of the marketplace (still significant) that does not yet utilize effective managed care purchasing techniques. The type of information provided by the new Commission will prove particularly important to such purchasers as the Medicare program, which will not be using formularies, and will need this information to make appropriate decisions with regard to what drugs it places prior authorization.

Chris -

These are the papers that you discussed with Bill.

Kim O'Neill

LAUNCH PRICES FOR NEW DRUGS

There has been concern voiced in the Administration and in Congress that efforts, voluntary or otherwise, to hold annual prescription drug price increases to the CPI will result in an increase in the price at which new drugs are introduced into the market -- the launch prices.

Launch pricing has been an issue in the past when a new single source drug has been introduced to the market at a price that exceeded consumers' and federal policy makers' assumptions about its reasonable cost. In part, the conflict over launch prices has been attributable to differences in perspective between consumers and manufacturers. While consumers focus on their drug expenses in relation to other goods in their market basket, and assume manufacturers should be compensated for the cost of production only; manufacturers weigh launch prices as part of the economics of attracting investment capital to underwrite the high-risk research efforts needed to continue bringing new drugs to market.

The climate is changing, however, and new drugs are introduced in an increasingly sophisticated and price-sensitive marketplace, where a drug is priced in relation to its value and cost effectiveness relative to alternative therapies.

Most drugs are launched into competitive markets

New drugs today which are therapeutically equivalent to an existing drug (so-called "me-too" drugs) are introduced into an increasingly competitive marketplace. According to a study referenced in the recent Office of Technology Assessment (OTA) publication on pharmaceutical R&D[1/], only 27 percent of the new chemical and biological entities entering the world market between 1985 and 1989 were therapeutic "breakthroughs."

"Me-too" drugs are entering a market that is increasingly price sensitive and have been an important moderating influence on drug prices. The more drugs are introduced with a similar therapeutic profile, the more important price will become in determining market share.

1.Barral, P. E., Fifteen Years of Results in Pharmaceutical Research Throughout the World, 1975-1989 (France: Fondation Rhone-Poulenc Sante, August 1990).

A recent article in the Wall Street Journal[2/] cited a number of classes of drugs where price competition and the growing influence of institutional purchasers have kept launch prices low and actually lowered the prices of existing drugs in order to maintain market share.

Launch prices are an issue with relatively few new drugs

Launch prices do remain an issue for drugs that have no price-based competition. There are essentially single source drugs that represent a significant therapeutic advance or provide the only treatment for a particular disorder. Surprisingly few drugs fall in this category of "breakthrough" products. The Food and Drug Administration classifies drugs that have "important therapeutic gain" in the "A" category. Between 1988 and 1992 there were only five to eight new drugs a year classified in the "A" category. Over the five years from 1985-1989, only 51 drugs (an average of 10 per year) were introduced to the world market that provided any therapeutic gain over existing drugs.[3/] Only a portion of these represented a significant enough advance to face no competition.

Even "breakthrough" drugs must increasingly be priced as a cost-effective alternative to existing non-drug therapies in order to gain acceptance in managed care settings and establish sufficient market share. It is not possible for manufacturers to be assured of a reasonable market share without regard to price for any new drug.

New drug pricing is complex and intricately connected to R&D incentives

The pricing of a new drug is based on a combination of risk and return assumptions aimed at maintaining the capacity of the company to attract investment capital and finance sufficient R&D to bring a stream of new products to market. On the risk side are the generally low probabilities that any new chemical entity (NCE) will be found effective in laboratory tests; proven safe and effective in clinical trials; and be marketable. On the return side are assumptions about the market environment in which the drug will be introduced. These include the patent life; the timing for introduction of "me-too" drugs; the nature of the condition being treated; the costs of alternative treatments; and the societal costs of the condition. Each drug is therefore priced differently.

2."Drug Prices Get Dose of Market Pressure", Wall Street Journal, March 11, 1993.

3.Barral, P. E., Ibid.

When all factors are considered, the margins for pharmaceutical products are not much greater than the margins for other products, especially when the greater risk in pharmaceutical R&D is factored in. For example, the OTA estimated that, on average, the net return on new chemical entities brought to market between 1981 and 1983 exceeded the cost for the research and development on those drugs by 4.3 percent.[4] This calculation does not appear to account for R&D costs not associated with successful NCEs. Overall, OTA determined the pharmaceutical industry produced an economic rate of return on investment that was 2 to 3 percentage points higher than non-pharmaceutical firms. This is justifiable enough to overcome the risk differences and still attract investment capital.

Changes in the returns on new drugs can significantly affect the R&D strategies of companies and the cost of capital to the pharmaceutical industry. During the 1980s, pharmaceutical manufacturers focused attention on developing "me-too" drugs which have less risk and cost in R&D. According to OTA, however, lower returns from an increasingly competitive market for "me-too" drugs appears now to be encouraging a shift in R&D emphasis toward "breakthrough" drugs where there is a greater potential for revenues to offset the higher R&D risks. This shift in emphasis may help shorten the timetable for introduction of new drugs to combat major diseases that are costly to society. Government action which would result in a significant reduction in the expected returns for "breakthrough" drugs, however, would encourage a shift of emphasis back to lower risk investments that are less likely to make a significant therapeutic advance.

HMO determinations provide an effective method for negotiating drug prices

A properly functioning market can value new drugs on the basis of their worth to the society and to the extent that they provide a cost-effective treatment alternative. Increasingly, institutional purchasers, and HMOs in particular, are establishing this kind of market, and creating a competitive price. The price that this market yields reflects the value to society of a new drug. What is significant about this pricing approach is that the drug is valued by a medical entity in the context of total patient care.

For a government entity to set a launch price that will produce returns to the manufacturer consistent with the drug's value, that entity must be able to view the drug in a therapeutic

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4.Office of Technology Assessment. Pharmaceutical R&D: Costs, Risks and Rewards (Washington, D.C. - U.S. Government Printing Office, February 1993) P. 104.

rather than economic context. In other words, the decisions of individual practitioners operating under financial constraints, and the considerations of manufacturers in introducing a new drug to that environment must somehow be considered in the process of determining a fair price. Simply considering the manufacturer's input costs, on the one hand, or the consumer's purchasing power, on the other, is not sufficient to determine whether the new drug can save money or add value in the aggregate. The result of a government controlled approach to pricing would be to preclude the development of costly drugs that can substantially reduce total treatment costs in the long run.

Canada does have a mechanism that reviews launch prices for "breakthrough" drugs based on the price of the drug in other countries. Importantly, Canada does not attempt to set prices, but merely reviews prices to determine whether they are "excessive". About 30 percent of new drug prices are found in the Canadian approach to be "excessive".[5/] Canada's approach is only workable in a country with small market share where competition plays no role than it would be in the dominant pharmaceutical market in the world.

Using pricing in other countries as a benchmark for U.S. prices would generalize the losses that manufacturers would otherwise be willing to suffer to enter small highly-regulated foreign markets. Generalizing these losses can substantially, and arbitrarily, reduce investment returns and would, most likely, force world prices higher. Any simple or arbitrary price standard unrelated to the value of the drug runs the risk of missing or distorting the economic decisions related to bringing new drugs to market.

Conclusion

Relatively few drugs are launched today into non-competitive markets where launch prices create a political problem. Even "breakthrough" drugs must be cost sensitive in order to meet a purchaser's test of cost effectiveness in a therapeutic context. The continuing development of managed care and knowledgeable purchasing is the best mechanism to manage launch prices.

To the extent governments want to review launch prices, it should use the same standard now being applied by knowledgeable purchasers. It is not clear that any government entity has the capacity to apply that test.

5.General Accounting Office; Prescription Drug Prices: Analysis of Canada's Patented Medicine Prices Review Board (GAO/HRD-93-51) (Washington, D.C. - U.S. Government Printing Office, February 1993).

Any other approach, particularly one that is arbitrary or narrow in the factors considered in deriving a price, will shift the returns on R&D investment and substantially alter the investment strategies of pharmaceutical manufacturers, in ways that could have long term negative effects on health care costs and the health status of the population.

The Wall Street Journal 3/11/93

MEDICINE

Drug Prices Get Dose of Market Pressure

By Elyse Tanouye
Staff Reporter of The Wall Street Journal

Even as the White House and pharmaceutical industry officials wrangle over how to control drug prices, market forces in some cases are at work doing just that.

For the first time in years, competition among drug makers is prompting some companies to try an aggressive marketing approach: lowering prices. It's a radical departure for drug companies that traditionally pitch drugs directly to doctors based largely on a medicine's medical benefits.

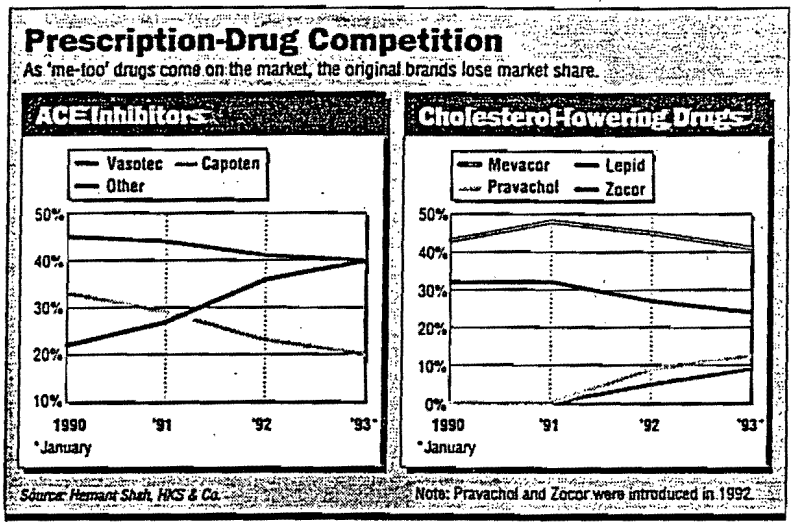
More skirmishes than full-blown price wars at this point, the competition is taking place in markets where several companies make equivalent or "me-too" drugs. But those markets—including some antibiotics, ulcer medications, antidepressants and blood-pressure therapies — are among the biggest.

These drug pricing battles were occurring before the Clinton administration began its recent attack on prices, which have increased by two to three times the rate of inflation during the 1980s and rose 7% last year. Some in the industry argue that new market forces will continue to push down prices, and they contend that the best thing the Clinton administration can do is to let that happen. But others point out that in a few years, the rush of me-too drugs may subside, reducing competition.

Fearful the Clinton administration will act price controls or attempt to roll back the prices of expensive medicines, drug-industry representatives met with White House health-care officials earlier this week, suggesting that the drug companies might go along with proposed laws that would monitor and enforce voluntary price controls.

Price Guarantees

But while the voluntary pledge to hold price increases down has received much public attention, behind-the-scenes pricing cuts are on the rise because of competition. Among recent pricing skirmishes, Ciba-Geigy Corp. has priced its Lotensin heart drug about 50% cheaper than Bristol-Myers Squibb Co.'s list price of Capoten, and 28% lower than Merck & Co.'s Vasotec. Moreover, Ciba-Geigy guarantees the price to patients for life, even if they need a higher dosage later on. Recently SmithKline Beecham introduced its antidepressant Paxil at a list price below those of Eli Lilly & Co.'s Prozac and Pfizer Inc.'s Zoloft. And Bristol-Myers priced its cholesterol-reducing drug Pravachol below Merck's Mevacor. Merck itself priced its second cholesterol-reducing drug, Zocor, below Mevacor.



Last week, American Cyanamid Co.'s Lederle Laboratories unit declared war in the nicotine-patch market by offering to rebate a third of the $4-a-day price to customers whose prescriptions aren't covered by Medicaid or insurance.

When the decisions to develop me-too drugs were made about a decade ago, they were considered to carry less corporate risk than new types of therapies. The first products on the market had already done the hard work of proving the drug's effectiveness and establishing the market. Me-too drugs chemically differ from the pioneer product but offer similar medical benefits.

Role of HMOs

In the past, late entrants to the market were usually able to set prices at or above those of competitors. But the emergence of big institutional buyers has reduced drug companies' pricing flexibility. Knowledgeable about drugs and determined to cut costs, these hospital, health maintenance organization and other managed care customers are particularly receptive to the cheaper-is-better marketing message. Bristol-Myers uses several marketing tools to sell Pravachol, says Senior Vice President Raymond C. Egan, but among managed care buyers, price "is the hot button."

Ciba-Geigy is hoping one name on that button is Lotensin. In 1990, the company began mapping out its marketing strategy for the heart drug in the ACE inhibitor class. Four ACE inhibitors were already on the market, and four more were expected to be launched about the same time as Lotensin in 1991. Capoten and Vasotec made up two-thirds of the market last year, according to Lotensin product director Henry Bloom. But gaining even a small slice of the $1.8 billion market can be profitable, he says.

Ciba-Geigy couldn't tout significant medical advantages because the ACE inhibitors are therapeutically similar. So executives at Ciba-Geigy gave the product-management team the mandate to come up with "a big idea" to sell the heart drug Lotensin: price cuts and guarantees.

Although Lotensin has gained just a tiny 4% market share, Mr. Bloom says the signs are good. "There's no question price helped us get the foot in the door with HMOs," he adds. Lotensin now is accepted on 65% of all HMO formularies, or lists of drugs covered by the HMO. As a group, lower-priced ACE inhibitors have begun to chip away at the market leaders. Since 1990, Vasotec's market share has declined to 41% from 45% and Capoten's share has fallen fell to 23% from 33%, according to Hemant Shah, an independent analyst.

SmithKline Beecham, which is considered among the most aggressive marketers to managed care buyers, emphasizes a "cost-effectiveness" pitch, which includes related hospital, physician and other costs to compare competitors' drugs. But price was the biggest selling point for the ulcer treatment Tagamet and the company's recently introduced antidepressant Paxil, priced 13% below Prozac. On the market for about a month, Paxil is on 80% of all managed health-care formularies, says Jean-Pierre Garnier, president of SmithKline's North American pharmaceutical division.

Managed care drug-buyers like Kaiser Permanente Medical Care Program, based in Oakland, Calif., welcome the entry of a lower-priced me-too drug as an opportunity to lower drug costs. When Bristol-Myers introduced Pravachol at a lower price than Merck's Mevacor, which was already on Kaiser's formulary, Kaiser opened up bidding for placement on its formulary, says Dale Kramer, Kaiser's director of materiel services. Mr. Kramer says Merck won with a "significantly" lower price for the drug.

Given the recent pricing skirmishes, Mr. Egan of Bristol-Myers says, "I think it's a shame that the administration enters the scene at a point where market forces are taking over and putting downward pressure on price."

For Kaiser's Mr. Kramer, "The potential is huge for competition, but there has to be a free-market environment." He points to a 1990 law requiring drug companies to give the Medicaid program the best price offered to any customer. It has caused companies to stop deeply discounting their drugs, he says. Kaiser was able to negotiate discounts as high as 40% to 60% in the past, he says, but now only gets the standard 15% that drug companies typically offer Medicaid. Kaiser's total drug costs, as a result, have increased by 5% to 8%, he says. Some big drug companies support the law because it restrains discounting—and competition, he says.

The flow of me-too drugs through drug companies' pipelines will continue for a few more years, putting more pressure on prices, Bristol-Myers's Mr. Egan says. But because price competition has reduced the profitability of developing follow-on drugs, companies are reviewing their portfolios and selecting pioneer, "breakthrough" drugs that can command premium prices, analysts and industry executives say. "Me-toos are out," says Mr. Garnier.

LAUNCH PRICE OPTIONS

Proposals for voluntary price restraints for prescription drugs are criticized on the basis that manufacturers would compensate for the revenue constraints of capped increases by setting high launch prices for new drugs.

Increasingly, new drugs are subject to pricing in a competitive market characterized by large and knowledgeable institutional buyers like HMOs and hospitals. Where new drugs are therapeutically equivalent to existing drugs, manufacturers are often forced to price them below the rest of the market to gain acceptance on HMO or hospital formularies. Even one-of-a-kind or breakthrough drugs are priced in this market on the basis of their cost-effectiveness in relation to alternative drug and non-drug therapies.

As the sophistication and influence of this institutional market grows, investors and manufacturers place greater emphasis on potential cost-effectiveness in their research and development decisions. In this way, the market redirects resources toward products that can add significant value to the society.

There is concern, however, that manufacturers would launch new drugs at high retail prices regardless of competitive pressures that forced them to negotiate low institutional prices. The following options would help assure the government that launch prices would be reasonable without leading to government-set prices:

1) Link retail pricing to HMO pricing

Retail launch prices would be capped at 150 percent of the average price received from institutional purchasers (excepting Medicaid and other government purchasers). The first retail launch price would be set independently. At the end of the first six months, manufacturers would adjust the retail price based on data on institutional market sales, and would rebate amounts in excess of 150 percent of the average institutional selling price.

Pros:

- Launch prices would be determined in the market place where knowledgable purchasers could effectively value the product. The retail market would benefit from the more sophisticated valuation of the HMO market.

Cons:

- Manufacturers expectations for retail revenues might force them to limit their discounts to institutional purchasers, raising HMO, Veterans Affairs, and Medicaid costs.

2) Require justification of launch prices

Currently, the government may reveiw the pricing of single source drugs that have benefited from NIH research or are licensed by the government for its reasonableness. Under this option, manufacturers would be required to disclose selling prices for all new drugs for the retail and institutional markets to the Secretary of HHS. The Secretary would be notified of a new drug price at the end of the first six months of sales. The Secretary could then request a justification of price for up to 20 percent of the new drugs launched each year, and could require negotiation with a manufacturer on any prices determined to be excessive. The Secretary could eliminate market exclusivity for a new drug in the event that the manufacturer failed to negotiate in good faith.

Pros:

- Would allow launch prices to be determined entirely in the marketplace for 80 percent of new drugs.
- Would allow a justification of prices for those thought to be excessive.

Cons:

- Would give the Secretary authority to influence the pricing of up to 20 percent of new drugs -- even if launch prices overall were lower.

3) Base launch prices on G-7 average

Pharmaceutical manufacturers would be required to set U.S. launch prices lower than or equal to the median of prices in the other G-7 countries (Germany, France, U.K., Italy, Canada, Japan). This is based on the assumption that a new drug will have entered the market in Europe first.

Pros:

- Leaves the manufacturers free to determine their own prices.

Cons:

- Locks in a pricing mechanism based on regulated countries in Europe and unrelated to the competitive pricing in the U.S. institutional market, and managed competition.

- Can be manipulated by manufacturers launching first only in countries in which they can get a high price approved.

- Could be sensitive to exchange rates.