Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. contract	personal document (1 page)	6/22/94	Personal Misfile

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [17]

gf65

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Revenues	
High Cost Plan Premium Assessment	$30.0
Tobacco Tax ($1. increase)	~~$86.0~~
HI State/Local	$ 7.6
SUBTOTAL REVENUES	$131.1
TOTAL FINANCING	$245.8

B. Fail-Safe Mechanism

A current baseline for federal health expenditures (CBO projected Medicare and Medicaid and tax spending) is established in the bill.

Under this act, it is anticipated overall federal health spending will decrease. However, in order to guarantee the act will not lead to deficit spending, a second baseline, called the health care reform baseline, is created. This second baseline includes existing and new spending.

In any year that the Director of OMB notifies Congress that health care reform spending, Medicare, Medicaid, Low-Income Vouchers, and Tax Spending will exceed the federal health expenditure baseline, the following automatic actions will occur to prevent deficit spending:

1. the voucher phase-in is delayed
2. the assessment on high cost insurance plans is ~~implemented~~ increased
3. the expanded tax deduction phase-in is slowed down
4. out-of-pocket limits in the standard and basic benefit packages are increased
5. starting in the year 2004, a tax cap is placed on supplemental benefits provided to employees and contributed to by employers.

Congress may act on alternative recommendations by the Health Commission to avoid the actions listed above.

IV. COST CONTAINMENT & CONSUMER PROTECTION

A. Benefits Package

The Commission will establish two benefit packages based on the categories of

benefits listed below.

1. A standard benefit package the value of which can not exceed the actuarial value equivalent of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program.

2. A basic benefit package which will contain higher cost sharing and/or fewer benefits. This package must be designed to prevent adverse risk selection when combined with the risk adjustments called for in the bill.

Provision will be included which will require individuals to show they can pay cost-sharing

Congressional priorities: within the constraints of the actuarial limits, Congress directs the Commission to adhere to the following priorities.

a) parity for mental health and substance abuse services (parity to be defined), which shall consist of a broad array of mental health and rehabilitation services managed to ensure access to medically necessary and psychologically necessary treatment and encourage the use of outpatient treatments to the greatest extent feasible.

b) consideration for needs of children and vulnerable populations, including rural and underserved persons.

c) improving the health of Americans through prevention.

Categories of Benefits:

Inpatient and outpatient care
Emergency, including appropriate transport services
Clinical preventive services, including services for high risk populations, immunizations, tests or clinician visits
Mental Illness and Substance Abuse
Family planning and services for pregnant women
Prescription drugs and biologicals
Hospice Care
Home health care
Outpatient laboratory, radiology and diagnostic
Outpatient rehabilitation services
Vision care, hearing aids and dental care for individuals under 22 years of age
Investigational treatments

For each package, the Commission will develop recommendations to clarify covered benefits; establish multiple cost sharing schedules that vary depending on the delivery system; and develop interim coverage decisions in limited circumstances. In making these determinations, the Commission will consult with expert groups for appropriate schedules for covered services. The Commission will have the authority to propose modifications to the benefits package that would not go into effect unless approved by Congress under base-closing procedures.

A qualified health plan shall provide for coverage of the categories of benefits described in this section for treatment and diagnostic procedures that are medically necessary or appropriate.

B. High Cost Plan Assessment

In each year beginning in 1996, an assessment will be imposed on the top 40 percent of all plans in an area. The assessment is equal to 25 percent of the difference between a target premium and the actual premium charged by an accountable health plan or self-insured plan for the standard benefit package in a community-rated area. The target premium is defined as the higher of the following:

1. the average premium of all qualified health plans offered to individuals and employees of small businesses in the HCCA

or

2. the geographically adjusted premium value at the 25th percentile of all accountable health plans in the United States.

The geographically adjusted premium value is calculated by adjusting each accountable health plan's premiums for regional variations. Such adjustments shall include but not be limited to variations in the cost of living and demographics.

For self-insured plans, the excise tax will apply to the difference between the target premium and the actuarial estimate used for meeting the COBRA requirements. The Department of Treasury will be given authority to develop regulations in this area.

C. Medical Liability Reform

There shall be a disincentive placed in the law to deter the continuation of lawsuits beyond the ADR process.

- No health care malpractice action may be brought in court until the final resolution of the claim under an alternative dispute resolution (ADR) method adopted by the state from models developed by the Secretary of HHS, or developed by the state and approved by the Secretary of HHS.

- ~~If the party initiating the court action receives a worse result, with respect to liability or the level of damages, from the court than in the state ADR method, such party shall pay the costs and attorneys fees of all parties to the litigation.~~

- Non-economic damages awarded to a plaintiff in a health care malpractice claim or action may not exceed $250,000, indexed for inflation.

- The liability of each defendant to a health care malpractice action for non economic and punitive damages will be based on each defendant's proportion of responsibility for the claimant's harm.

- Seventy-five percent of punitive damage awards will be paid to the state in which the action is brought and such funds will be used for provider licensing, disciplinary activities and quality assurance programs.

- A twenty year statute of repose will be applied to medical malpractice actions.

- Lawyers may not charge contingency fees greater than 33 1/3% of the first $150,00 of the award in a health care malpractice action and 25% of amounts in excess of $150,000, using after tax amounts.

- State laws that limit malpractice awards and fees to a greater extent are not preempted.

- ~~Defendants shall be permitted to make payments on awards in excess of $100,000 on a periodic basis.~~

D. Administrative Simplification

This section streamlines administrative processes in the health care system by establishing standards for a health care electronic data interchange (EDI) system to reduce administrative waste in the health care system; provide the information on cost and quality needed to make competition work; create the tools needed to conduct outcomes research to improve the quality of care;

and, to make it possible to track down fraud. This subtitle also sets requirements to protect the privacy and confidentiality of health care information, and establishes a National Health Information Commission of private-sector experts.

E. Quality Standards

The Secretary, in consultation with relevant private entities, will develop standards to assess the quality of health plans. In addition, the Secretary may:

- set priorities for strengthening the medical research base;
- support research and evaluation on medical effectiveness through technology assessment, consensus development, outcomes research and the use of practice guidelines;
- conduct effectiveness trials in collaboration with medical specialty societies, medical educators and qualified health plans;
- maintain a clearinghouse and other registries on clinical trials and outcomes research data;
- assure the systematic evaluation of existing and new treatments, and diagnostic technologies in an effort to upgrade the knowledge base for clinical decision making and policy choice;
- design an interactive, computerized dissemination system of information on outcomes research, practice guidelines, and other information for providers.

F. Anti-Fraud and Abuse

This subtitle establishes a stronger, better coordinated federal effort to combat fraud and abuse in our health care system. It also expands criminal and civil penalties for health care fraud to provide a stronger deterrent to the billing of fraudulent claims and to eliminate waste in our health care system resulting from such practices.

G. Patent Self-Determination Act extension.

V. PUBLIC PROGRAM REFORM

A. Medicaid Reform

INTEGRATION OF MEDICAID INTO PRIVATE INSURANCE

The Secretary shall study the impact on private health insurance premiums and make recommendations on the integration of AFDC and non-cash recipients into the community-rated private insurance pool. In general, the objective will be to treat both of these groups like other low-income families and individuals for the purposes of enrollment in health plans and subsidies. Services not covered in the standard benefit package will be retained and provided through the current Medicaid program for mandatory and optional eligibility groups.

OPTIONAL COVERAGE UNDER QUALIFIED HEALTH PLANS

- At state option, the Medicaid program will permit AFDC recipients and SSI recipients to receive medical assistance through enrollment in a qualified health plan offered in a local HCCA. The state may not restrict an individual's choice of plan and is not required to pay more than the applicable dollar limit for the HCCA area (as determined under section 2001 of the Act). The number of individuals electing to enroll in a qualified health plan is limited to a fifteen percent of the eligible population in each of the first three years, and ten percent in each year there after.

LIMITATION ON CERTAIN FEDERAL MEDICAID PAYMENTS

- Federal financial participation for acute medical services, including expenditures for payments to qualified health plans, is subject to an annual federal payment cap. The cap is determined by multiplying the per-capita limit times the average number of Medicaid categorical individuals entitled to receive medical assistance in the state plan.

- The per-capita limit for fiscal year 1996 is equal to 118% of the base per capita funding amount. This amount is determined by dividing the total expenditures made for medical assistance furnished in 1994 by the average total number of medicaid categorical individuals for that year. Expenditures for which no federal financial participation was provided and disproportionate share payments are excluded from this calculation.

- In years after 1996, the per-capita limit is equal to the per capita funding amount determined for the previous fiscal year increased by 6 percent for fiscal years 1997 through 2000, and 5 percent for fiscal year 2001 and beyond.

- States are required to continue to make eligible for medical assistance any class or category of individuals that were eligible for assistance in fiscal year 1994.

STATE FLEXIBILITY CONTRACT FOR COORDINATED CARE SERVICES

- At state option, the Act establishes a risk contract program within the Medicaid program which allow states to enter into contracts with at-risk primary care case management providers. An at-risk primary care case management provider must be a physician, group of physicians, a federally qualified health center, a rural health clinic or other entity having other arrangements with physicians operating under contract with a state to provide services under a primary care case management program.

- Risk contracting entities must meet federal organizational requirements, guarantee enrollee access and have a written contract with the state agency that includes: an experienced-based payment methodology; premiums that do not discriminate among eligible individuals based on health status; requirements for health care services; and, detailed specification of the responsibilities of the contracting entity and the state for providing for or arranging for health care services.

- Standards are established for internal quality assurance and state options regarding enrollment and disenrollment are specified. State and federal monitoring of quality and access standards are also established.

- In addition, each risk contracting entity providing Medicaid services shall also enter into written provider participation agreements with an essential community provider; or at the election of an essential community provider, each risk contracting entity will enter into an agreement to make payments to the essential community provider for services. Essential community providers include: Migrant Health Centers, Community Health Centers, Homeless program providers, Public Housing Providers, Family Planning Clinics, Indian Health Programs, AIDS providers under the Ryan White Act, Maternal and Child Health Providers, Federally Qualified Health Centers, and Rural Health Clinics.

OTHER PROVISIONS

- The Act phases out Medicaid Hospital Disproportionate share adjustment

payments by fiscal year 2000.

Medicare Reform

Maintain Medicare as a separate program.

Medicare remains a separate program and continues to be federally administered. Beneficiaries enrolled in part B continue to pay a monthly premium. The statutorily defined Medicare benefits continue to be the Medicare benefit package in both fee-for-service and managed care.

A. Individuals could maintain coverage through private health plans when they become eligible for Medicare.

Individuals have the option to remain in an accountable health plan (AHP) when they become eligible for Medicare. If they remain, they continue to receive the standard benefit package with the full range of options available to the non-Medicare population.

Plans may offer a separate rate for the Medicare-eligible population. The Board is required to prescribe methods for risk adjustment.

For individuals choosing an AHP, Medicare will pay the federal contribution calculated for Medicare risk contracts. Individuals are responsible for paying the difference between the premium charged and the federal contribution.

During the annual enrollment period, Medicare-eligibles may choose a new plan through their employer/purchasing cooperative or they may return to the traditional Medicare program.

B. Medicare Select would become a permanent option in all States.

Medicare Select is a demonstration program limited to 15 states (including North Dakota, Missouri and Minnesota) established in OBRA 1990 to allow managed care organizations to deliver supplemental benefit packages to Medicare beneficiaries. An individual buying a Medicare Select policy is buying one of the 10 standard Medigap plans. The only difference is that

Medicare Select policies deliver care through preferred providers. The program is scheduled to expire in 1995.

Medicare Select would be a permanent option in all States. Medicare Select policies will be offered during Medicare's coordinated open enrollment period. Plans may not discriminate based on pre-existing conditions.

C. Medicare risk contracts would be improved. (Medicare Choice Act)

GRADUATE MEDICAL EDUCATION

This subtitle features mechanisms to increase the number of primary care physicians.

Medicare GME Demonstration Project

- The Secretary will allow up to seven states to experiment with Medicare direct graduate medical education (DME) payments to increase the number of primary care physicians. Under this program, qualifying states may use different weighting factors, or a community-based health care training consortia, to direct a greater share of its DME funds for primary care medical education. A consortia will be composed of teaching hospitals, medical schools, and ambulatory training sites, with the goal of increasing the number of primary care providers;

- Up to seven training consortia nationwide will be eligible to receive Medicare DME waivers directly from the Secretary. Each such consortium will be permitted to determine the most appropriate mechanism to use its DME resources to increase the number of primary care providers, including distributing funding to medical schools.

Community-Based Physician Training

- Medical resident training time in non-hospital-owned community-based settings will begin to be counted in the determination of full-time-equivalent residents for the purpose of making Medicare DME payments with the goal of

moving more residency training out of hospitals and into the community;

- For the purpose of Medicare indirect graduate medical education payments (IME), training time in non-hospital-owned ambulatory settings will be counted in the determination of full-time-equivalent residents with the goal of providing equal incentives for hospitals to train primary care residents and sub-specialty residents. In addition, per-institution IME payments are adjusted to assure budget neutrality.

Expansion of National Health Service Corps

- Increases funding for the National Health Service Corps scholarship and the State Loan Repayment programs.

Increased Resources for Primary Care Health Professions Training

Enhances resources for Public Health Service programs which support training of primary care providers as follows:

- Increases funding for programs under Title VII of the Public Health Service Act for the training of family physicians, general internists, and general pediatricians;

- Creates a new scholarship program and increases Title VII Public Health Service Act funding for physician assistants;

- Increases Title VII Public Health Service Act funding for nurse practitioner training and scholarship programs.

State Programs for Non-Physician Providers

- A demonstration program is created for states and non-profit organizations to experiment with changes in state scope-of-practice laws for nurse practitioners and physician assistants, the retraining of subspecialists to deliver primary care, and other mechanisms to increase the supply of primary care providers.

How much does this cost?

The effect on the deficit will be zero (Fall-Safe)
We raise $250 billion over five years
These funds will be used to provide direct subsidies to individuals at 240% of poverty and below, and to expand the deductibility of health insurance premiums for individuals and the self-insured.
We expect additional savings from system reforms.

We expect the combination of these elements to lead to insurance coverage for at least 93% of all Americans by 2002, and coverage of about 98% of all health care costs in the

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE: Chris Jennings

PHONE: _____

FROM: Joanne Pokaski
OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: 202-690-6726
FAX : 202-690-6262

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:
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REMARKS: This came from the White House Liaison's office to HCFA for you today.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

JUN 24 1994

MEMORANDUM TO : OPDIV/STAFFDIV Heads and Deputies
All Political Appointees

FROM : Ray Martinez RM
White House Liaison

SUBJECT : 4th of July Celebration in Room 800

Please come join your co-workers and their families for a 4th of July Celebration in Room 800, Monday, July 4, 1994 from 7:00 p.m. until the fireworks are over.

Bring a picnic dinner for you and your guests, and let's gather together to enjoy the fireworks which will begin at approximately 9:30 p.m.

Please R.S.V.P. to Marie Absher (690-6625) by noon on Thursday, June 30th as to how many people will be attending with you, (and remember that space is limited, especially on the outside patios). Please be sure to call Marie, because we need to know the amount of refreshments (assorted soft drinks and cake, but no alcohol), and paper products to purchase. I am asking that each of you attending donate $5.00 to help with the cost of these items. Marie will need the money by noon on Thursday.

Due to the fact that it is a holiday, please remember to bring your building pass and to arrive and enter the building with your guests at the Independence Avenue entrance. You will not be permitted to enter the building without your pass nor will your guests be able to enter without you. Parking is available on the street for those of you who do not usually park in the garage.

Arrangements have been made to have the patio doors unlocked for outside viewing of the fireworks. Please note that there will be signs posted on the railings that will say "do not touch". There is a chemical painted on the railings to keep the pigeons from landing.

If you have any questions, please feel free to call Marie at [redacted].

Look forward to seeing you on the 4th.

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DRAFT: NUMBERS PRELIMINARY

MEMO FOR: Chris Jennings and Len Nichols

FR: Ken Thorpe

RE: Age-Rating in the Kennedy Mark

DT: May 23, 1994

****

These are the latest estimates (once, of course, a mistake was corrected). We are still working on the Medicare worker savings. This is not nearly as easy as originally thought, we have the actuaries working on the savings.

Table 1. Partial Budgetary Impact of Age-Rating, Changes Relative to the HSA.

1996-2004	Kennedy Mark	With Age Rating
Subsidies	-$46	-$16
Medicare Worker Savings	$0	+$6
Total Relative to HSA	-$46	-$10

Table 2. Distributional Impacts, Household Subsidies in Billions (Assumes full 1994 Implementation)

Age of Head of Household	Kennedy Mark	With Age Rating
<30	$27.9	$21.8
30-39	$8	$6.1
40-49	$5.5	$5.3
50-54	$2.7	$3.4
55-59	$4.0	$6.3
60-64	$8.8	$16.6
Total	$56.9	$59.5

Table 3. Distributional Impacts: Household Payments As Percent of AGI

Age of Head of Household	Kennedy Mark	With Age Rating
<30	2.2%	1.8%
30-39	1.4%	1.2%
40-49	1.2%	1.2%
50-54	1.1%	1.3%
55-59	1.2%	1.7%
60-64	1.4%	2.3%
Total	1.4%	1.4%

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May 16, 1994

TO : Senate Labor and Human Resources Committee
Attention: David Nexon and Mary Beth Fiske

FROM : Michael J. O'Grady
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : Varying the Benefits in the Health Security Act, S. 1757--
Premium Effects

In response to our meeting and subsequent phone conversations I have prepared the following memorandum analyzing the effect of various benefit changes on health insurance premiums.

In the first stage of this analysis we used the Health Security Act, S. 1757, as a basis for comparing any changes in the benefit package. In conjunction with our consulting actuaries at Hay/Huggins Co., Inc., we then estimated the actuarial value of the benefits changes specified in Chairman Kennedy's mark dated May 11, 1994.

With the estimates of actuarial value, I have used the Census Bureau's March 1993 Current Population Survey (CPS) to model the distribution of the U.S. population[1] into the four types of coverage groups specified in S. 1757: self only, two adults, single-parent families and two-parent families.

Table 1 details the effect of the benefit changes on the four premium types specified in S.1757. The percentage change estimates are of the total premium and have been calculated for both the high and low cost sharing plans. It is unclear how the premium estimates under the combination plan would be effected, but given the hybrid nature of the combination plan we are comfortable with the assumption that the high and low cost sharing estimates provide a reasonable range of estimates for the combination plan. No assumptions have been made about how people might sort themselves into the different plans. It is assumed that the populations covered by the high and low cost sharing plans are demographically similar to the population overall.

[1]Except those people who primarily rely on Medicare for their health insurance.

Table 2 provides some details of our interpretation of the provisions. We have tried to put ourselves in the position of an insurer determining what benefits are covered, at what cost sharing. If in any of these provisions we have misinterpreted the intent please let us know.

There are a few areas where we are not yet able to make estimates of the effects of Chairman Kennedy's mark. Our work on the premium effects of your changes to the mental health coverage should be completed shortly.

The overall effect of the benefit changes specified in table 1 reduces premiums between 1.2 and 2.6 percent. Keep in mind, that we have only analyzed the changes specified in table 1 and other modifications could alter the overall result considerably.

The methodology and assumptions underlying the estimates have been coordinated with the Budget Analysis Division of the Congressional Budget Office to ensure that they are consistent with estimates you may receive from them later.

If you have any questions or we can be of further assistance, I can be reached at 7-7347.

TABLE 1. Percentage Change in Premiums for Expanded Benefits, Under Four Types of Coverage

Benefit	Individual		Couple		Single-parent family		Two-parent family	
	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing
Clinton baseline	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
A) Clinical preventive services								
1) Tests	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.2%	0.3%
2) Clinician visits under age 20	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.2%	0.3%
B) Hearing aids for children	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%
C) Rehabilitation services extensions	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
D) Home health care and extended care facilities	0.6%	0.7%	0.6%	0.7%	0.6%	0.7%	0.6%	0.7%
E) Enhanced mammograms								
1) Ages 50-64 annually	0.6%	0.6%	0.6%	0.6%	0.3%	0.3%	0.3%	0.4%
2) Ages 40-49 biennually	0.3%	0.4%	0.3%	0.4%	0.2%	0.2%	0.2%	0.2%
F) Enhanced pap smears	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
G) Contraceptive drugs and prescription devices	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%
H) Extended care annual limit	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
I) Medical foods (PKU, etc.)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
J) Outpatient drugs—accessories and supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
K) Outpatient speech pathology and audiology services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
L) Durable medical equipment—replacement	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
M) Vision care limitation to periodicity schedule	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

TABLE 1. Percentage Change in Premiums for Expanded Benefits, Under Four Types of Coverage								
Benefit	Individual		Couple		Single-parent family		Two-parent family	
	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing
N) Investigational treatments--discretion of plan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
O) Extracontractual items and services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
P) Hospital deductible of $250--low cost sharing plan	-1.6%	0.0%	-1.6%	0.0%	-1.5%	0.0%	-1.5%	0.0%
Q) Drug copayment of $10--low cost sharing plan	-2.0%	0.0%	-2.0%	0.0%	-1.9%	0.0%	-1.9%	0.0%
R) Individual max. out-of-pocket increased from $1,500 to $2,500--high cost sharing plan	0.0%	-4.9%	0.0%	-4.9%	0.0%	-4.7%	0.0%	-4.7%
Insurance units--in thousands* (total = 107,076)	51,503		17,220		11,419		26,933	
Population--in thousands* (total = 223,621)	51,503		34,522		31,954		105,641	
Percentage children	0.0%		0.0%		60.6%		46.6%	

*Except those people who primarily rely on Medicare for their health insurance.

Source: Actuarial value of benefit variations calculated uses CRS Health Benefits Model v. 5.3. Demographic adjusters developed from data provided by major insurers, the Office of Personnel Management and the Nation Medical Expenditures Survey. Insurance units and population data developed using the Census Bureau's March 1993 Current Population Survey.

TABLE 2. Modifications to the Health Security Act

Benefit	Proposed Benefit Changes
A. Enhanced Children's Preventive Services 1. Tests 2. Clinician visits under age 20	Modifications to S. 1757 that either increase or decrease the incidence of clinical preventive services.
B. Hearing Aids and Comprehensive Hearing Assessments for Children under 18	Benefit added to S. 1757 for children who have failed a hearing screening as originally covered by S. 1757.
C. Rehabilitation Services Extensions	S. 1757 benefits clarified include coverage for outpatient respiratory therapy, and audiology services for outpatient speech-language pathology services. Established a maintenance or prevention program to include the following services: 1. Rehab health professional to provide initial evaluation & periodic oversight of the patient. 2. Rehab health professional to design a maintenance or prevention program appropriate for the patient. 3. Instruct patient and family members on how program is to be implemented. 4. Periodic reevaluations (in addition to a reevaluation at the end of each 60 day period). The plan will not deny coverage for outpatient occupational therapy, outpatient physical therapy, outpatient respiratory therapy and outpatient speech language pathology services and audiology services as a result of a disorder or other health condition. (S. 1757 only provides coverage if condition is a result of an illness or injury.
D. Home Health Care and Extended Care Facilities Extensions	Extends the coverage clause under S. 1757 to include conditions that did not result from an illness or injury. Also extends the annual number of visits in ECF if the care is found to be a "cost-effective alternative to necessary inpatient hospitalization".
E. Enhanced Mammograms	Augments the benefit under S. 1757 for: · Age 50-64 to cover mammograms annually rather than biannually. · For 40-49 to cover mammograms biennually.
F. Enhanced Pap Smears	Benefit added to S. 1757 to cover pap smears annually unless individual has 3 years of negative pap smears and no risk factors for STDs or cervical cancer.
G. Contraceptive Drugs and Prescription Devices	Extends benefit to include coverage for contraceptives drugs and prescription devices.
H. Extended care annual limit	Provides for an annual limit of 100 days for extended care services, with conditions under which the limit can be waived.

TABLE 2. Modifications to the Health Security Act	
Benefit	Proposed Benefit Changes
I. Medical foods (PKU, etc.)	Medical foods prescribed by a physician are added to the outpatient prescription drugs and biologicals coverage.
J. Outpatient drugs accessories and supplies	Clarifies accessories and supplies typically covered under current health insurance policies. For example, syringes and glucose testing supplies for diabetics.
K. Outpatient speech pathology and audiology services	Under outpatient rehabilitation services, clarifies that outpatient speech language and audiology services are covered for the purpose of attaining or restoring speech.
L. Durable medical equipment--replacement	Clarifying language covering the replacement of durable medical equipment. Conforms with typical current insurance practices.
M. Vision care limitation to periodicity schedule	Allows the Board to establish the periodicity schedule for benefit.
N. Investigational treatments--discretion of plan	Allows the plan to cover an investigational treatment at it's discretion, as long as it's done based upon objective protocols and applied consistently.
O. Extracontractual items and services	Allows the plan discretion to use cost effective alternatives, as long as appropriate treatment is provided.
P. Hospital deductible of $250 - low cost sharing plan	Increase from $0 to $250
Q. Drug copayment of $10--low cost sharing plan	Increase copayment from $5 to $10
R. Individual maximum out-of-pocket increased from $1,500 to $2,500--high cost sharing plan	Increase individual maximum out-of-pocket liability from $1,500 to $2,500. Leave family liability at $3,000.

Congressional Research Service · Library of Congress · Washington, D.C. 20540

May 17, 1994

TO : Senate Labor and Human Resources Committee
Attention: Ron Weich

FROM : Michael J. O'Grady
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : **Varying the Mental Health Benefits in the Health Security Act, S. 1757--Premium Effects**

In response to our meeting and subsequent phone conversations this memorandum analyzes the effect of various changes in the mental health benefits on health insurance premiums.

In the first stage of this analysis we used the Health Security Act, S. 1757, as a basis for comparing any changes in the mental health benefit package. In conjunction with our consulting actuaries at Hay/Huggins Co., Inc., we then estimated the actuarial value of the benefits changes specified in Chairman Kennedy's mark dated May 11, 1994.

The mental health benefits changes specified in the Chairman's mark would increase premiums by 1.6 percent in the high cost sharing plan for all four types of coverage groups, self only, two adults, single-parent families and two-parent families. In making these estimates we used a $2,500 maximum out-of-pocket limit for individuals and $3,000 for families. Further we allowed the maximum out-of-pocket limits to apply to mental health charges for inpatient, residential, intensive nonresidential and outpatient services. The coinsurance used was 20 percent for all four types of service.

A less costly alternative would be to use the cost sharing provisions specified in S. 1757 for outpatient psychotherapy--i.e., require a payment of 50 percent coinsurance. This modification increases premiums by only 0.1 percent in the high cost sharing plan for all four types of coverage groups.

If, in conjunction with the modification in the cost sharing provisions for outpatient psychotherapy, a further modification were made to strengthen the language regarding managed care, there would be no premium increase over S. 1757. Language that would require and specifically define quality managed care, rather than leaving it to the discretion of the plan would be sufficient for this purpose.

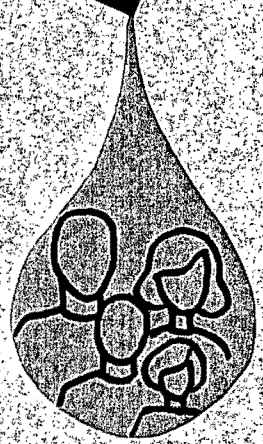
It is our understanding that these modifications to the outpatient cost sharing and managed care provisions are consistent with later versions of the Chairman's mark. With the modifications as specified, CRS estimates no premium increase for mental health benefits compared to S. 1757, the Health Security Act.

The methodology and assumptions underlying the estimates have been coordinated with the Budget Analysis Division of the Congressional Budget Office to ensure that they are consistent with estimates you may receive from them later.

If you have any questions or if we can be of further assistance, I can be reached at 7-7347.

FAMILIES USA REPORT TEN DOLLARS

DOING WITHOUT



THE SACRIFICES FAMILIES MAKE TO PROVIDE HOME CARE

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TIME: 5:00 PM
FROM: Pat Griffin

I. PURPOSE

Review current status of health care legislation in Committees.

Outline necessity to complete committee action by July 4 and floor action by August break.

Restate bottom-line commitment to universal coverage.

Underscore desire for bipartisan cooperation but need for Democrats to unify under any event.

II. BACKGROUND

You will be meeting with the House and Senate leadership (and Chairmen with jurisdiction over health care) to discuss the status of health care reform. It is important that this meeting focus on progress that has been made as well as the obstacles that remain. In particular, it is important to proceed on the basis of a common understanding of the necessity to complete committee action before July 4.

Press coverage has raised expectations that this is a meeting to reassess and redirect strategy. We have worked to reverse that impression, characterizing the meeting as consistent with a pattern of periodic meetings to coordinate White House and congressional efforts. If the meeting is characterized as a reassessment of the Administration's health care strategy, raising expectations that even the objective of universal coverage is being reconsidered, it will become much more difficult for the committees to complete action.

This meeting will be very constructive if it produces a plan for completing action in June on legislation providing for universal coverage, making it possible for bills to be on the respective floors in July.

III. SUGGESTED APPROACH

The regular order of listening to each chairman report on the status of health care in their committee is likely to produce a complete list of the remaining problems, but is less likely to underscore the progress that has been made. To impress the members with your interest with their work, we would suggest that you consider opening with remarks that illustrate that you are

closely following the progress in the committees. Following your brief remarks, we would suggest that you ask the Chairmen how best he and the First Lady can best assist them achieve their mutual goals of reported bills by the July 4th recess.

IV. STATUS IN EACH COMMITTEE

Ways and Means: Ways and Means will complete its preliminary business by Memorial Day, and will be prepared to begin marking up in earnest immediately after the break. While the Chairman must continue to work for a majority, and he will not have a mark to put before the Committee for consideration until CBO completes its cost estimates, the prospects for reaching a majority remain promising. Rostenkowski has met with his Republicans privately, expressing a willingess to work together, but he continues to assume that he will need 20 Democratic votes to report the bill.

Education and Labor: The Williams Health subcommittee plans to complete action on its mark either today or tomorrow. While the mark-up has been slow, there still appears to be a clear majority in both subcommittee and full committee for a strong bill. The bill clearly adds significant additional spending for increased benefits, but will come the closest to mirroring the Health Security Act.

Energy and Commerce: While Chairman Dingell has had a most difficult time, he is stuck only one vote short of reporting a strong bill from committee. There is some talk of reporting two bills -- Cooper and Dingell, which might be a way to break the deadlock there. Even if the committee cannot report out, the legislation could move forward, but progress in other committees should help. In particular, any indication from Senate Finance that an employer mandate is likely will help advance the issue in Energy and Commerce.

Senate Labor and Human Resources: Chairman Kennedy hopes to complete his mark-up before the Memorial Day break. Like the Education and Labor committee's mark, it adds some benefits. Unlike the House counterpart, the Chairman is trying to accomodate some Republican and conservative Democrat interests.

Most notably, Senator Kennedy has incorporated provisions providing for a carve-out from the mandate for firms with 5 or fewer employees. It also provides for a voluntary alliance mechanism, as well as an alternative to opt into the Federal

Employees Health Benefits Program (FEHBP).

Last week, in an unanimous vote, the committee voted for an amendment to reduce benefits if the costs of the benefits package exceeded the statutorily allowable limits. It is likely that there will be further notable amendments prior to the final vote on the mark, including expanding the firm carve out to 10 and under (by Senator Bingaman and others). Although there is likely to be additional bipartisan support during the amendment process, it is highly unlikely that any Republican (other than Senator Jeffords) will vote for the final package.

Senate Finance: Chairman Moynihan has been holding bipartisan and Democrats-only Finance committee meetings for a number of weeks. He announced last week in one of these meetings that he planned on going to mark-up soon after the members returned from the Memorial recess. The uncertainty surrounding the direction the Finance committee will eventually head is making other committees and members quite nervous. It is also fueling rather wild speculation in the press and in the lobbying community.

It seems clear that Senator Chafee is still trying to find a way to get cover to bridge to at least the conservative Democrats on the committees. The conservative Democrats, i.e., Boren, Breaux, and Conrad appear to be trying to do the same. So far, however, neither side has achieved agreement on an acceptable compromise package. Causing the greatest concern of late, however, is an ongoing flirtation with lowering the standard of the definition of universal coverage. Any signal that you are open to modifying your definition will immediately move the debate to the right.

V. PARTICIPANTS

See attached

VI. PRESS PLAN

Photo-op and very brief Q&A prior to House Caucus meeting

VII. SEQUENCE OF EVENTS

-- Speaker Foley will introduce President.
-- President will give brief remarks.
-- Majority Leader Mitchell, Majority Leader Gephardt and others follow.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503

URGENT

May 24, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-2809

TO: Legislative Liaison Officer -

EOP - Review Only, See Distribution Below - ( ) - -

FROM: Robert J. PELLICCI (for) RJ Pellicci
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI (395-4871)
Secretary's line (for simple responses): 395-7362

SUBJECT: HHS Qs and As RE: S 1757, Health Security Act

DEADLINE: NOON May 25, 1994

COMMENTS: SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES REQUEST -- The attached HHS prepared response shows the impact of the funding levels for the AHC pool proposed in Sen. Kennedy's mark.

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

CC:
Nancy-Ann Min
Ira Magaziner
Chris Jennings
Jack Lew
Lynn Margherio
Judy Feder
Judy Whang

LRM #I-2809

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is **simple** (e.g., concur/no comment) we prefer that you respond by **faxing** us this response sheet. If the response is **simple** and you prefer to call, please **call the branch-wide line** shown below (NOT the analyst's line) to leave a message with a secretary.

You may **also respond** by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please **include** the LRM number shown above, and the **subject** shown below.

TO: Robert PELLICCI
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-4871
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Qs and As RE: S 1757, Health Security Act

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet

m:\wp\cbar.14

MAY 24 1994

NOTE TO JUDY FEDER

The Labor and Human Resources staff has requested a table showing the impact of the funding levels for the AHC pool proposed in the Kennedy Chairman's mark.

Attached is a draft table showing payments to hospitals in years 1996 through 2000 if the AHC pool were funded at the levels specified in the Kennedy mark.

If there are any questions regarding this material, please call Kate Rickard at 690-5824.

5/24

B[illegible]Bailes

cc: Bob Pellicci

DRAFT

IME Comparison of Transitional Funding Levels Under Healthcare Reform, 1996 to 2000

			Inpatient Plus Outpatient Revenue Base				
			1996	1997	1998	1999	2000
		N	(Thousands)				
All Teaching Hospitals		1017	$6,280,000	$7,250,000	$8,220,000	$9,400,000	$10,640,000
	AMC Hospitals	116	$3,193,618	$3,686,900	$4,180,181	$4,780,256	$5,410,848
	Non-AMC, COTH	168	$1,735,367	$2,003,410	$2,271,452	$2,597,524	$2,940,176
	Non COTH	733	$1,349,836	$1,558,390	$1,766,824	$2,020,456	$2,286,984
Interns-Residents to Beds Ratio							
	Low	531	$441,120	$509,255	$577,390	$660,276	$747,376
	Medium	272	$1,326,824	$1,531,763	$1,736,702	$1,986,010	$2,247,994
	High	88	$1,033,305	$1,192,907	$1,352,510	$1,546,666	$1,750,694
	Highest	126	$3,477,571	$4,014,712	$4,551,853	$5,206,282	$5,891,936
Medicare Proportion of Revenue							
	Under 60%	924	$6,174,693	$7,128,427	$8,082,161	$9,242,374	$10,461,581
	Over 60%	93	$104,127	$120,211	$136,294	$155,859	$176,420
Type of Hospital							
Urban		962	$6,193,129	$7,149,712	$8,106,294	$9,269,971	$10,492,818
	Large Urban	860	$4,421,455	$5,104,387	$5,787,319	$6,618,102	$7,491,128
	Other Urban	402	$1,771,672	$2,045,322	$2,318,972	$2,651,866	$3,001,687
Rural		55	$85,692	$98,928	$112,164	$128,265	$145,186
	Rural Referral	37	$72,045	$83,173	$94,301	$107,838	$122,063
	Sole Community	5	$428	$494	$560	$641	$725
	Other Rural	13	$13,218	$15,259	$17,301	$19,785	$22,394
Payment Adjustments							
	IME & Disp Share	571	$4,996,416	$5,768,155	$6,539,895	$7,478,712	$8,465,265
	IME Only	446	$1,282,404	$1,480,482	$1,678,561	$1,919,522	$2,172,736
Size							
	Urban 0-100 Beds	50	$25,905	$29,906	$33,908	$38,775	$43,890
	Urban 100-199 Beds	192	$222,091	$256,394	$290,698	$332,429	$376,281
	Urban 200-299 Beds	231	$660,858	$762,933	$865,008	$989,182	$1,119,670
	Urban 300-399 Beds	206	$1,112,629	$1,284,484	$1,456,340	$1,665,400	$1,885,092
	Urban 400-499 Beds	123	$1,197,608	$1,382,588	$1,567,569	$1,792,597	$2,029,068
	Urban 500+ Beds	160	$2,974,039	$3,433,405	$3,892,771	$4,451,588	$5,038,818
	Rural 0-50 Beds	8	$673	$777	$880	$1,007	$1,140
	Rural 50-99 Beds	9	$1,430	$1,650	$1,871	$2,140	$2,422
	Rural 100-149 Beds	8	$4,074	$4,703	$5,332	$6,098	$6,902
	Rural 150-199 Beds	10	$6,566	$7,580	$8,594	$9,828	$11,124
	Rural 200+ Beds	20	$72,949	$84,216	$95,484	$109,191	$123,596
Region							
	New England	74	$536,838	$619,757	$702,676	$803,547	$909,546
	Mid Atlantic	232	$1,670,358	$1,928,359	$2,186,360	$2,500,217	$2,830,033
	South Atlantic	217	$1,260,118	$1,454,754	$1,649,391	$1,886,164	$2,134,978
	East North Central	81	$323,192	$373,112	$423,031	$483,759	$547,674
	East South Central	130	$907,022	$1,047,119	$1,187,217	$1,357,644	$1,536,738
	West North Central	44	$223,530	$258,066	$292,582	$334,583	$378,720
	West South Central	90	$388,155	$448,109	$508,063	$580,997	$657,639
	Mountain	38	$168,263	$194,252	$220,242	$251,858	$285,082
	Pacific	111	$801,343	$925,117	$1,048,891	$1,199,462	$1,357,689
Ownership							
	Voluntary	820	$4,474,456	$5,165,573	$5,856,692	$6,697,433	$7,580,924
	Proprietary	70	$126,253	$145,764	$165,264	$188,977	$213,906
	Government Urban	118	$1,664,926	$1,922,088	$2,179,250	$2,492,086	$2,820,829
	Government Rural	9	$13,186	$15,223	$17,260	$19,738	$22,341

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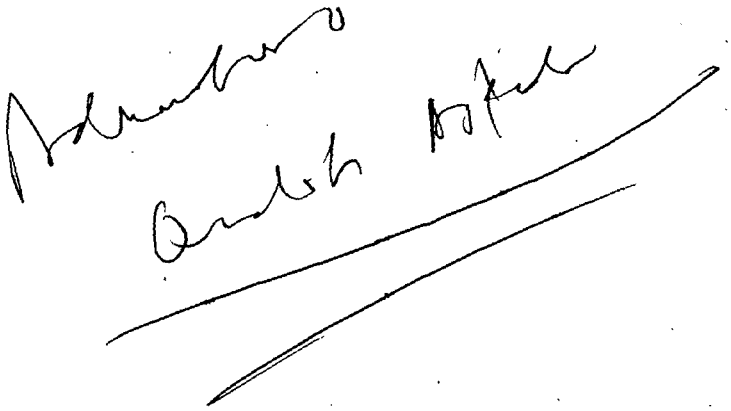

Families USA FOUNDATION

PRESS RELEASE

SENATE FINANCE COMMITTEE HEALTH PLAN FALLS FAR SHORT OF CLAIMS, NEW STUDY FINDS

LESS THAN 25% IMPROVEMENT OVER TODAY'S CRISIS

The Senate Finance Committee's health care reform bill would fall far short of its stated goals, with 1.8 million Americans losing health insurance each month, according to a report issued today by the consumer health advocacy organization Families USA. This would be less than a 25% improvement over the current 2.25 million who lose insurance each month.

Middle class working families would be hardest hit by the weaknesses of the Finance Committee bill, according to the report.

Some members of the Senate Finance Committee have claimed that their bill is designed to make sure that at least 95 percent of the country has insurance by the year 2002. The Families USA report is the first to assess whether that goal is realistically achieved by the Committee's bill, and it found that, at best, the bill would leave 23 million Americans without health insurance, primarily in middle class working families.

According to the report, the Committee's bill falls far short of its goals even if the bill is fully financed. In fact, the bill has an apparent shortfall of $80 billion to $100 billion over the next five years. The legislation would automatically require cuts in subsidies if this shortfall occurs, causing additional millions of additional people to lose insurance, according to the report.

The report concludes that the Finance Committee bill might provide significant help to the poor and near-poor, but would provide very little help to middle class families. Only ten percent of the middle class who don't have insurance would receive insurance by the year 2002, according to the study's findings.

"Calling this a 95% solution is just false advertising. It's no better than a 25% solution, that would guarantee full security to no one, and would leave most of those at risk today still at risk tomorrow," Pollack said.

"It's a hollow promise that would leave the middle class unprotected. Why shouldn't Congress just give all Americans the high quality health security Congress has voted for itself?" Pollack said.

- 30 -

CONTACT: ARNOLD BENNETT OR AVIVA SHLENSKY (202) 628-3030
1334 G STREET NW • WASHINGTON DC 20005 • FAX (202) 347-2417

SPECIAL REPORT

A Publication of Families USA, July, 1994

SENATE FINANCE BILL: No Help for the Middle Class

The health reform legislation passed by the Senate Finance Committee establishes a national goal of achieving universal health insurance coverage, defined as coverage of 95 percent of the U.S. population, by the year 2002. At that time, a national commission would assess whether the goal had been met and, if not, make fast-track recommendations to Congress on how to achieve the goal.

The Finance bill is likely to fall far short of its goal. By the year 2002 under the Finance reforms (assuming no fiscal shortfall resulting from the bill), a minimum of 1.8 million Americans would lose their health insurance each month. This would leave an estimated 23 million Americans without insurance, on average, each month. Today, 2.25 million Americans lose their insurance each month and 31 million are without insurance, on average, each month. At best, the Finance reforms get the nation only one-fourth of the way to universal coverage.

The Finance reforms would likely leave many more millions without health insurance, since the bill has a funding shortfall of about $100 billion over five years and the bill specifies that the provisions designed to expand coverage be delayed if federal spending for health programs is expected to exceed the anticipated savings and revenues from the bill.[1] Without taking into account this likely funding shortfall, the Finance bill would cover only 91.6 percent of the population by 2002.

The Finance reforms would help many of the poor gain insurance coverage, but would do little to guarantee health insurance for middle class Americans with incomes above poverty. Not only would few Americans with incomes above poverty benefit from these reforms, but some Americans will be newly vulnerable to losing their insurance as a result of specific provisions in the bill.

COVERING SOME OF THE UNINSURED

Under the Senate Finance reforms, the primary mechanism for increasing the number of Americans with health insurance is subsidies that would help low-income individuals and families afford insurance. As of 1996, individuals and families with incomes up to 100 percent of poverty would be eligible for subsidies that cover the cost of the average insurance plan in the area with the standard benefit package. Between 1996 and 2000, individuals and families with incomes between 100 and 200 percent of poverty could become eligible for some subsidies. These subsidies would be based on the percentage of the average insurance premium in the area that their income is between 100 and 200 percent of poverty. A family with

Families USA
1334 G Street, NW
Washington, DC 20005
(202) 628-3030

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Families USA FOUNDATION

PRESS RELEASE

FOR RELEASE
THURSDAY, JULY 21, 1994

NEW STUDY SHOWS GREAT FINANCIAL AND EMOTIONAL SACRIFICE ON THE FAMILIES THAT PROVIDE HOME CARE

"There is a pain in every line of these new statistics, pain and sacrifice. Wherever families face long term care crises at home, the pain and sacrifice are almost overwhelming," according to Ron Pollack, executive director of Families USA.

Families USA today released a new in-depth study of the sacrifices American families make to provide home care to elderly parents, spouses and other relatives.

Two-thirds of older Americans who need long term care at home get no paid help at all, depending entirely on relatives and friends. On average, they get 27 hours of unpaid help a week; those with the most severe disablities get an average of 47 hours a week of help, according to the Families USA report.

"To understand how great a sacrifice is involved, you have to understand that fully half of the caregivers themselves are elderly and the vast majority of them provide care for more than a year, sometimes at risk of their own health," Pollack said. The study found one-third of the caregivers are themselves in less than good health.

"The fact is that we as a society have not figured out how to help families cope with the enormous cost of long term care, and we pay for that failure in pain and sacrifice," Pollack said.

- more -

CONTACT: ARNOLD BENNETT OR AVIVA SHLENSKY (202) 628-3030
1334 G STREET NW • WASHINGTON DC 20005 • FAX (202) 347-2417

"A lot of families are watching carefully to see whether Congress includes home care in health care reform, as President Clinton recommended," Pollack said.

Even the majority of disabled Americans who can afford some paid home care must rely on help from families and friends, 31 hours a week on average, 39 hours a week for those with the most severe disabilities.

Approximately one-third of those who receive paid home care pay for it entirely out-of-pocket for an average annual cost of approximately $4,000.

The Families USA report was funded by grants from the United States Administration on Aging and the Open Society Institute. Data was based on large government surveys, analyzed and updated by Lewin VHI, Inc. Families USA is the national nonprofit, nonpartisan consumer health advocacy group which has been leading the fight for long term health reform.

- 30 -

HEALTH CARE – RHODE ISLAND STATE OPINION LEADERSHIP BRIEFING
AGENDA

1:25 pm - 1:30 pm	Alexis Herman Welcome and Introduction
1:30 pm - 2:00 pm	Ira Magaziner
2:00 pm - 2:30 pm	Christine Heenan
2:30 pm - 3:00 pm	Chris Jennings 212
3:00 pm - 3:30 pm	The Vice President
3:30 pm - 3:35 pm	Alexis Herman Closing Remarks
3:35 pm	Refreshments served
	Participants are escorted to the stakeout

-Ed (ok)

-Christine

To:
(Vice President)

COPY

HEALTH CARE -- RHODE ISLAND STATE OPINION LEADERSHIP BRIEFING

Roosevelt Room, White House
3:00 - 3:30 pm; Tuesday, June 28, 1994

EVENT

You will make remarks and take questions at the end of this briefing. Ira Magaziner, Christine Heenan and Chris Jennings are the other three speakers who will brief the 35 participants from the state of Rhode Island about the provisions, benefits and importance of the President's Health Care Security Act. This group consists of business and labor leaders, DNC supporters, doctors, nurses, educators, seniors, social workers and other community activists These are all individuals who are supportive of universal coverage.

YOUR ROLE AND CONTRIBUTION

Because this group represents influential leaders from Rhode Island, recommended by supportive organizations (labor, seniors, businesses, hospitals, and providers); it is important to re-emphasize the importance their role is in delivering the President's message to Capitol Hill and stress the critical time line we are faced with in passing a universal health care bill this session. These people are newsmakers: they are opinion makers in their communities; have relationships with Members of Congress; and have been actively participating in the health care reform campaign. In addition, we targeted not only those who are politically important in Rhode Island, but also those who are close to and are willing to carry the message to Senator Chafee.

LOGISTICS

- When you arrive outside of the Roosevelt Room, Alexis Herman will announce you into the room. (enter through the the door closest to your office)
- You can either speak from the chair in front of the group or you may stand.
- You will make remarks and take questions.
- You will greet participants and depart.

PROGRAM NOTES

- This is the sixth state opinion leaders briefing on the President's health care initiative. The First Lady has participated in briefings for the states of Virginia, Pennsylvania, Kansas, California and Oklahoma. We have scheduled briefings for Oregon and North Dakota for Wednesday and Thursday of this week.

- As we have done with opinion leader briefings on other issues (economic plan, NAFTA and crime), we have invited health care reform supporters from targeted communities for in-depth briefings on the issue -- Ira Magaziner; message -- Christine Heenan; and a congressional update -- Chris Jennings.

- Our goal is for these individuals to leave here prepared to contact their Member of Congress, actively support health care organizational activities in their state, and serve as advocates in their communities on behalf of the Clinton health plan. It is to our understanding that while these leaders are in Washington, they will be meeting with Senator Chafee on Capitol Hill.

- The briefing is closed to the press. There will be a stakeout following the briefing. In the past, we have been successful in generating local regional media back home about their meeting at the White House.

ATTACHMENTS

- Agenda

- Talking Points

- List of Participants

RHODE ISLANDERS KNOW 91% IS NO SOLUTION

- Some in Washington say universal coverage is a worthy goal, but not one worth any heavy lifting. They say 91% is close enough -- that it solves most of the problem. Well, Rhode Island has 91% coverage today -- and those of you in this room know that's no solution at all.

- More than 90,000 Rhode Islanders have no coverage at all, and thousands more are just one job change, one move, one pink slip away from losing their insurance. Nearly one in three of your tax dollars goes to pay for Medicaid -- which covers only 8% of the population.

- And one in six Rhode Islanders with insurance pays all or most of the premiums themselves -- costs that can run as high as $12,000 for a family just for health care.

- That's got to end -- working Rhode Islanders deserve the security of knowing their health care will always be there.

Why Is Universal Coverage So Important?

- If we don't achieve universal coverage, we fail the hard working middle-class.

- Partial solutions will protect the wealthy and help the poor, but stick it to the middle-class. These half-measures and quick fixes would leave every American at risk of losing their insurance. And at least 24 million Americans who work for a living would have no coverage at all. (CBO analysis, 5/94, p. 20)

- More than half of uninsured Rhode Islanders are middle class working people.

Without Universal Coverage....

- Rhode Island will continue to lose $60 million in uncompensated care each year.

- Rhode Island tax-payers will pay $107 million more to finance Medicaid, the health program for the poor and the elderly.

- Nearly 350,000 Rhode Islanders will still risk being denied health insurance or forced to pay higher rates due to pre-existing conditions.

- 8,000 Rhode Islanders will continue to lose their health insurance each month.

Q: What does the Administration think of Senator Chafee's plan?

A: There is a great deal of activity in the Senate Finance Committee right now, and that's very encouraging. I'd like to think we're seeing good-faith efforts to craft a plan that can answer the concerns of some members, but at the same time meet the President's bottomline goal of universal coverage. Senator Chafee has repeatedly said he's for health care reform, and he's for universal coverage. His knowledge and experience has placed him at the center of activity in the Finance Committee. He has been a critical to the negotiations. But if in the end his plan does not contain universal coverage, it won't be a plan we can support.

Q: But does his plan achieve universal coverage? If not, isn't it close enough?

A: The President has said time and time again that his bottom line is guaranteed private insurance for every American. The Finance Committee is still working on this -- the proposal that came out last week moves us in the right direction, but there's work yet to be done. Our bottom line hasn't changed.

Why? Because without universal coverage it's the middle class that gets hardest hit. We think health reform has to be about helping middle class working people, not leaving them out in the cold.

Q: What will the Adminstration accept as universal coverage? 91% 95%

A: We don't think it's useful to get into a numbers game. Universal means universal -- it means guaranteed private insurance for every American.

Q: What should we be doing to make sure Senator Chafee gets the message on universal coverage?

A: Well, the White House isn't allowed to suggest that outside groups lobby the Congress. The best I can say is that what makes democracy is work is when individual citizens rise up and tell their elected leaders what they need, what policies will help make their lives better. That's why I'm so heartened you're here in Washington today.

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