Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Howard Paster, Steve and Lorraine Re: Ways and Means Subcommittee on Health Interaction Meetings (2 pages)	4/4/93	P5
002. draft memo	Linda Bergthold, Robert Valdez to Hillary Clinton Re: President Clinton's Meeting with Congressional Caucus for Women's Issues on Thursday, March 11, 1993 (9 pages)	3/11/93	P5
003. memo	Mike Lux to Vince Foster Re: Health Political/Policy Working Team (2 pages)	4/12/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Staff
Chris Jennings (Health Security Act)
OA/Box Number: 23754

FOLDER TITLE:
April 1993 HSA [1]

gf75

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]

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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]
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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]

April, 1993

The Honorable Hillary Rodham Clinton
First Lady
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

Thank you for taking time from your extremely busy schedule to meet with us on the issue of health care reform. The task before us is an enormous one, and we appreciate your attentiveness to our concerns about the impact of such reform on women.

Our current health care system, originally designed to provide insurance protection for employed men, and only expanded in patchwork fashion to address the needs of women and children, has long been inadequate. We must now build the foundation of a health care system that focuses on prevention and health maintenance, not just on the treatment of illness and injury. A cornerstone of that foundation must be access to comprehensive reproductive health services, including family planning and abortion services.

Reproductive health care is an essential component of primary care for women. For many woman, particularly the uninsured and the underinsured, reproductive health care has been their only point of entry into the health care system as a whole. It is critical that national health care reform recognizes the importance of these services, and ensures that all women have access and coverage for them.

In addition, under a national health care plan, all women must be guaranteed the right to make reproductive health care choices, including abortion, with their physicians free of government intrusion.

We were elected to the Senate with a clear mandate for change. Health care reform and protecting the right of every women to make her own reproductive choices are top priorities for us and our constituents. We urge you to include coverage of abortion services in the comprehensive benefits package which the task force is now formulating. We stand ready to help you and the President achieve this goal.

Sincerely,

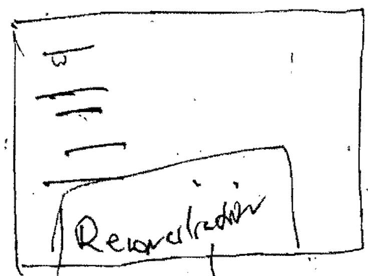
BARBARA BOXER
U.S. Senator

DIANNE FEINSTEIN
U.S. Senator

- Sonte
- wants conference
- wants paper before meeting. outline!

Staff on drafting

- Scheduling discussion will take an hour



we raise

- Process is substantive

Governors do not vote

- Presidential Decisions.

- Documents. Generally open to doing a complete 180°

- When I met in front of your Members

  & voted to...

- Relationship of Reconciliation to health reform.

Staff idea

meet Sunday

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Hispanic Caucus

UMD NEW JERSEY

MB

UMDNJ, New Jersey's University of the Health Sciences
University Hospital

Medical Director & Associate Dean for
Clinical Affairs-University Hospital
Phone: (201) 982-3665

150 Bergen Street
University Heights
Newark, NJ 07103-2406

April 8, 1993

Ira Magaziner, Ph.D.
Senior Advisor Policy Development
Old Executive Office Bldg, Room 122
Washington, DC 20500

Re: Health Care Reform and the National Puerto Rican Coalition

Dear Dr. Magaziner:

The National Puerto Rican Coalition (NPRC) recognizes the immense challenge of crafting a health care system that can address public needs and expectations within acceptable cost parameters. This can be accomplished only if Americans accept fundamental changes in how this country delivers and receives health care. We need to be cautious, however, that in our overzealousness to "sell reform," we do not promise more than can be delivered in the short run. Very significant changes will need to take place, particularly with regard to the supply and distribution of health care personnel.

As we make health care available to the underserved and change the U.S. health care delivery system, we will need more primary care physicians, physician assistants, nurses, and allied health personnel; and we will need them in different locations. These adjustments cannot be made overnight. In the long run, these structural changes should reduce the need for certain kinds of acute and tertiary services. Better prevention and early diagnosis should reduce treatment needs and costs. However, these effects will occur only in the long term.

I have enclosed a position paper from the National Puerto Rican Coalition on health care reform. We stand ready to assist the new Clinton administration in the days ahead.

Sincerely,

Eric Muñoz

Eric Muñoz, M.D., M.B.A., F.A.C.S.

cc: Congressional Hispanic Caucus

NPRC

Statement of

The National Puerto Rican Coalition

on

ASSURING ACCESS TO QUALITY HEALTH CARE FOR PUERTO RICAN

Presented to

The President's Health Care Task Force

by

Eric Muñoz
Chairman, Public Policy Committee

National Puerto Rican Coalition
1700 K Street, N.W.
Suite 500
Washington, D.C. 20006

April 6, 1993

Tricky issue — check w/ John Hart or Chris Jennings

PUERTO RICAN HEALTH CARE POLICY AND AGENDA

INTRODUCTION

The provision of health care services to all Americans is a challenge to public policy. Most Americans have physician and hospital services available with some regularity. However, those Americans in lower socioeconomic groups, or with language barriers face severe disadvantages to adequate medical care. **Puerto Ricans are probably the single most disenfranchised group in the United States vis-a-vis health and human services.**

ACCESS TO HEALTH CARE SERVICES AND MEDICAL CARE

The single greatest health care challenge facing the Puerto Rican community in America is "reasonable" access to health care services. Despite a number of past and current programs by federal and state government as well as industry, there is a growing cohort of Puerto Ricans who lack any access to many basic health care and human services. This is manifested, in part, by "excess" morbidity and mortality for many diseases, and the sad fact that the hospital emergency ward is the routine environment, often times, for Puerto Ricans to interface with the United States' health care delivery system.

The recent outbreak of measles epidemics, a preventable disease, with deaths from this disease in Puerto Rican communities, represents a very serious problem. We have a startling juxtaposition of high tech expensive medical services for many in America, while even "basic" preventive immunizations are foregone for others. While this phenomenon is not new, it is occurring at an increasingly troubling rate. Population projections for Puerto Ricans suggest that under the current health care delivery model, the number of unserved or underserved Puerto Ricans may soon reach alarming proportions.

Physician Services

A growing number of Puerto Ricans have limited availability for physician services. Throughout the last two decades a number of programs have targeted strategies at improving physician services for Puerto Ricans; unfortunately, these programs have had only limited success for a variety of reasons.

New strategies are needed to impact the growing physician shortage in urban and rural Puerto Rican areas. Despite an increase in aggregate physician supply in the United States to 650,000 in 1990, the number of physicians working in underserved Puerto Rican areas remains remarkably low.

Hospital Care

Aggregate spending on hospital inpatient care has increased dramatically during the last two decades. Puerto Ricans, however, have not enjoyed a full return on these expenditures. Hospitals have been only marginally successful at redirecting some of the large inpatient funding stream into programs designed at ambulatory and/or community based health care delivery. The majority of acute hospital inpatient care for Puerto Ricans are for emergency generated admissions to the hospital.

Ambulatory Services

Most worrisome for Puerto Ricans is the continued decline in the availability of "user friendly" ambulatory health care services which incorporate culturally sensitive and, at times, bilingual programs for Puerto Ricans. Language continues to be a problem. The lack of outpatient care, along with other social and economic factors, leads to a greater severity of illness with regard to inpatient admissions for Puerto Ricans.

Rapid expansion of ambulatory health services is needed. There are a number of strategies which may accomplish this goal. Using managed care models, redirecting and retraining groups of physician extenders and nurse practitioners into Puerto Rican areas could be effective. Significant fiscal incentives are needed to encourage outpatient health care delivery and to download certain services from the hospital based setting.

Quality of Health Services and Medical Care

The quality of medical care for Puerto Ricans is marginal. There are two major issues here: 1) the health care infrastructure, i.e. the existing base of hospital, physicians, and outpatient services, is limited when dealing with the health care needs of Puerto Ricans, and 2) inadequate services are reflected, in part, by an excess morbidity and mortality for many medical disorders found within the Puerto Rican community.

The merging of quality of care data and health outcomes research should be valuable in tracking changes in health care delivery and quality or outcome. Data to measure such criteria should be developed for Puerto Ricans as well as other Hispanic communities.

Cost of Medical Care

Aggregate costs of medical care continue to increase at a much greater rate than real GNP growth. Strategies at cost containment (in the aggregate) have not been successful during the last two decades. This increasing health care bill and the lack of successful cost containment has had two serious effects on Puerto Ricans.

Medical out-of-pocket expenditures for Puerto Ricans have increased relative to family income and have had a greater impact on Puerto Ricans compared to the non-Hispanic population at large. This is due to lower family incomes for Puerto Ricans (on average). A second significant impact of this medical cost inflation is reflected in a decrease in relative program dollars, for those tax supported programs, which have not kept pace with demand. Significant fiscal incentives are needed to encourage outpatient care delivery, and download certain services from the hospital based setting.

Thus, the impact of spiralling health care costs have been doubly serious for Puerto Ricans.

AIDS and Drug Abuse

In the midst of this health care delivery strain for Puerto Ricans, comes a lethal and costly disease, AIDS. Data suggests that AIDS continues to grow unabated among the Puerto Rican population. There has, for example, been substantial growth in AIDS in the Puerto Rican community, not only for substance abusers, but also for women and the children. This presents a challenge to the current health care delivery system.

Drug abuse continues to trouble many Puerto Rican communities. Targeted resources will be needed for AIDS prevention, education and treatment for Puerto Ricans. New programs designed to halt the spread of drug abuse which utilize the resources of churches, schools and the private sector are necessary.

Health Manpower

A new direction in health care policy is essential in addressing health manpower needs for Puerto Ricans. Certain traditional health manpower programs of the past could perhaps be revisited: for example, student loan programs and give-back arrangements for physicians working in underserved Puerto Ricans areas. More importantly, given population increases, new strategies to meet access for health care needs for Puerto Ricans are vital.

The most promising of these new strategies for the United States would be to develop a large "nurse practitioner corp." This strategy would utilize an existing cohort of culturally sensitive nurses, perhaps 50,000 of the 1.6 million nurses, who would be retrained and directed as "nurse practitioners" into underserved Puerto Rican locales. This strategy would require the implementation of programs to train, empower, supervise, and finance this labor pool, which would have political and organizational implications.

Conclusions

The problem concerning Puerto Rican health care needs has reached epidemic proportions. Access to adequate health care services is the single greatest challenge facing the Puerto Rican Community, particularly physician, hospital, and ambulatory care services. However, the quality of medical care, as well as, spiralling health care costs are very important issues for Puerto Ricans. The coordination of medical care for Puerto Ricans can have a major impact on health services in America. Emphasis on AIDS and drug abuse among the Puerto Rican population are essential. Health manpower requirements for Puerto Rican underserved areas require immediate attention.

The Federal Government, specifically the Department of Health and Human Services, should target strategies to address each of these issues in reducing the problems for the Puerto Rican community. Federal support and federal initiatives are needed to improve the health status of Puerto Ricans.

AIDS/SUBSTANCE ABUSE ISSUE AND FACT SHEET

AIDS/SUBSTANCE ABUSE

Issue: AIDS in the Puerto Rican community is most often caused by the use of contaminated needles or through sexual contact with IV drug users.

Facts:

- Heterosexual IV drug users account for 40% of Hispanic AIDS cases. In Puerto Rico this figure stands at 58%.
- In New York City, where the majority of Hispanics are Puerto Rican, 60% of Hispanic women contracted AIDS through drug injection, compared to 31% who were infected through sexual intercourse.
- Within the Puerto Rican population of New York city, 54% of Hispanic men contracted AIDS through IV drug use, compared to 36% of men who were infected through homosexual contact.

Issue: Substance abuse cases are growing within Hispanic communities at an increasing rate.

Facts:

- The number of Hispanics aged 12 and over who had used illegal drugs between 1985 and 1988 increased by 1.1. million.[1]
- Cocaine use by Hispanics grew by 4% between 1985 and 1988.
- Forty-one percent of Hispanic IV drug users have never been in treatment.

[1]National Institute on Drug Abuse. NIDA Capsule, March 1990

Ryan White Act (32): Fully fund HIV/AIDS prevention efforts under the Ryan White Act by Increasing 1993 grants by $200 million.

- More federal spending on AIDS prevention, treatment, and research that targets Puerto Rican IV-drug users, and sexual partners of IV-drug users.

- Increased financial support for the Ryan White AIDS legislation which provides emergency assistance to the 16 cities hardest hit by AIDS - seven of these cities have large Puerto Rican concentrations: New York, Chicago, Philadelphia, Boston, Newark and Jersey city, and San Juan. The legislation also provides "early intervention" drugs to slow the spread of AIDS in HIV-infected people.

- Increased spending is needed for AIDS prevention on the island of Puerto Rico. although Puerto Rico has the highest rates of AIDS cases per 100,000, it does not receive adequate federal funding to meet its needs. The lack of funding for the AIDS epidemic on the island compels residents to leave and find appropriate care in the United States.

Substance Abuse Prevention and Treatment (60): Challenge grants to the states to create substance abuse treatment capacity where it is needed most and for hard-to-treat populations. The change will serve 30,000 people in 1994 with outlays of $800 million in 1997 and $1.5 billion over four years.

- Further spending needs to be channeled to community-based organizations (CBOs) to implement AIDS prevention and substance abuse treatment programs. CBOs can also become more involved in testing people for HIV infection in addition to providing counseling.

Other Comments:

- Medicaid guidelines in Puerto Rico that prohibit the free distribution of condoms to sterile women, due to the fact that they are defined as birth control devices, must be changed.

HEALTH ISSUE AND FACT SHEET

HEALTH

Issue: Puerto Ricans are more likely to visit a hospital emergency room for basic medical care than other Hispanics.

Facts:

- Almost five percent of Puerto Ricans use the hospital emergency room for basic medical care, compared to 0.8% of Mexican-Americans and 0.2% of Cuban-Americans.

- During the period from 1985 to 1988, Puerto Rican persons between the ages of 45 and 64 used a physician's office only 4.8 visits per person compared to African-Americans (5.6 visits per person) and non-Hispanic Whites (6.5 visits per person).

Issue: Among Hispanics, Puerto Rican mothers have the highest infant mortality rate and are more likely to give birth to underweight babies.

Facts:

- Puerto Ricans had the highest Infant mortality rate of 12.3% between 1983 and 1985 which is 3% rather than the rate of the general population.

- Puerto Rican mothers are almost twice as likely to give birth to underweight babies (9.4%) than non-Hispanic Whites (5.7%).

Issue: Puerto Ricans have less private health insurance than African-Americans or non-Hispanic Whites.

Facts:

- Between 1983 and 1986, only 50% of Puerto Ricans had private health insurance compared to 81.5% of non-Hispanic Whites and 57.6% of African-Americans.

Issue: Between 1983 and 1986, a greater number of Puerto Ricans lacked health insurance.

Facts:

- Twenty-one percent of Puerto Ricans were uninsured, compared to 12% of non-Hispanic Whites.

Childhood Immunizations (31): An increase in childhood vaccinations to immunize one million children during the summer of 1993, through an award of $300 million to support a community-based effort to finance vaccine purchases, education, and outreach campaigns.

- Expand federal support to include community-based organizations which have been able to provide the Puerto Rican community with information on immunization, preventive, and prenatal care. Studies in the mental health field have indicated that Puerto Rican use of facilities increases when outreach campaigns have been conducted with the assistance of community-based organizations.

Head Start Related Medicaid (58): Fund new entrants in the Medicaid program resulting from Head Start expansion; costing $116 million in 1997, and $275 million over four years.

Other Comments:

- A fair Medicaid reimbursement policy must be pursued. Many physicians have refused to care for Medicaid clients because of lower state reimbursement rates, thereby, overburdening the emergency room capabilities of inner city hospitals.

- Support must be given for hospitals and clinics with staff who understand the distinctiveness of the Puerto Rican community and who ar culturally sensitive to Puerto Rican issues, such as kinship and family.

- Increased spending on student aid programs to encourage Puerto Rican students to pursue studies in the medical field.

- Assistance must be provided to minority-owned small businesses who wish to ban together to form larger health purchasing groups. This plan must also base employer insurance ratings on a community-based rather than an experience-based rating system.

- Increased Medicaid benefits provided to residents of Puerto Rico. Although not ideal, a current proposal hike of $25 million over 5 years should be enacted as soon as possible to help the island deal with its health care crisis.

DRAFT DRAFT DRAFT DRAFT DRAFT

MEMORANDUM

TO: Judy, Ira, Chris
FROM: Karen
RE: notes on House Leadership staff meetings
DATE: April 9, 1993

I thought it might be helpful to you, and perhaps to the drafting committee, to summarize my notes from our meetings so far with the House Leadership staff. Specific information promised to staff is noted in indented, bold type.

APRIL 6 MEETING

Benefit design

Staff asked for and was promised they would receive more information on the distribution of existing health insurance benefit packages and on the premium associated with each.

Employer participation in HIPCs

Several staff raised concerns about the implications for adverse selection and for cost containment of permitting large, self-insured plans to remain outside of the HIPC. David Abernethy suggested it would be smarter politically to draft the bill with large employers in the HIPC, leaving to them to make the case why they should be left out. David also reflected his strong view, and that of certain Ways and Means members, of doing away with employer self insurance altogether.

On the question of permitting employees of self insured plans to participate in the HIPC, Karen Nelson raised the issue of minimum participation standards in the employer plan. She also noted the critical importance of setting strict standards for the employee opt out in order to avoid selection problems. The tendency would be for self insured employers to "encourage" their sicker employees to take advantage of the HIPC coverage while retaining their healthier workers in the self insured plan.

Ira asked the group to give some thought to the political implications of a premium-based, vs. payroll tax-based system.

Treatment of low-income persons

In response to Ira's suggestion that HIPCs will face some requirement to help establish or strengthen provider networks in

underserved areas, Mike Hash noted that concerns could arise in low income communities that "outsider" plans are taking over their clinics and delivery systems. He urged awareness of the politics of "community sensitive" providers. Karen Nelson agreed with the theory of encouraging community sensitive providers, though noted that experience has fallen short of the theory. Ira noted that redundant protections must be included in the bill. HIPCS must steer funding into underserved communities to support network development. In addition, AHPs must be required to participate with providers (and/or place their own network providers) in underserved areas. Other incentives and protections may need to be built into the reform bill, as well. The group agreed to think about a blending of approaches.

David Abernethy asked how the health plan differs from proposals to give the poor "vouchers" with which to purchase private coverage. He noted that terminology will be crucial here to avoid defections from liberals, in particular. He also stressed the need to lay out in strict detail what will happen to low income persons in private sector plans. His specific concerns include: (i) how can we avoid IMC-type mills in the future? (ii) how will a community health center/community sensitive provider network infrastructure be built up? (iii) will we pay insurance companies a profit to cover the poor? (David noted this would be especially problematic.)

Cost of fee for service plans

Karen Nelson inquired about the cost of subsidizing low income persons who select the fee for service insurance option. Ira suggested the cost of this (presumably most expensive) plan might be brought more in line with lower cost plans through imposition of premium bands. For example, the highest cost plan might be limited to 125% of the lowest cost plan. Ira also suggested that one risk adjuster applied to plan premiums might take into account the percentage of enrollees with low-income subsidies.

Community rating Medicaid disabled enrollees

Ira raised the possibility of community rating coverage for these individuals, thus shifting much of their cost onto the private sector.

Staff requested and was promised additional information on this proposal, including its impact on private sector insurance premiums (particularly those paid by small employers.)

Ira noted that, in general, the reform bill's approach to community rating could swamp the impact of mandates and payroll taxes on small employers. More discussion on the timing and approach to community rating was invited for future meetings.

Employer mandates

Ira invited a future, frank discussion of the politics of employer mandates. In particular, he noted the division of winners and losers among employers and asked for political insights on which groups should be protected.

The issue of employers now providing coverage in excess of the basic benefit standard was raised. Should we permit these employers to continue offering additional coverage? Should require a maintenance of existing effort? The same questions apply to those employers who now pay 100 percent of the premium for their workers' coverage.

APRIL 8 MEETING

Global budgets

Ira described budgets expressed in terms of a weighted average premium of all health plans covering basic benefits. Each year's budget would provide for a percentage increase in this weighted average premium over the prior year's weighted average premium. Budgets might be enforced annually, with over spending recouped retroactively, on on a two-year rolling average, with the over spending triggering an adjustment in the following year's spending.

States would have a range of options for staying within the budget. For exmple, they might tax high cost plans to subsidize low cost plans. They might impose rate setting on providers. etc. States might be provided a band, or margin of error, for permitted spending in excess of the budget. However, states would be responsible for covering such excess spending (presumably, though raising revenues.) Excess spending above the band would not be permitted by the federal government.

Phyllis Borzi asked whether states would be authorized to tax ERISA plans in the event the state budget is exceeded.

Karen Nelson asked about establishing the base year for global budgets. Ira noted the options include (i) applying existing Medicare geographic adjusters to a national average

budgeted amount, (ii) determining the actuarial cost of providing basic benefits in each state, according to that state's demographic characteristics and utilization patterns.

David Abernethy raised many technical concerns about the operation of state-based budgets. For example, how is migration between states taken into account? How does a state count a person who lives in one state and works for an employer purchasing coverage in another? What about two earner families with jobs in two or more states? He noted these technical concerns could threten the accuracy of the base year, as well as accounting for spending in future years.

"Banding" health plan premium within a HIPC

Karen Nelson noted the potential for high cost plans to pressure the HIPC to squeeze savings out of lower cost plans in order for the weighted average premium to remain within the budget. IRA restated his idea of "banding" plan premiums so limit the variation in cost. He elaborated that bands might be applied around like plans (eg, a band around all HMOs, another around PPOs, a third around indemnity plans.)

Balance billing

Tricia Neuman asked about balance billing. Ira suggested the options include banning extra billing or limiting it to a small percentage above the plan's provider payment, similar to Medicare's balance billing limit. David Abernethy asked if balance billing expenses would be included in the global budget. Ira thought they would.

Scored savings

Andi King inquired about "scorable" savings and CBO estimates. David Abernethy noted that for savings to be scorable, CBO first requires that the savings targets be specified in law. The law must further specify in stepwise fashion how the global budget will translate into state targets, into regional and/or per capita spending, and finally into premium amounts. The law also should specify that any provider negotiations over fees will focus on the RVUs, not the conversion factor.

David thought the structure for provider payments, and hospital payments in particular, also would be important to CBO in determining scorable savings. Are provider fee schedules

consistent with the budget available for plans to use? imposed by states on plans?

He also stressed that the structure of the budgeting system as it relates to non-managed care plans must be carefully specified. CBO needs to see that some defined entity has the responsibility and the capacity to control resource use by plans. David also noted the importance of specifying what steps an entity would take when a health plan appears to be bumping up against the budgeted limit. CBO needs to see that, over time, those plans unable to control costs will be excluded. David summarized by suggesting that loosely managed fee for service plans must operate within a defined structure that drives payments, especially hospital payments, for savings to occur.

Ira noted that while this entity must be defined in law to meet certain federal criteria, it nevertheless must be permitted to vary in its appearance and operation. For example, in some communities, the medical society might set up a board and appoint agents to negotiate with the HIPC. In other areas, the hospital might contract with physicians and negotiate on their behalf.

Treatment of Medicare

Ira noted that several options are under consideration. One would be to add prescription drugs and/or other benefit enhancements to the Medicare program and then leave it alone. Another option would be to require seniors to declare the name of their primary care physician to the HIPC when they go there to purchase medigap coverage. There was some discussion of whether seniors would comply with such a requirement and what it would accomplish. Phyllis suggested the requirement could begin to sensitize seniors to the gatekeeper concept. Ira noted they then might be more willing to purchase a medigap option that employs the gatekeeper feature to manage utilization and costs. Tricia and Andi raised a concern that the purchase of managed care medigap through the HIPC might interrupt seniors' insurance coverage or established relationships with physicians. This would be especially true for seniors with several regular physicians, each of whom participated in a different medigap plan.

Several staff pointed out that CBO will not score Medicare savings if seniors remain in fee for service coverage. Ira agreed and reiterated the importance of short term cost controls applied to Medicare.

David asked whether the global budget would apply to Medicare. Ira responded that it would, but noted his expectation

that, over time, Medicare would rely less on a price-directed approach to cost control. He predicted that physicians who participate in successful accountable health plans would experience a gradual widening of the difference in Medicare and private plan payments. Ira suggested this tension, over time, would move physicians to more responsible behavior in controlling unnecessary services under Medicare.

David responded that CBO would need to see specific price controls applied to Medicare in order to score Medicare savings. He further suggested that the terms "short term" and "long term" be obscured. If CBO reads the law to require cost controls in Medicare over the short term, alone, they will not score outyear savings. Mike Woo disagreed and urged that short term cost controls had to be clearly designed as either transitional or permanent.

David suggested the application of short term cost controls for Medicare over a 5-year period, during which time a national commission would make recommendations on the long run treatment of Medicare.

Next meetings

The group agreed to continue discussion on treatment of Medicare. They also want to discuss **administrative simplification.** Questions were raised about the feasibility of cutting administrative costs under a reform strategy with many competing health plans.

THE WHITE HOUSE

WASHINGTON

April 12, 1993

MEMORANDUM FOR ALEXIS HERMAN

SUBJECT: Health Political/Policy Working Team on Business Outreach

FROM: Mike Lux

The political communications group that has been working on health care decided that we should set up three working teams to resolve critical dilemmas on the health care package. One of the dilemmas to resolve is, given the divisiveness in the corporate world of this issue, how do we enlist the maximum amount of business support for the plan. We would like you to lead this team. Our assumption going in is that it will be difficult to attract business association support, so we will have to sign up individual CEOs and small business owners.

I plan to be involved in coordinating the work of all three teams and plan to assist all of them in their work. I would recommend the following additional people to be a part of this team:

- Amy Zisook
- Nancy Rubin
- Caren Wilcox
- John Edgell (from Commerce)
- Chris Jennings or Steve Ricchetti
- someone from the communications department

As with the economic package, we should get Mack McLarty and Bob Rubin personally involved in recruiting business support, and we should call on our friends outside the administration with good business contacts (Anne Wexford, Vernon Jordan, Michael Berman, Laticia Chambers, etc.) to help us in this effort as well.

Major Issues

I need to brief you more thoroughly on the major issues involved, but I would identify the following as the most fundamental issues relating to the business community.

1. Financing. Fundamental to all chances for business support is the financing issue, which translates in great part into whether businesses will be paying more or less for health care costs in the future. (Obviously, the cost control features of the plan are important to them as well, but I think we've done a good job of convincing the business world on that part of our package.) A VAT would be very popular with business because it would shift costs from business to the general taxbase. However our polling indicates that a VAT large enough to pay for our health care package would not be readily accepted by the public.

In general, regressive taxes would be supported by business. However, consumer groups, labor unions, and the general public are not likely to go along (although unions have said they will sign on to a VAT under some conditions.)

2. Mandates. A related issue is mandates. Small business associations generally hate the idea of business mandates for health care. Our plan, since it sticks with an employer based system, does have mandates in it.

We will never get NFIB or the Restaurant Association to sign onto our plan because of their ideological hatred of mandates, so the question is what policy incentives for small business do we need to build into the plan to attract some other significant small business support.

3. Opt outs. The question here is whether every business needs to be part of the health insurance purchasing cooperative (HIPC), or whether businesses above a certain size (say 500) can retain the right to self insure. While some businesses (mostly in more mature industries) don't care about this issue, many care a great deal. Single payer groups and labor unions, on the other hand, argue strongly against allowing anyone to opt out because of their fears of a two tier health system. Our message people also believe that any suggestion of a two tier system is disasterous for gaining broad public support.

Ira believes we can create a middle ground that can satisfy most of the people on both sides of this issue. Such a policy would community rate self-insurance plans, mandate that they provide all the same benefits, and allow employees to pick a plan in the HIPC if they prefer. Other options might include forcing companies to offer multiple plans to employees, and allowing non-employees of that company to buy into the company's plan.

Ira is convincing in his argument that this kind of approach would solve our problem here, but it is complicated and needs continued work.

4. Community Rating. Our plan has community rating as a fundamental part of our package. This generally helps small business and big businesses with older, more blue collar work forces. It hurts companies with younger, better educated work forces. This is one of the reasons this package is so divisive in the business community.

As with any general concept, there are some important nuances to be worked out. The chamber and some other businesses argue strongly, for example, that the medicare population should not be thrown into the rating mix with the general population. Issues like this will need to be thought through for their political ramifications.

Summary

I would recommend that the working group begin meeting this week. I think the first meeting should be with Ira Magaziner so he can guide us as to where we are right now on some of these key policy matters. Thank you for your help on this urgently important part of the health care outreach plan.

THE WHITE HOUSE

WASHINGTON

April 12, 1993

MEMORANDUM FOR RICKI SEIDMAN AND MELANNE VERVEER

SUBJECT: Health Political/Policy Working Team on Abortion

FROM: Mike Lux

The political/communications group that has been working on health care decided that we should set up three working teams to think about resolution of our most problematic issues, and one of those teams will be on the abortion issue. We would like the two of you to lead this team. I plan to be involved in coordinating the work of all three teams, and will be a part of all of them. I would recommend that Linda Bergthold from the benefits working group of the task force be involved and Heather Booth from the DNC. I would also include someone from congressional relations as well as anyone else you think appropriate.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. memo	Mike Lux to Vince Foster Re: Health Political/Policy Working Team (2 pages)	4/12/93	P5

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M E M O R A N D U M

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Ways and Means Subcommittee Meeting
cc: Melanne, Ira, Judy, Steve, Lorraine

April 13, 1993

Because of its jurisdiction, Members, staff resources and expertise, the House Ways and Means Committee and its Subcommittee will probably be the most influential body in the Congress as it relates to health care. As challenging as it may be, we must have and continue to build a close and productive working relationship with the Committee.

With this in mind, you, Ira and Judy are scheduled to meet with the Ways and Means Subcommittee on Health in the Roosevelt Room tomorrow morning. This meeting was originally requested by the Subcommittee following the last Subcommittee Members' meeting with Ira and Judy on March 31st.

To focus discussion, the Subcommittee Members requested that the meeting review two major issues: (1) System Organization: Federal and State Roles and (2) Cost Containment: Short-Term and Long-Term (but will focus primarily on short-term). In terms of meeting format, the Subcommittee has suggested that you or Ira, for each issue, give a brief 15 minute presentation, followed by a 45 minute Q&A session. Attached for your use is a summary of the direction and options Ira and his work groups have been discussing for all of these issues.

In preparation for this meeting, Pete Stark suggested that all the Subcommittee Members submit questions that they may pose during your meeting. The questions will be focused on the two issues outlined above. As of 6:30 tonight the questions had yet to arrive, but we will send them over as soon as they arrive.

Lastly, as you will recall, the last time you met with the Committee, we had a press leak problem. At some point during the meeting, without being overly confrontational, you may want to discuss the importance of keeping these meetings quiet, so that we can have as constructive and productive a working relationship as possible. This, in my mind, is entirely appropriate and should be well received by most.

April 13, 1993

Attached are three sets of memoranda related to proposals for national health reform:

Tab A: A description of the role of state and federal government

Tab B: A description of a national health budget and administrative simplification as sources of long-term cost containment

Accompanied by a longer paper related to global health budgeting

Tab C: A brief description of options for short-term cost controls

Accompanied by a slightly longer description of each option and a paper providing further details about each option

APRIL 13, 1993

SUMMARY OF ISSUES UNDER NATIONAL HEALTH REFORM:

FEDERAL/STATE RELATIONSHIP
LONG-TERM COST CONTAINMENT
SHORT-TERM COST CONTAINMENT

In the new system, we assume a cooperative federal-state relationship. The federal government will not regulate the new system heavily; rather, it will set parameters to ensure that the national goals of universal access, high quality care and cost containment are met.

States will have substantial flexibility and authority to implement the new system. They will have the financial responsibility to meet a budget and will be responsible for overruns. The federal government will provide the states with the tools to enforce the budget.

This memorandum describes preliminary proposals for national health reform related to federal-state relations, long-term cost controls obtained through a national health budget and through administrative simplification and options for short-term cost controls. Specific options described represent one set among several under consideration and are intended for illustrative purposes.

FEDERAL GOVERNMENT ROLES AND RESPONSIBILITIES:

Under national health reform, the federal government will:

- Establish guarantees for health-care coverage and delivery to be carried out by the states
- Ensure protection of citizens if states fail to meet federal standards
- Establish an employer and individual responsibility to contribute to health insurance costs
- Enforce a national health budget, holding states accountable for spending to meet the budget
- Determine the annual increase in the national health budget

- Establish and oversee formulas for adjusting payments to health plans based on demographic and clinical characteristics of enrolled patients

- Update and refine the comprehensive benefit package

- Establish and oversee federal subsidies for low-income persons and eligible small employers

- Establish and implement national quality and access standards

- Manage and analyze national collection of information related to health care access, quality and coverage

- Establish a mechanism for assessment of health technology and emerging treatments

- Oversee federal funding for training of health professionals

- Provide technical assistance and start-up grants to support the development of consumer health alliances and health plans

- Administer any limits placed on tax-deductibility of employer contributions to premiums in excess of locally established benchmark premium

- Override state anti-managed competition laws and other statutes inconsistent with the principles of the new health care system

- Delegate these functions variously to a national health board and an executive branch agency

STATE GOVERNMENT: ROLES AND RESPONSIBILITIES:

Under national health reform, the states will:

- Establish at least one consumer health alliance

- If they choose, opt out of the consumer health alliance structure and operate as a

single payer that negotiates directly with providers or sets all-payer rates

• Set boundaries for consumer health alliances to ensure:

  - Minimum population of one million, or entire state population if less than one million

  - No discrimination against low-income or high-risk populations

  - Contiguous boundaries

• Administer and assure compliance with national health budget

• Establish and enforce performance standards for consumer health alliances under federal rules, including:

  - Enrollment in health plans of all persons residing in assigned geographic area

  - Inclusion of a range of health plans within budget targets

  - Solvency requirements

  - Appointments to, composition of, and membership on policy-making boards

  - Administrative expenses

• Protect people enrolled in health plans or health alliances in case of financial failure

• Operate a state health plan if necessary to correct gaps in the market

MEDICAID:

Under national health reform, Medicaid beneficiaries will enroll in health plans offered through consumer health alliances:

- Medicaid beneficiaries will receive subsidies toward the cost of premiums and co-payments on the same basis as other low-income people

- Health plans will provide supplemental services such as transportation and clinical case management as appropriate to ensure access to care

- States will continue to contribute to the cost of care for low-income people:

  - Initially under a requirement for maintenance of effort and later subject to a new formula determined by a commission and adopted by Congress through an expedited procedure

  - Requirements for maintenance of effort could include all state health expenditures, not just Medicaid

LONG-TERM COST CONTAINMENT: A NATIONAL HEALTH BUDGET

National health reform will establish a budget for health care spending consisting of two parts:

- The federal government will enforce an annual budget for spending through consumer health alliances
  - Determined by the average premium (weighted by enrollment in each plan) for the comprehensive benefit package
  - Enforced at the state level
  - States held accountable for spending in excess of the budget
  - States and health alliances will meet budget limits through:
    - Authority to negotiate and regulate premiums
    - Authority to freeze enrollment in plans
    - Authority to set and regulate payments to providers
    - Authority to approve investments in health resources and technology
- Self-insured plans also will be required to meet state budgets

The federal government will enforce budget limits through the following mechanisms:

- Allow states to share in savings for federal subsidies if costs increase less than budgeted
- Require states that exceed budget to submit plans for correction
- Require states to finance additional cost of subsidies to small employers, individuals and families if budget exceeded

- If budget exceeded in successive years:

  - Impose a penalty tax on providers, with revenues to pay for federal subsidies

  - Implement rate setting

  - Operate consumer health alliance

- Consistent with the national health budget, the federal government will constrain payments to providers to limit spending for its programs

LONG-TERM COST CONTAINMENT: ADMINISTRATIVE SIMPLIFICATION

National health reform will establish rules intended to reduce burdensome data collection and information processing while assuring privacy and security of personal health information:

- Simplify information collection requirements for billing and enrollment purposes

- Require use of national, standard forms

- Require use of national, standard data sets for financial, clinical, quality and other information

- Develop national procedures for coordination of benefits until new health system fully implemented

- Develop and adopt unique provider, patient, plan and employer-identification numbers

- Set national communication standards for electronic data interchange

- Set uniform national rules regarding privacy and security

- Simplify utilization review

GROUP 4: GLOBAL BUDGETS

Note: The budget structure presented here presumes the following:

- *That states would have substantial latitude, and that the federal government would be unwilling to create an uncapped federal liability for low-income subsidies in a system that is not largely within its own control. These assumptions, taken together, lead to a system in which states are financially accountable for the cost of low-income subsidies in excess of the allowable increase in the budget.*

- *That there should be a federal guarantee to slow health spending (including private spending). This assumption leads to the need for a federally-defined outside limit on the rate of increase in health spending (at least for the guaranteed comprehensive benefits within the purchasing cooperative), with some sanctions if spending within a state rises at a more rapid rate. It is presumed that elements of the federal program (e.g. a limit on the tax favored status of health coverage) would restrain spending.*

1. HOW IS THE BUDGET DEFINED?

a. **Private spending budget.** There would be a budget for private health care spending that would be defined as the average premium (weighted by enrollment in each plan) for the guaranteed comprehensive benefits.

The budget would not include spending for supplemental benefits, balance billing (if permitted), out-of-pocket costs (though consumer costs for the comprehensive benefits would be expected to rise along with the budget), and public health.

[Note: The viability of a budget only on the guaranteed benefits presumes that the guaranteed package is relatively comprehensive. To the extent that is not the case, a budget applied to supplemental coverage as well might be appropriate.]

i. **Enforcement inside the purchasing cooperative.** The budget would be strictly enforced inside the purchasing cooperative.

States would have broad authority to control health care spending, and

- *A budget imposed only on the purchasing cooperative could raise difficulty equity issues. If per capita spending inside the purchasing cooperative were substantially lower than outside, two tiers of quality might develop (or be perceived as developing).*

It would difficult to enforce directly a budget on self-insured employers outside the purchasing cooperative. However, large employers exceeding a spending target could be required to join the purchasing cooperative. This would bring these employers under the budgetary control of the purchasing cooperative. This approach would work as follows:

- *Multi-year Target. Large employer spending would be monitored on the same multi-year budget cycle as used for states and purchasing cooperatives. A multi-year budget is particularly important for individual employers, since even large employers experience substantial random variation in costs from year to year.*

- *Spending Targets. If the rate of increase in spending for the guaranteed comprehensive benefits by a large employer exceeded the allowable increase in the federally-defined budget over the multi-year cycle, the employer would be required to join the purchasing cooperative. The Society of Actuaries would develop a methodology for separating the cost of the guaranteed benefits from an employer's total health expenses (which might include supplemental benefits).*

- *Premium for Large Employers. A large employer required to join the purchasing cooperative would pay the purchasing cooperative the same premium that would have been charged if the employer had joined the cooperative voluntarily.*

b. **Public spending budget.** There would be a budget for federal Medicare spending. [Note: We are working on options for how a Medicare budget could be defined and enforced.]

Federal spending for low-income subsidies would also be limited, as described in Section 6b below.

a. Formula example. Note, in particular, that the period for narrowing differentials could be compressed (e.g., to 5 years) or extended and that the rural offset figure could be adjusted.

In the first year of the global budgeting system, a state's budget will largely reflect its historical expenditure level. At the end of seven years, each state will have the same budget except for adjustments for differences in demographics and input prices.

Let
H_i = historical expenditure level for state i, trended forward by national target growth rates to year 1 of budget
T = national budget level
T_i = adjusted national budget level for state i = $T*P_i*D_i$
B_i = actual budget for state i
P_i = input price index for state i
D_i = demographic adjustment for state i.

In year 1, $B_i = (.14*T_i)+(.86*H_i)$. Each year the weights change by .14 so that in the seventh year $B_i=T_i$. This transition is similar to the PPS and Medicare fee schedule transitions.

P_i is a weighted average of expenditure-specific input price indices (e.g., hospitals, physicians, and drugs) where the weights for P_i are based on national spending patterns. Initially, the HCFA hospital wage index would be used for hospital expenditures, although eventually a broader wage index could replace it. The Geographic Cost of Practice Index (GCPI) would be used for physician expenditures. However, the GCPI will be multiplied by 1.20 for "very rural areas" (defined, for example, as areas with population densities below 50 persons per square mile) to recognize the difficulty of attracting physicians to these areas. Drug expenditures will not be adjusted for geographic variations – the index will be 1 everywhere.

b. *The Commission would make its determination based on the factors described below. Congress will vote on the annual allocation to States on an up-or-down vote. If Congress rejects the Commissions recommendations, the allocation would be the baseline. The Commission shall allocate funds so as to narrow variations in spending due to practice pattern variations and differences in health resource endowments.*

Updates of the budget baseline should reflect two sets of factors:

an increase in unemployment — since federal financing for subsidies would account for the number of people receiving subsidies.

(Note that spending rising faster than the federally-defined budget would mean that employer and consumer premiums would also rise.)

ii. If health spending in a state rose slower than the federally defined budget, then the state would retain the savings in federally-financed low-income subsidies that would result from lower than budgeted health care spending in the state.

iii. State financial accountability for low-income subsidies would compound over time. For example, consider a state that exceeded the federally-defined budget by 1% in a given year, but then tracked allowable budget increases thereafter. The state would always be spending more than was budgeted, and would therefore have to finance the additional low-income subsidies that result.

iv. Technically, state financial accountability would be tied to the amount the state is over (or under) budget relative to the weighted average premium in the purchasing cooperative, regardless of how subsidies are structured. For example, if total subsidies in a state were $1 billion and the state exceeded the budget (i.e. the weighted average premium in the purchasing cooperative) by 1%, then the additional state financial responsibility would be $10 million.

(Subsidies may very well be based on the benchmark premium, which could increase at faster or slower rate than the weighted average premium. However, tying state financial accountability to the benchmark premium would provide a strong incentive for a state to hold down the cost of the benchmark plan, potentially resulting in a deterioration in quality in that plan relative to others.)

v. The National Health Board (or a Commission) would prepare a formula with the characteristics described above. The formula might appropriately be designed in conjunction with development of maintenance of effort provisions for state Medicaid spending.

c. **Outside limit on state health care spending.** As described above, the federally-defined budget update would determine the level of federally-financed low-income subsidies, with states financially accountable for subsidies in excess of this amount.

iii. **Federally-imposed ratesetting.** If spending exceeded the outside limit over an entire multi-year budgeting period, the federal government would implement rate-setting systems in that state, which would assure compliance with the federally-defined budget.

- In order to implement rate-setting systems that are best suited to local circumstances, the federal government would have flexibility to implement different systems in different states and various approaches by provider type.

- For staff model HMOs and other fully-capitated delivery systems, the federal government would impose the expenditure limit through limitations in premium increases.

- The federal government's systems would remain in effect until the state provided the federal government with evidence that its proposed expenditure restraint policies would achieve conformance with the federally-defined budget.

- In carrying out its functions, the federal government could require states, health plans, providers, and insurers to submit relevant information to assess compliance with the expenditure limits and to assure timely and effective implementation of any necessary federal actions.

budprop2.wp

Short-term cost control options

Option 1: Insurance premium regulation

- Would set allowable rates of increase for insurance premiums (or premium equivalents for self-insured firms).
- Limits one of the most visible costs to consumers and introduces the concept of operating under a budget.

Option 2: All-payer rate setting

- Would extend Medicare payment methodology to all payers and set rates to control spending.
- System already in use; familiar to providers.

Option 3: Provider price controls

- Would control prices based on historical levels, without regard to whether or not the charges were excessive in the first place.
- Could be imposed immediately.

Option 4: Marginal revenue ~~taxes~~

- Would impose a temporary revenue surtax on providers whose revenue growth exceeds a target.
- Could be imposed immediately.

Option 5: Voluntary controls

- Would require enlisting industry in voluntary controls and passing standby authority for the President to impose mandatory controls if the voluntary goals are not met.
- Mandatory control option could be developed during a trial period for the voluntary controls.

Short-term cost control options

Option 1: Insurance premium regulation

This option calls for setting allowable rates of increase for insurance premiums (or premium equivalents for self-insured firms).

Regulating premium increases limits one of the most visible costs to consumers and introduces the concept of operating under a budget. It may also thwart price gouging during the transition.

However, implementing premium regulation requires a complex administrative apparatus. Limiting premium increases may lead to "dumping" of insured individuals with costly health conditions, denials of treatment or reimbursement, or bankruptcy of insurance companies. Effectiveness also depends upon enlisting states as enforcers.

Option 2: All-payer rate setting

This option calls for extending the Medicare payment methodology to all payers and setting rates to control spending.

Health care providers and insurers that have served as carriers or fiscal intermediaries for Medicare all have experience and mechanisms in place to implement this method of cost control. Some states that have adopted all-payer rate setting have had success in controlling costs in the private sector.

However, experience under Medicare indicates that volume increases may offset some savings. Cost shifting to unregulated sectors may occur until rates are established (for outpatient services, for example).

Even if rate-setting aims to make no aggregate change in provider payment levels, it will redistribute income among providers, since the new rates will differ from current charges. Providers will face a double shakeup--first, rate-setting; then, managed competition. Turning health care upside down once might be thought enough.

Option 3: Provider price controls

This option would control prices based on historical

levels, without regard to whether or not the charges were excessive in the first place. Prices would be decontrolled as managed competition becomes fully operational.

Price controls can be imposed immediately. They do not threaten any sharp change in current provider incomes.

However, price controls are likely to trigger an increase in volume, which will offset some savings. They are hard to enforce, especially on physicians. The longer they are in place, the greater the inequities and unintended consequences.

Option 4: Marginal revenue taxes

This option imposes a temporary revenue surtax on providers whose revenue growth exceeds a target.

The surtax can be imposed immediately and will deter volume increases. Although evading the controls would be a form of tax evasion, providers may well find ways to game the system and legally avoid the tax. They could also respond to marginal revenue taxes by turning away patients.

This option is untested and could adversely affect the development of efficient plans experiencing rapid growth.

Option 5: Voluntary controls

This option calls for enlisting industry to adopt voluntary controls, with standby authority for the President to impose mandatory controls if the voluntary goals are not met. A mandatory control option could be developed during a trial period for the voluntary controls. This option might make providers more favorable to the plan.

This option does not ensure cost savings.

AN OPTION TO FREEZE AND CONTROL PROVIDER PRICES

This option is designed to reduce aggregate health care spending as much as possible and as soon as possible.

TIMING:

- o First, prohibit increases in provider prices.
- o After 3 to 9 months replace the freeze with a system that is flexible and enforceable. Officials from Carter's Council on Wage and Price Stability (CWPS) state that an inflexible freeze of longer than 5-6 months would lead to rapidly declining compliance.
- o Decontrol prices gradually, as managed competition addresses the causes of cost growth.

GENERAL DESIGN:

- o As with all price control options, ban increases in balance billing and limit balance billing, e.g., to 20%. To facilitate enforcement, allow consumers to sue providers who violate balanced billing guidelines for triple damages.
- o To combat anticipatory price hikes, begin the freeze by requiring that prices be rolled back a constant percentage.
- o For administrative simplicity, do not control wages or input prices.
- o In stage 2, set price growth, e.g., equal to inflation. Anticipate volume offsets, e.g., of 50 % for physicians. Define criteria for special exemptions, and establish a review process.

DESIGN BY SECTOR:

Physicians: MDs typically earn a fee for service, (FFS), or a fixed "capitated" payment per patient. Physicians' revenues were $152 billion in 1991, (20% of NHE) and are projected to grow at 5.8% annually in real dollars during the 1990s; 361,000 MDs are office-based.

- o For FFS payments, all private third party payers, including self-insured employers, would freeze usual and customary rates, effectively capping reimbursements to MDs. Third party payers that do not use usual and customary rate screens to limit payments to physicians would be mandated to use an acceptable screen within 3 months of the date the freeze begins. To be 'acceptable' the usual and customary screen would be derived from a data base that meets Federal quality standards, e.g., a random sample of sufficient size, etc.

- o For capitated payments, health plans would freeze payment schedules to preferred provider organizations, or to independent practice associations. Changes in bonuses, or other compensation would be banned.

Hospitals: Payments to hospitals are based on charges, capitation, or private DRGs. For-profit and not-for-profit

hospitals could be treated identically. Revenue of 7000 hospitals was $324 billion in 1991, and is expected to grow at 5.8 % annually in real dollars during the 1990s.

o DRGs and capitated payments are typically negotiated by the health plan with the hospital. Prohibit health plans from increasing payments above historic levels.

o For hospitals paid on the basis of charges, the lack of standardized billing codes may prompt the spurious redefinition of products. Therefore ban charge-based billing and base payments on average revenues per admission. These are calculable using IRS revenue data, and HAA admissions data.

HMOs: Premia for staff model HMOs could either be frozen and controlled or left alone. Compliance by 550 HMOs could be monitored Federally.

OTHER: Dentists, medical labs and some nursing homes are also compensated by third party payers. These could also be subject to controls.

ENFORCEMENT:

o Require quarterly compliance reports of all third-party payers, including HMOs and self-insured employers to a Federal Office of Health Care Cost Control.

o Interested third party payers may monitor provider prices more cost-effectively than Federal agencies. Additional record keeping by health plans and by providers, nonetheless, appears necessary.

o CWPS in 1978 used 300 staff to supervise voluntary price controls for 2000 large manufacturing firms.

EFFECTIVENESS: The medical services deflator during the Nixon price controls grew by about 2% less than in preceding periods. Medical care spending growth during the freeze was about 2.5% less than earlier periods, and during Phase 2 about 1% less.

MARGINAL REVENUE TAXES

SUMMARY: Impose temporary revenue surtaxes on providers whose revenue growth exceeds a target.

DESIGN: The tax could begin at two cents on the dollar for revenues greater than a base, e.g., last year's adjusted gross revenue, as reported to the Internal Revenue Service. It would rise linearly to 30 cents on the dollar for revenues greater than 115 percent of the base. Variations would include beginning the tax above the base, raising it more sharply as revenue increases above the base, and giving different tax schedules to different classes of providers. Since the IRS collects revenue data from all providers, including not-for-profit hospitals, this approach could be effective January 1994.

New providers, e.g., recently graduated physicians, could be given special schedules so that their base revenue is the average revenue for new physicians in their specialty. Corporate mergers could be taxed using the sum of the base revenues of the merged entities. Other new physicians' practices could simply be given a base equal to the average revenue of their type of practice.

SCOPE: This approach, with variations, could be applied to hospitals, physicians, nursing homes, medical labs, and dentists.

ENFORCEMENT: Despite the extensive experience of the IRS, the extent of compliance is uncertain, because providers would try to shelter revenue. Accounts receivable could be given to collection agencies with understandings to undertake long-term investments. Medical practices could be reorganized, and billings collected by entities without visible connections to the practices. Medical practices that own rental income could sell these assets to allow for greater tax free growth in medical revenue.

Relatively low tax rates, carefully drafted legislation and strict enforcement could increase compliance. In addition third party payers could be required to report to the IRS summaries of payments made to particular providers.

EFFECTS: Unlike price controls, marginal revenue taxes would not increase the volume and intensity of services. By causing physicians to take more leisure, they may lead physicians to cutback either patient loads or the intensity of service. Prices may rise. A graduated revenue tax allows some flexibility to all providers.

ALL PAYER RATE SETTING OPTION

Extend Medicare payment methodology to all payers and set rates so that spending is controlled.

I. Implementation Schedule

For 1994:

- DHHS completes initial schedule modifications for hospital inpatient, physicians
- DHHS uses Medicare data or limited private data to calculate conversion factors/standardized payment amounts
- DHHS establishes volume controls using Medicare as a proxy
- DHHS completes Medicare software adaptation
- During first 6-9 months after enactment, insurers adopt rates or contract with Medicare contractors

For 1995:

- DHHS will complete rates for hospital outpatient services
- More extensive private data for physician conversion factors and volume standards/controls will be available
- DHHS will refine data to handle uncompensated care and other hospital adjustments
- DHHS may include hospital outpatient services in ratesetting, covering about 75% of health spending
- DHHS will begin/consider development of a wider variety of volume control mechanisms, including medical group controls, bundled payments for some ambulatory services, etc.

II. Administration and Monitoring

- Requires start-up costs for both the federal government and insurers, to a lesser degree for providers
- Requires establishment of a national all-payer database which may be valuable for other purposes

- Requires continued data collection for updating prices, enforcing volume standards, and accomodating potential savings slippages

III. Implications of All Payer Rate Setting

- Slow phase-in schedule limits scope of spending controlled:
  - Would cover only about 60-65% of total health care spending during the first year. Could not implement rates for outpatient hospital during first year.
  - Volume controls would be limited to withholds and for physician spending would have to be based on Medicare experience as a proxy during first year.
- Negative consequences may inhibit smooth transition to managed competition:
  - Provider dislocations
  - Lock-in of current resource allocations in a way inconsistent with managed competition
- Imposing structure could potentially smooth the transition to managed competition by:
  - Continuing controls for fee for service sectors
  - Standardizing service definitions for payers and consumers
  - Serving as a point of reference for the purchasing cooperatives in rate negotiation

TIMELINE FOR IMPLEMENTING ALL PAYER RATESETTING APPROACH

For July 1994 Implementation

April 1993	Complete detailed workplans for APRS, for hospital, physician, and other services
May 1993	Begin developing payment rates for pediatric, OB-GYN, and preventative services
June-Aug. 1993	Developmental to develop hospital and physician conversion factors
June-July 1993	Modify Medicare software packages to accommodate changes for non-Medicare
Aug.-Sept. 1993	Validate software, test in large Medicare contractors
October 1993	Legislation enacted
October 1993	Begin training private insurers in use of software, payment rules (e.g., surgical global packages, DRG bundling)
Nov. 1993 to March 1994	Large insurers install conversion programs to use Medicare adapted software
May-June 1994	Small insurers contract with Medicare contractors to price claims

For 1995

May to December 1993	Developmental work to develop hospital specific and physician area conversion factors
Oct. 1993 to Sept. 1994	Insurers would adopt converted software, validate before paying claims
Dec. 1993 to Aug. 1994	Payment rates for hospital outpatient services would be developed and provided to insurers
Fall 1994	Standardized claims forms and structure for data collection would be available to be adopted by private insurers
Jan. 1995	Implementation of APRS for hospital (inpatient and outpatient), physician, lab, medical equipment, and ambulatory surgery settings

Health Insurance Premium Regulation as an Interim Measure

I. Why

- Premiums are highly visible. Consumers will gain immediately and help enforce it;
- Creates incentives to control costs without requiring governmental micro-management;
- Compatible with capitated payment systems;
- Promotes move to managed competition (e.g., cost-effective provider networks, global budgets)
- May be necessary to prevent opportunism by some insurers during transition.

II. What

Set allowable rate of increase for:

- Actual premiums for policies currently in force;
- Average premium per covered life for each insurer in states that have already implemented small group reforms;
- Premium equivalent (applicable premium) for self-insured firms.

III. How

- Maximal use of existing state regulatory resources;
- For self-insured firms, use IRS authority to audit and enforce premium equivalents filed pursuant to COBRA;
- Supplement state departments with federal resources

  -- People or technical assistance in most states

  -- Complete office in nine relatively small states.

Primary State functions:

- Certify compliance with target;
- Respond to consumer complaints;

- Recommend hardship adjustments to the cap;
- Implement a credible random audit process;
- Guarantee continuity of coverage for currently insured.

Primary Federal functions:

- Retain ultimate authority and responsibility for premium control program, including setting the targets;
- Review state certifications of non-compliance, choose and apply penalties, including: premium tax surcharges, fines, corporate income tax surcharges, revoke the right to self-insure;
- Make final determinations of hardship exemptions;

IV. Problems and Solutions

Without consumer protections, this could INCREASE uninsured.

Therefore, for the currently insured, require limited market reforms, including: guaranteed renewability, limited pre-existing condition restrictions, no medical underwriting, retroactive reinstatement, and balanced billing limits.

Allow higher rates of increase to states who wanted greater reform or to expand access quicker.

Mechanisms for insuring continuity of coverage for the currently insured:

- Market absorption;
- Guaranteed issue for currently insured;
- Residual pools -- carriers of last resort, state high risk pools, joint underwriting agreements.

V. Implementation Requirements

- Pennsylvania regulates coverage for 12 million people with a staff of 40. Most states would need at least a few more trained staff, and a Federal staff of at least 100-150 would be required. Three months between the passage of legislation and the start of the program would be highly desirable.

Increase Use of Managed Care as an Interim Cost Control Measure

This option focuses on increasing the use of managed care in the public and private sectors and fostering greater competition among plans.

A. Private Sector Options

- Give employees in companies with multiple plans greater incentive to choose lower-cost providers

  For employers offering their employees a choice of health care plans, employers would pay a set dollar amount regardless of the cost of the plan. The amount could be set at the lowest-priced option, the highest-priced option, or some amount in between. Employees would be allowed to take the difference between the employer contribution and the price of the plan they chose as additional wages or as tax-free savings contributions. At Alcoa, this led to an increase from 15 to 68 percent in the number of persons in lower cost plans. At Xerox, this practice lowered rates of increase for <u>all</u> plans because they were put into price competition with each other. Larger employers without multiple plans could be encouraged to offer multiple options through tax incentives.

- Give employees in small firms the option of choosing to join larger Federal or state pools.

  The Federal Employee's Health Benefits Plan or state employee's health plans could be opened to small employers on a risk-adjusted basis. Government plans offer a wide selection of plans, group rates, and reduced administrative costs. This would be coupled with a defined contribution requirement as for employers offering multiple plans.

- Reduce the tax code bias towards excessive health spending

  This could be accomplished either by imposing a limit on the amount of employer-provided health benefits which may be deducted or excluded from income. The cap should be set so that individuals choosing a low cost plan receive the full tax deduction and exclusion.

- Remove barriers to managed care

  Remove state laws that limit managed care plans' ability to contain costs, such as:

  - willing provider requirements

- open pharmacy requirements
- benefit mandates
- utilization review restrictions
- freedom of choice requirements
- restrictions on negotiating discounts with providers

- Implement standardized performance/quality measures

Hospitals would be required to report in a standardized, severity-adjusted format the extent of variation in physician practice patterns (resource utilization, length of stay and charges per patient) and clinical indicators of quality (mortality and morbidity rates, readmissions, and rates of immunizations, C-sections, pap smears, etc.). Health plans and employers could then use these quality-cost comparisons to manage hospital networks better.

In Cincinnati, four large employers convinced all 14 of the city's hospitals to submit such data. After a single year, the hospitals reduced their average length of stay per patient by 0.6 days and their average charges per patient by 5 percent, for a one-year savings of $75 million.

B. Public Sector Options

- Increase the use of managed care in Medicare

Medicare beneficiaries would be offered an open annual enrollment in qualifying area HMOs and the traditional Medicare fee-for-service plan. HMOs would bid for the right to serve the Medicare population and would offer a more generous benefits package than traditional fee-for-service Medicare. Beneficiaries and fiscal intermediaries would be given some of the savings from a move to lower-cost plans.

Alternatively, if the integration of Medicare into the managed care institutions is not to occur for several years, a Medicare PPO could be established in each state. Beneficiaries who joined the PPO would be given some share of the savings, as well as additional benefits.

- Require increased coinsurance for Medigap policy-holders

Medigap coverage of Medicare's cost sharing requirements has been estimated to add 24 percent to Medicare's costs because of induced demand. Increased cost sharing would lower the burden of this induced demand to the government and make Medicare HMOs more attractive to beneficiaries.

- **Remove barriers to use of managed care in Medicaid**

  Currently, states must receive HCFA and legislative waivers in order to use managed care effectively for their Medicaid populations. Those restrictions, intended to ensure quality care, would be repealed and replaced with quality, marketing and solvency standards.

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

April 13, 1993

TO: Chris Jennings

FROM: David Abernethy

SUBJ.: Questions for tomorrow's meeting

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Attached are the questions we discussed. The first set are from the Chairman of the Subcommittee. I am enclosing the copies of the questions from individual members so that you will be aware of their concerns. Please call me if you have any questions.

Questions

1. If a state fails to insure that health plans provide coverage tc all low-income persons, will the Federal government, by default, cover the low-income population?

2. What short-term cost containment strategies are under consideration?

   * Will these options be administered by the Federal government or by states?

   * Will there be a Federal program which would go into effect during the time prior to the development of any state-administered option?

   * Have you considered the effect on scorable savings of Federal versus state administration of the cost containment program?

3. What long-term cost containment strategies are under consideration?

   * At what point would the short-term strategies give way to the long-term strategies?

   * What would be the mechanism for making the change from the short-term to the long-term?

   * How will budget limits, allocated to the States, and ultimately to local health alliances (HIPCs), be enforced?

4. Under the proposed plan, the state would designate one or more entities to serve as a health alliance (HIPC).

   This health alliance will have unprecedented responsibilities, including: enforcement of budgets, selecting and approving health plans, enforcing compliance with insurance standards, risk adjustments, etc.

   * Who will supervise the HIPCs? The states or the Federal government?

5. Other entities already exist at the state and Federal level to perform most of these functions.

   * What is the value of adding an additional bureacratic layer to duplicate existing programs?

6. What Medicare savings are expected to be included in the package?

7. What will be the allowed rate of growth in health spending, once the national health budget is established? What is the target percent of GDP for health by the year 2000?

8. Will states be required to establish HIPCs -- even if they opt for a single payer system?

9. There is a history of fraud and abuse in loosely-organized networks that cover low-income and Medicare beneficiaries.

   * Does the plan envision creation of new types of networks at the local level? Perhaps plans organized by medical societies?

   * Would these plans be licensed or qualified under existing state and Federal laws?

   * What will be done to protect vulnerable populations from the kinds of fraud and abuse which have occured in the past?

10. How can we assure portability, if each State is permitted to do something different?

MEMORANDUM

TO: Tricia Neuman

FROM: Sean

RE: Mr. Cardin's questions for Hillary Rodham Clinton

In order of importance and likelihood of actually being asked:

1. Will states have the flexibility to maintain existing cost containment systems or develop new ones in addition to whatever is in the President's package?

2. Will the federal government provide the states with the tools they need (ERISA, Medicare waivers, etc.) to implement these cost containment measures?

3. If states are going to be given budgets or budget targets, how will baseline budgets be determined?

4. Will the President's package propose strict controls on the apportionment of graduate medical education slots in order to address the current imbalance of generalist versus specialist doctors per the recommendations of the Physician Payment Review Commission?

5. Will participation in purchasing cooperatives be mandatory for businesses of a certain size?

SANDER M. LEVIN
12TH DISTRICT, MICHIGAN

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Congress of the United States
House of Representatives
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Questions for Health Reform Meeting -- April 14, 1993

Congressman Sander Levin

COST CONTAINMENT:

1) At many Town Meetings people have said -- one way or another -- the experts say that $100 billion in health care spending is now being wasted, so don't tax me more until you get rid of the waste and inefficiencies. How will reforms be structured to significantly and visibly reduce waste both in the short and long term?

2) At a Roundtable meeting we had yesterday in Michigan to talk about the solutions to our health care problems, a majority of interest groups were represented, and the points were made that meaningful competition can only occur in the presence of budgetary pressures, and our current problems are in some ways the result of competition operating without any financial constraints. How will the transitional system place limits on doctor, hospital and pharmaceutical spending to produce cost controls in the short term and promote competition overall?

FEDERAL - STATE ROLES:

1) Assuming substantial state flexibility, how will it be assured that a state does not attempt to "game" the system, by implementing strategies which allow lower cost health benefits to younger workers as a mechanism for attracting new businesses to their state?

2) At our Roundtable yesterday, there was a great deal of discussion about prevention and health education -- especially focusing on preventable behaviors such as drug abuse, smoking, and violence. How will the responsibility for increasing health education generally be determined? Will it be primarily a Federal or a state function?

3) Assuming substantial state flexibility, how will accountability for the areas of quality, access, necessary data collection, and required service uniformity be assured?

COMMITTEE ON WAYS AND MEANS
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Congress of the United States
House of Representatives
Washington, DC 20515

QUESTIONS FOR MEETING
WITH MRS. CLINTON
APRIL 14, 1993

1. Assuming a global budget, will the global budget apply to all providers and all insurance markets, including secondary insurance markets and self-insurers outside the HIPCs? If not, how will cost-shifting and escalation to the non-regulated market be controlled?

2. What is the extent of the states' responsibility for staying within budget and how is it enforced?

3. Has a goal been established for a specific numerical reduction in administrative expense and what are the mechanisms for reduction in administrative expense?

4. Since copayments are a utilization control mechanism to achieve cost-containment, how will they be structured to avoid creating administrative expense and complexity?

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LEGISLATIVE UPDATE

Congressman Stokes recently introduced legislation, H.J. Res. 136, designating April 1993 as **National African American Health Awareness Month**. The Resolution recognizes the need for national attention to the serious health problems which impact the African American community in particular. As outlined in the 1985 Report of the Secretary's Task Force on Black and Minority Health, minorities are not equitable beneficiaries from advances in the medical arena. The report concluded that minorities suffer nearly 60,000 deaths annually. That figure has now skyrocketed to approximately 75,000 deaths each year.

The Stokes' Resolution finds historical precedent in a previous effort by Booker T. Washington. In 1915, Washington instituted the observance of "National Negro Health Week". This initiative was a response to the then health care crisis of African Americans and became precedent for a nationwide commemorative. Under the direction of the U.S. Public Health Service, from 1932 through 1950, "National Negro Health Week" was observed during the first week of April. House Joint Resolution 136 adopts the month of April in recognition of this observance. The measure is pending consideration by the House Committee on Post Office and Civil Service.

In addition, the Department of Health and Human Services has selected the National Medical Association to lead its initiative in bringing this problem to the forefront. The National Medical Association will lead health and civic organizations across the United States in health promotion and disease prevention efforts that address this serious issue.

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Both the House and Senate have acted favorably on the **National Institutes of Health Reauthorization Act**. This bill was quickly brought back for consideration after being vetoed last year by President Bush. The NIH bill reauthorizes several of the research institutes at NIH and establishes other authorities under NIH. The bill incorporates several provisions that Congressman Stokes offered in legislation during last year's deliberations on NIH and efforts he has formulated through his work on the Appropriations Committee. These initiatives focus on minority health and minority biomedical research concerns at NIH.

Specifically, the NIH bill requires that minorities and women be included as subjects in NIH-funded research projects except in special circumstances. This would be in situations where it would be inappropriate to the purpose of the research; where it could put the participants at-risk; and where it is determined to be inappropriate under the circumstances specified by the Director of NIH.

The legislation also provides for the establishment of a scholarship and loan repayment program to address the continued under-representation of individuals from disadvantaged backgrounds pursuing careers in biomedical research and in mid-level and senior scientific and administrative positions at NIH. Such a program allows NIH to enhance it ability to recruit and retain scientists and administrators while increasing their representation of individuals from disadvantaged backgrounds within their professional force.

A key provision of the NIH measure is the statutory authorization of the Office of Research on Minority Programs which has been in existence since 1990. The NIH bill would allow this program to carry out a coordinated and strategic plan to implement NIH's minority health initiative. Through this office, NIH can work to meet its goals of improving health in minority communities and attracting minorities into careers of medicine and research. Congressman Stokes was the catalyst behind the creation of this office in 1990. The NIH Reauthorization Act is awaiting House and Senate conference action.