Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Distribution Re: Upcoming CBO Reports (2 pages)	4/15/93	P5
002. memo	Chris Jennings to Hillary Clinton Re: Tomorrow's Finance Committee Meeting (19 pages)	4/19/93	P5
003. memo	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Legislative/Congressional Distribution List (2 pages)	4/20/93	P5

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

FOLDER TITLE:
April 1993 HSA [2]

gf77

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

13 April 1993

To: Judy Feder and Ira Magaziner

From: Robert Valdez

Subject: Impact on Local communities - Immigration & Health Care Reform

Copies: Latino Work Group Members

FEDERAL POLICY IN THE 1980s WILL INCREASE AND DIVERSIFY IMMIGRATION STREAM IN THE 1990S AND EARLY 2000

The 1980s was marked by a wave of immigration nearly equal to the peak number who arrived in the first decade of the century. With an acceleration of immigration since the 1960s, the proportion of immigrants in the total population has reached 8 percent in 1990. Nearly one of every two foreign born persons now residing in the country entered within the last decade. They account for 40 percent of the 22 million 1980-1990 population growth in the nation and for more than half of the growth if the U.S.-born children of immigrants are included.

During the last decade we witnessed a comprehensive redesign of the U.S. policy towards refugees, undocumented immigrants, temporary immigrants, and those gaining permanent immigrant status. Three new statutes - the Refuge Act of 1980, the Immigration Control and Reform Act of 1986 (IRCA), and the Immigration Act of 1990.- are the most important components of this redesign. Together they will increase the number of immigrants - documented and undocumented - coming to the United States. The key expansionary provisions include:

* number of documented immigrants allowed entry increased from 500,000 to 675,000 or more.

* Refugees and asylees will remain outside the limit.

Conservatively they can be expected to add 150,000 to 200,000 entries every year, up from about 100,000 in the 1980s. In light of the profound international geopolitical changes and growing incidence of regional conflicts throughout the world, we can expect increased pressures to admit refugees and asylees. (In June 1993, the President must decide the fate of the Salvadorean immigrant community because their temporary status expires again. Many Salvadoreans live in the D.C. area. and many have lived in the United States for over 10 years and raised their children here.)

IMMIGRATION IS MORE THAN A BORDER ISSUE

In addition the new laws provide for four new categories of immigrants that will profoundly affect the size and composition

of immigration in the United States. First, the largest amnesty program for undocumented immigrants will move more than 3 million from the underground to the mainstream of American life. The majority of applicants were Mexicans (75%) living in four states along the U.S.-Mexico border. As amnestied immigrants become permanent residents and citizens they will be able to sponsor additional family members. Second, each country's quota for documented immigrants increased from 20,000 to 47,000. Countries most likely to benefit are those with long waiting lists, including the Philippines, Mexico, India, China, Korea, and Vietnam. Third, creation of a diversity visa (55,000 annually) to be granted to nationals from counties sending few documented immigrants to the U.S. This is likely to increase immigration from some European countries (e.g., Ireland and Eastern Europe) and Africa. Lastly, establishment of a "temporary protected immigration status" for a selected group of undocumented immigrants provides beneficiaries protection against deportation and authorization to work. Currently two groups are so covered: spouses and children of the amnestied immigrants and nationals from El Salvador and a few other counties.

MANY IMMIGRANTS CAN PARTICIPATE IN SOCIAL PROGRAMS

Because immigration is expected to continue at peak levels throughout the 1990s, the local effects of immigration and the fiscal capacity of local areas and of individual communities to integrate successive waves of immigrants has emerged as a significant policy issue. Considerable confusion exists regarding what programs and services are available to immigrants - documented and undocumented. (This distinction is not very useful from a practical point of view, particularly at the local level. It is virtually impossible to separate out the document from the undocumented. Families are often composed of a complex mixture of immigration statuses - citizens, residents, undocumented.) The following chart provides a quick look at the status quo.

Program	LPR	Refugee	PRUCOL	PRE-82	SAW	Family	TPS	Undoc
AFDC	Y	Y	Y	-5 YR WAIT FROM '86-			N	N
SSI	Y	Y	Y	Y	Y	Y	N	N
UNEMPLOY	Y	Y	Y	Y	Y	Y	Y	N
MEDICAID	Y	Y	Y	-CHILD/ELDERS FULL OTHERS EMERGENCY for 5yrs from '86			MCH&Preg Emergency	
FOOD STAMP	Y	Y	N	-5 YR WAIT FROM '86-			N	N
WIC	Y	Y	Y	Y	Y	Y	Y	Y
SCHOOL LUNCH	Y	Y	Y	Y	Y	Y	Y	Y

(LPR - Legal permanent resident; PRUCOL - Permanently Residing Under the Color of Law; SAW - Special Agricultural Worker; TPS - Temporary Protected Status)

As you can see there are numerous Federally funded programs that do not discriminate immigrants based on their immigration status. It is important to note that the PRUCOL are technically undocumented immigrants who have established themselves as if they are documented residents. This can be done in a variety of ways including filing a regular tax form 1040 rather than a form for non-permanent residents.

FEDERAL POLICIES GREATLY STRESS LOCAL COMMUNITIES ALREADY

Immigration affects most of the countries major cities and local communities. The twenty-five largest communities in the country have experienced large growth in their immigrant communities. Local communities with large immigrant populations were promised federal financial assistance with IRCA but SLIAG funds were never made available because they were politically vulnerable as set aside funds.

CONCENTRATION OF IMMIGRANTS IS INCREASING

Between 1980 and 1990, 8.7 million new immigrants (documented and undocumented) entered and remained in the country. Most (71%) reside in just five states: California, New York, Illinois, Florida, and Texas. The remaining quarter are spread throughout but generally in specific local communities.

RELATIVE CONCENTRATION INCREASES AS SIZE OF JURISDICTION DECREASES

Within a state, about 80 percent of immigrants concentrated in the largest metropolitan areas. With the exception of New York and Chicago, these metropolitan areas have been among the fastest growing areas of the country, expanding at 2 to 3 times the national average. In these areas, immigration in the last decade accounted for 60 to 100 percent of population growth.

IMPLICATIONS FOR HEALTH CARE REFORM

- Increased diversity of metropolitan area consumers creates demand for culturally competent health care delivery systems
- Creates a two-tiered system if immigrants left out
- Increased needs for public health and community development and health promotion perspectives that go beyond medical care delivery reform
- Tremendous fiscal stress on local communities due to Federal policies.
- System could collapse in major metropolitan areas under weight of the transition to the new system and rapid population growth.

HOUSE JURISDICTION ISSUES

Attached is an analysis of jurisdictional issues raised surrounding the health reform legislation. This analysis was prepared for the House Majority Leader's office and was given to me by Andie King. It provides basic background information that may be helpful for your meeting tomorrow.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Distribution Re: Upcoming CBO Reports (2 pages)	4/15/93	P5

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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

FOLDER TITLE:
April 1993 HSA [2]

gf77

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

310-313-3946
LA - Home #

16 April 1993

TO: Judy Feder and Ira Magaziner

FROM: Robert Valdez, Henry Montez, Ciro Sumaya, Richard Veloz, Elena Rios

SUBJECT: Options for defining UNIVERSAL COVERAGE

In response to your request we have put together the following options for defining univeral coverage that address several issues regarding the treatment of immigrants and visitors. Valdez's 13 April memo provided background information for reconsidering the publicly stated position by you and Mrs. Clinton that only citizens and permanent residents would be included in the new system. The implications of defining univeral coverage in this way in the wake of a comprehensive redesign of U.S. immigration policy during the 1980s may not be readily apparent. The major implications include:

- A large number of U.S. residents remain "uninsured," especially in the large and rapidly growing Latino and Asian communities across the country. Dr. Valdez's February 17 JAMA article documents the extraordinary increase in the number of uninsured in these communities despite their extremely high rate of participation in the labor force.

- A two-tiered system for citizens and "second-class" immigrants will be created, especially if the reforms must be phased in over a number of years. Uncompensated care for catastrophic events and the wasteful use of emergency rooms for non-life threatening care will continue the pattern of costly care we wish to eliminate. Eligible children may not fully participate in the system because their parents' fear deportation.

- Cities and counties will bear an unusually heavy fiscal burden in maintaining personal health care services for a large number of immigrants and other disenfranchised individuals. Maintence of effort funds for the new system may not be available as result of these demands.

- Numerous states, especially California, Texas, New York, Florida, Illinois, New Jersey, Connecticut, Washington, and Michigan, will bear the brunt of federal policies on health care reform and immigration policy.

Among the 37 million or so uninsured residents of the United States (Mrs. Clinton apparently does not know that our estimates of the uninsured include non-citizens and citizens alike.), include about 6 million blacks and about 7.1 million Latinos. It is important to keep in mind that no matter what strategy the President chooses Latinos may still face major health care access difficulties. Ensuring adequate medical care services to the Latino community and immigrant communities requires attention to

both the financing mechanisms and the structure of the medical care and public health delivery systems. Even Latinos who are currently covered by health insurance cannot find an adequate supply of providers in their communities.

EXPECTED: 10 MILLION IMMIGRANTS IN THE 1990s

Current statutes assure the expansion of opportunities for immigration and undocumented immigration is likely to continue unchecked. As a consequence, we can expect immigration to reach one million a year or more during the 1990s. For more than a century, formulating and enforcing immigrant policy have been the exclusive prerogative of the Congress and the federal executive branch. But today, as in the past, the effects of immigration policy are felt mainly at the local level, a fact that has yet to be fully recognized by Congress, by immigration advocacy groups, or even by analysts. The largest demands on local jurisdictions are for education and health care. Two recent Supreme Court rulings have broadened state/local responsibility in the area of education, first by mandating equal access to K-12 education for the children of undocumented immigrants (Plyler v. Doe,1982) and second by requiring greater state and local attention to language-minority students (Lau v. Nichols, 1974). These rulings and the extension of Medicaid coverage under state option to immigrants, documented and undocumented require a careful examination of how "universal coverage" will be defined.

OPTION 1: DEFINE ELIGIBLES BASED ON ESTABLISHED RESIDENCY

Many programs currently define eligibles based on residency rather than citizenship. These programs have largely followed the basic American principle, "justice and liberty for all." Under the Equal Protection Clause of the Fourteenth Amendment as set forth in Plyer v. Doe, 1982 the Supreme Court said that undocumented students have a right to a public education. A permanent injunction by the U.S. Court of Appeals in California in Crespin v. Coye specifically stated that county welfare departments and others are enjoined from denying Medicaid coverage upon verification of immigration status.

The major objection to defining eligibility by residency reflects fear of immigrants and the notion that some individuals espouse that immigrants are a drain on the public coffers. Numerous Presidential Blue ribbon panels and policy analyses including those by Dr. Valdez have demonstrated that nationally immigrants add to the economic and social fabric of American society. The negative effects, as Dr. Valdez points out fall on local jurisdictions largely in the form of demands on the education and health care systems.

Provisions for the many populations who do not fit the narrow definition of citizen or permanent resident must be given renewed consideration if adopted. These populations include, many categories of immigrants, foreign students and other visitors who

live in the U.S. for extended periods of time, and guest workers.

OPTION 2: RESIDENTS PARTICIPATE BUT ONLY CITIZENS AND PERMANENT RESIDENTS ARE ELIGIBLE FOR FEDERAL SUBSIDIES

Residency could be used to define eligibility to participate in the new system. However, a more severe test such as citizenship could be used to establish elibility for the range of subsidies funded by the federal government. States could choose to provide these subsidies for special populations such as immigrants or visitors.

OPTION 3: REMAIN SILENT ON PARTICIPATION REQUIREMENTS

A number of program statutes are silent with regard to citizenship or residency. States vary in how they determine who is or is not included in their programs. In general, groups with legitimate claims excluded from the programs have pressed their case in the courts. Program eligibility reflects the individual community values and concerns.

Programs funded in large by federal monies have largely included citizens, permanent residents, and other residents (many of whom are technically undocumented immigrants). Others individuals are included in medical care programs on an emergency basis.

OPTION 4: INCLUDE SET ASIDE FUNDS FOR SPECIAL POPULATIONS, SUCH AS IMMIGRANTS, STUDENTS, TOURISTS, AND OTHERS

Set asides are extremely vulnerable to political whim. For example, a set aside for states with large numbers of newly documented immigrants under the Immigration Control and Reform Act of 1986 with the exception of the first year has never been funded by Congress.

If such a set aside were to be developed it is extremely important that major metropolitan areas directly be identified for funds as well as providing state level relief.

After your presentations and Mrs. Clinton's recent meeting with Latino health care professionals in which it was stated that the undocumented would not be included in the new system, we have received indications that Congressional leaders, state legislators, and local county officials are extremely concerned. We look forward to working with you in finding a workable resolution to this and the related issues. Defining who is part of the universe under "universal coverage" is a key parameter in the reform initiative.

We should probably meet to discuss how best to address this issue and to consider how best to respond to the concerns of the national, state, and local representatives.

Congressional File
Senate Retreat 1994

CHRIS - WE'VE DONE THE BEST WE COULD WITH YOURS, LARRY AND LYNN'S NOTES - THIS INCLUDES STEVE'S INTERPRETATIONS - PLEASE FILL IN BLANKS IF YOU CAN - MAUREEN

NOTES FROM SENATE RETREAT APRIL 15-17, 1994

BAUCUS: Wants distribution tables, to see how it effects businesses. Liked Model 1 more than Model 2, size and types. Percentage of permanent versus temporary employees. Impact of model 1 (cutoff 1000; individual wage cap) on businesses of different sizes.

Commends you for keeping concept of universal coverage. Jury is still out on this. Uwe Reinhart talks about pursuing shared ethics. Given these structures I tend to prefer Model 1 because it hits concerns I hear at home (small business and retail business)

Do we have distribution tables for Model 1 -- how it effects different sizes of firms and households? Size and types of firms. A percentage of permanent vs. temporary employees. 30,000 (perm) vs. 10,000 (temp)

BIDEN: Present insurance plans are all over the board. Can you generalize what the payment is for an average plan currently in the marketplace? Not withstanding the 8% inflation rate. Distribution tables of current household spending. What major blue chip -- eg. average DuPont employee pays. Copayment is relatively scary notion, but if copayment is looked at in terms of what people have or don't have today. E.g. people don't have drug coverage now. Wouldn't be that hard a sell.

Distribution for percentage of Americans with coverage who have had to spend one day or more in the hospital. I have an embarrassing high percent of uninsured in my state. Translate this to the average person. Raising copays wouldn't seem too bad, relative to the current system.

Can you generalize? Wants numbers -- re: individual plan. Benefit reduction may not be so bad. Distribution for % of those who have utilized services.
(Exxon): Benefits: looking at premiums payments and out of pocket payments, describe impact on families of benefit package -- family payments today, under HSA, under HSA minus 5%.

Discussion focused on tradeoff between premiums and copays -- Do we want to show anything that distinguishes users from general population (e.g. x for the y percent who don't get sick;

z for the others?)

Later: compare premiums today and under reform to major employer in each state (by employer name?)

What are copayments now in comparison?

BINGAMAN: Wants more of other options to reduce value of benefit package. Wants to see menu of benefits reductions (likes copays as deterrent on services use) Raised now at 50/50 but customs very for individuals. Much more interested in legislating something affordable for benefits. You suggest there were three changes to reduce value of benefits package by 5%. I think that's useful. The more you can do to raise copay, the more you place individual responsibility. I'd like to see menu of other reductions.

Raised issues of impact of alliance size change; of 50-50 on families (MOE raised in Ira's response)

What do we lose by taking threshold from 5,000 to 1,000. My understanding was that premiums for firms inside alliance would go up.

Model 3: My understanding is that HSA caps household payments at 3.9 percent to 40K.

55% of my employers don't provide insurance. I'm more interested in affordability than level of benefits.

BOXER: I support deficit reduction. You can do it without too much pain. Dropping from 5,000 to 1,000 is good. Consistent with what she hears at home. If we base this system on wages, doesn't this encourage firms to keep wages down? Since this is an employer based, how can we fix the problem of independent contractors? Can people still buy additional benefits?

Individual wage cap -- won't it encourage keeping wages down? (need rhetorical argument)

BREAUX:

- Risk defeat from claws of victory if we do too much too soon.
- All plans have a substantial agreement about what is needed: a standard benefit package; purchasing coops; insurance reform; subsidies for poor people; medical malpractice; and anti-trust. We're not giving reform a chance to work before mandates.

Price controls don't work. Medicare has price controls. The increase in Medicare alone was higher than all foreign subsidies. Doesn't want mandates or premium caps.

BUMPERS: (Heflin - does this mean Heflin had same concerns?) Concern about cliffs (subsidy for firm size) - Would keep him from hiring that 75th worker if you target higher subsidies to small firms. (Heflin(?) Allow regulatory flexibility to smooth subsidies.)

CONRAD: Deficit reduction important. Need charts on the effects of health care expenditures and subsidizing effects. We're talking about holding the rate of deficit reduction growth. Would like to see charts that show how we're changing health care spending and how we're affecting the actual deficit (i.e. reducing rate of increase in deficit)

Howard raised the point we're talking about holding down the amount of deficit increase, not deficit reduction. Net lifetime tax rates for future generations of 82% if there aren't substantial reductions. We've got to take action as quickly as possible. It would be useful to have big charts that show effects on national health expenditures and federal budget effects from what we do.

DECONCINI: How verifiable is the feasibility of the tobacco tax. Black market rise / reduction in compensation etc. subsidy too small.

I find troubling that we don't use the word "taxes." Can you give me background on taxes involved. $126 B. that CBO scored included individual taxes, right? How much would be raised with tobacco tax? If you're looking to increase small business subsidy without increasing employee contributions or decreasing benefits package, is there any consideration of other taxes? i.e. liquor tax or individual income?

We don't want to lower benefits below 50th percentile of Fortune 500.

DORGAN: Pressure on business now of the threat of reform. What is driving reform is health care costs. Why go through all of the agony and still increase costs of GDP that goes from 14 to 18. Why can't we keep around 14-15%.

I've not been surprised at costs moderating -- they're under direct threat that we're not going to do something about this. What is driving the demand to do something about this is middle income families faced with increased costs. BC says spend 14 percent of GDP for health care. We've constructed a plan that increases 14% to 17.3%. If we go through all of this agony, will we do anything to address their concerns about increased costs? Can't we hold health care to 14% of GDP.

All respond to who aren't economists. When we say to them we've done nothing to address this, I fear that.

EXON: Any cost to family, rather than just insurance premiums.

Wants total costs.

Model 1: Can we talk about average cost of family instead of premiums? Premiums don't include out of pocket? Need way to judge premiums and overall costs.

FEINGOLD: Opposed to liquor and wine tax.

FEINSTEIN: Closer philosophically to Lieberman and Glenn than to Wellstone. My husband employs 30 people and pays 87-8,000 for 100% of their coverage. I believe he should be able to continue to do this. Concerned about how people who now have Cadillac benefits will stay whole.

Concerned about part-time, temporary employees (The Gap).

We should get people without coverage covered. Illegal immigrants-- all in CA won't be covered. It's better to cover those without insurance gradually and then phase in the rest as we move along. If the average worker earns $28K, are they better or worse under reform?

In deficit reduction in Models, is it reduction in increase or is it an actual reduction? How did you select break point of 75 employees?

Providers of last resort--the county hospitals of the bay area-- are concerned that the money available to compensate providers won't be sufficient.

GLENN: Our economy depends more and more on service industries. I'm not sure I understand subsidy. Size of businesses has little to do with ability to pay. Profitability would determine ability to pay. I looked at small companies. 3 out of 5 businesses fail in the first 18 months. Our economy depends more and more on service industries. Number of firms between 75 and 5000 employees. Concerned about 500 to 600 range. Was any consideration given to tying this to profitability and not just size? Do we have numbers about number of firms and their contributions to economy under 25 employees and over 5,000. Maybe link to profitability.

GRAHAM: Early retirees concerns and long-term care. The impact of tax cap concerns. Regional alliances and their role with regard to cost containment.

I would suggest continuing this type of analysis for LTC, early retirees among other things. Consider some nonquantifiable effects -- as you widen the gap between those covered in HSA and those outside as I understand it, there will be unrestricted employer deductibility for 10 years -- what kind of systems are we bringing people in when you, after 10 years, bring people closer to a common plan? RE: setting of initial premiums I thought the negotiation of premium bids would take this into

account and alliances would take care of this.

HARKIN: Let's not fool ourselves by reducing the costs of benefits. It increases out-of-pocket costs.

Model 1: employer premium goes up/household share goes up.
Model 3: Employer premiums go down, but household payment goes up.
Model 2: Both payments go down, but you have savings. What is that? (Mitchell response) You're getting less. Reducing the benefits package.

HEFLIN: What happens to indigent when you reduce benefits? Impact of higher copays on the indigent. (Kennedy concerned too) Does this reduce jobs?
Will business have to increase administrative burdens on business?
What about a 1% corporate profit tax instead of a 1% assessment on payroll?
Won't firms have to increase people to calculate how much they pay? How will model 1 be reported, monitored, checked and audited?
Does this reduce jobs over the long run? How does it effect 500-600 employee size firms? How would businesses fare under 1% of payroll vs. 1% of income tax?
How does overall cost to business on per employee basis effect firms above threshold as opposed to the smaller firms? If each of us had our largest employers current payments calculated and we could show how much they'd pay under reform?

JOHNSTON: Do you have figures about how much employers pay? What do we do if we're wrong and when do we do it? How about triggering in expansion as savings come in?
Figures were based on a number of assumptions. What are the assumptions about prices we have least degree of certainty? What would we do about this? Isn't there any way to do this gradually as uncertainty decreases?

Kennedy: Never get federal deficit under control; Gap of people without insurance growing, especially children -- children are most vulnerable. For every five people that are hired in Mass. hospitals, three are administrators. Every line is going in the wrong direction; Labor and Human Resources has had 48 hearings.
We should explore downward pressure on wages.
We were looking at 1% payroll tax as a way to finance small business subsidies.

LAUTENBERG: Wants deficit reductions. Wants to be careful about costs. Don't get too ambitious.
If you don't have this characterized as deficit containment or reductions, it'll be impossible to sell. Model 3 -- does not support this model, but wants to point out do we use increased assessment from Treasury to mitigate employee payment? Does employer pay assessment on wages or total compensation?

Likes idea of increasing gatekeepers to keep people from seeing specialists, etc. Doesn't think we can expand coverage -- home health, LTC, drugs -- right away. Thinks we should focus on basic services.

LIEBERMAN: Concerned about trying to do too much too soon. Doesn't want to hurt a good thing -- believes that we have an extraordinary system in terms of progress made. Cited a trip to Boston to meet with staff at Massachusetts General Hospital about the impact of new drugs, new technology and the overcapacity due to shortened stays. More than 50% of people get care through managed care plans. Health care costs are only rising about 3.3% a year. Feels that there is a lot of positive stuff going on in the marketplace now. Politically, the majority of the people today are satisfied with their health care. The number of satisfied Americans has risen since we've been talking about health care reform. Have to be concerned about not making impact on quality or costs people face. Concerned about the 1996 elections. Supports universal coverage, but on a more evolutionary basis. Concerned that employer mandate will cost jobs and reduce wages. Believes that people are most concerned about health security and cost containment and portability. Thinks we should have managed competition, higher malpractice. Alliances would allow small businesses and individuals to buy health care at a lower rate (cost containment). Managed competition will work for cost containment. Suggests giving incremental and then come back to see where things stand in two or three years. Wants a bipartisan approach. Believes Breaux's bill should be tried first and then come back and see where we are in two-three years.

I think consumers of health care have said to providers "we can't continue to pay double digit increases in health care costs."

LEVIN: Concerned that the first year premium cap administration is perceived to be too intrusive. Fear that there will be a reduction in benefits. Will there be a MOE for businesses that offer good plans. Very leery of reducing benefits. It will pay into the hands of those opposed

Initial premium will be different region by region. In the first year there's a requirement to lower the cap. Is the first year going to work any differently from subsequent years? Is it any more bureaucratic in the first year?

With the 5% reduction in benefits package it would be at 35th percentile. One of the arguments I hear is that the President's plan will lead to reduction in current benefits. Another negative perception is that it will cost more. Where there's a supplemental package that has extra cost is going to be tax deductible. Is there going to be a maintenance of effort so that employers will have and continue providing current level of benefits? I'd be leery of reducing benefits package below the

median. It'll play into the hands of opponents.

METZENBAUM: Why do we need to get deficit reduction out of health reform? Why ask businesses, employers and federal government to pay more for that end?

Mitchell: Has a slide presentation -- No questions were asked through slides.

Q&A's after presentation:

Q: Why aren't we giving any attention to the deficit?

A: I feel that increasing changes for employers of individuals or decrease the benefits will be hard enough. WE should deemphasize the deficit.

All government programs have cliffs because they're targeted.

If HSA were adopted as proposed, health care costs will rise 7.3 percent per year with covering everyone, but 8.4 percent without covering anyone else.

Employer subsidy -- every employer gets a subsidy under HSA depending on size and payroll. 7.9% cap applies to firms, including those at 500-600 employers. In addition, there's a lower percent for small firms.

MOYNIHAN: Will start meetings on Tuesday, April 19, to see where we are relative to drafting. Physics = Biology now.

Define universality - Thinks Social Security's 95% is about right. that's what we got in fee. Relative price of personal services increase and there's nothing you can do about it. That's life. Police, teachers, nurses costs relative to will increase.

We have a higher percentage of GDP, now, paying for education. That's just the way it is for a modern society.

Development of DNA research, pharmaceuticals, etc.. Large surplus of hospital beds. Sixty percent of surgical procedures involve one day in hospital now. As progress brings leaves us confident of future.

PELL: Won't employers the subsidy system? Will there be bipartisan interaction and a process set up?

Payment - don't subsidies encourage keeping wages low?

ROCKEFELLER:

- Job loss won't be a problem.
- Negligible job loss should not get in the way of reform.
- 15 cents an hour.
- Real emphasis at small business in various states.
- Individual mandate effect on marginal rates.
- Alliance defense -- passionate. Let's make sure that we design something that is based solely on how it works not how it

sells.

SARBANES: It's absolutely imperative we pass universal coverage. Other developed countries have all done this. Need this to make everything else work. Look at inequities in current system - one employer wants to do right by his people and provides health insurance. His competition doesn't. Not only is that not right, but the responsible employer has to pay for the others employees when they go to the hospital. The system isn't rational. As a practical political matter, we have to pass something with universal coverage because President said he'd veto a bill without it.

Wants real universal coverage. It is the right thing to do and it won't work without total reform. Look at all the incentives/rewards we give to irresponsible behavior.

Can you tell us how much of deficit reduction comes from each policy change?

SIMON: Interested in Board size.

WELLSTONE: Argument we must be concerned about is less choice and fewer benefits.

- Democrats have made a commitment to coverage.
- We must make certain that benefits are affordable to businesses.
- Concerned about lowering to a 1,000 firm size.

Universal coverage has galvanized people around health reform. When it comes to families paying more, we need to look at distribution effects. If it's not affordable, it's not universal. I worry about companies opting out of community rating if you go below 1,000 you run risk of risk selection above 1,000. There would be incentives for companies to hire health people or let people go. Need to be serious about explosion of costs, but we can't pare down benefits too much.

WOFFORD: Could we have greater state flexibility to address tradeoffs? Do we have to have same system across states? e.g. 50/50 in some states; 80/20 in others.

Malpractice file

April 19, 1993

MEMORANDUM FOR

FROM: Chris Jennings for First Lady Hillary Rodham Clinton

SUBJECT: Malpractice Reforms at the State Level

As you requested, we are forwarding information on state-level malpractice reforms. We have briefly summarized the findings of this report below, I hope this is helpful, and I know Mrs. Clinton is looking forward to working with you on this and other health reform issues in the weeks and months to come. If you have any questions regarding this material, please contact me at 456---2645, or Christine Heenan at 456-2929.

The effects of reforms-- background and summary:

After four years of relatively flat rates, malpractice premiums and tort costs began to rise again in 1991 and 1992. Medical malpractice coverage cost jumped from $7 billion in 1991 to an estimated $9.1 billion in 1992, and jury verdict research found a nationwide increase in the number of jury verdicts exceeding $1 million.

Both the direct and indirect costs of malpractice suits are hotly disputed. While many analysts (and more doctors) feel that filing rates are unnecessarily high and litigation too costly, others contend that a very small percentage of medical negligence-related injuries ever become claims. The indirect costs, or so-called "defensive medicine", are also in question; tort reform proponents believe defensive practices-- particularly excessive and redundant testing-- add significantly to our national health bill. The AMA, for example, estimated the costs of defensive medicine to be $15.1 billion in 1989. Skeptics claim that doctors hide behind "defensive medicine" as a reason to do more tests and procedures which raise their income, and that many "defensive" practices, like keeping more detailed records, getting more consultations, and telling patients more about risks, are actually good medicine.

Many states have enacted malpractice reforms as part of overall state health care reform packages, others as more narrow policy targeted toward improving access to care by limiting provider liability for harm to recipients of reduced-cost care.

This memo focuses on 2 types of malpractice reforms at the state level:

1. ALTERNATIVE DISPUTE RESOLUTION
2. CAPS ON DAMAGES

Main sources of data:

"Medical Malpractice: An Overview of 1992 State Legislative Activity", GWU Intergovernmental Health Policy Project

"Compendium of State Systems for Resolution of Medical Injury Claims", Agency for Health Care Policy and Research, DHHS

1. Alternative Dispute Resolution

States have enacted statutes authorizing the following four alternatives to traditional litigation:

A. Arbitration (38 states)[1]
B. Screening Panels (31 states)
C. No Fault (2 states-- VA and FL-- have compensation pools for birth-related neurological injuries).
D. Mediation (2 states-- Colorado and Wisconsin)

A. Arbitration

Arbitration statutes may apply to disputes generally or to medical malpractice in particular, and are usually voluntary. Twenty states have statutes based substantially on the Uniform Arbitration Act. In Nebraska, the arbitration statute does not apply to personal injury cases; and in Texas, it applies only upon advice of attorneys from both sides. Few arbitration statutes have been challenged on constitutional grounds; Michigan's was upheld in 1984.

B. Screening Panels

Use of screening panels are usually mandatory. Colorado requires screening only for claims under $50,000. Statutes have been repealed in Illinois and Florida. Wyoming's Supreme Court struck down its statute on constitutional grounds in 1986; statutes have been challenged and upheld in Massachusetts, Montana, New

[1] Based on statutes on the books as of 1991, updated where possible

York, Nebraska, and Virginia.

C. No Fault

Under Florida and Virginia's statutes, claims are administered by a designated organization and, if the injury falls within the program's definitions, the injured parties receive total coverage for medical and other expenses (i.e. custodial care, special equipment) for the life of the infant. Physicians who choose to participate pay an annual $5,000 fee, and all others are assessed a $250 fee.

A no-fault proposal failed in the North Carolina legislature in 1992, but is likely to be reconsidered in 1993.

Results/Legal Ramifications

The effectiveness of arbitration and panels is limited by the fact that many of their decisions are appealed to the courts. However, studies have found that the existence of screening panels tend to reduce premiums.[2]

The lack of accountability of non-judicial decisionmakers also undermines their credibility and the strength of their decisions, which contributes to the high rate of appeal.

Washington state's Health Care Commission's Committee on Malpractice rejected the no-fault concept, particularly for birth-related neurological injuries. It also rejected the use of mandatory screening panels, concluding that only time, not money, was saved due to the high costs of preparing for the screening panel.

The Commission did recommend that parties to all claims engage in mediation and or have at least one settlement conference before trial. It would protect the information disclosed in mediation from being used at the trial. The Commission also recommended mandatory collateral source offsets.

The constitutionality of these measures have also been challenged, particularly the no fault concept. Compensable events can be viewed as unconstitutionally limiting an individual's access to the courts, since the compensation is substituted for the right to sue. (Virginia's law did survive a challenge in the state supreme court in 1991)

---

[2] "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A MicroAnalysis"

2. Caps on Damages

Twenty two states have enacted laws which limit the amount of recoverable damages in medical malpractice claims. The most common limit is on non-economic damages (pain and suffering, disfigurement, loss of enjoyment of life or expected lifespan, and loss of companionship) to the range of $250,00 to $400,000.

Hawaii caps pain and suffering alone at $375,000, leaving the value of mental anguish and disfigurement to the jury. (Soon to be repealed)

New Hampshire would permit recovery of $875,000 for non-economic loss, Wisconsin $1 million.

Six states place caps on the total amount awarded. This strategy is on weaker constitutional grounds, due to the argument that it deprives fair compensation to the most severely injured. Therefore, a number of states provide an "out": for example, Massachusetts caps total damages at $500,000 unless the jury finds that elements in the case would make the cap unfair.

Results/ Legal Ramifications

Some analysts believe that placing caps on damages appears to be effective in lowering or stabilizing malpractice premiums, because it limits the largest awards and therefore reduces the cyclical increases necessary to maintain the pool.

The constitutionality of caps has been interpreted differently in different parts of the country. And many states have overrules laws implementing caps on constitutional grounds.

In late November, 1992, The U.S. Supreme Court refused to hear a case challenging Missouri's damage cap of $430,000 on non-economic damages. The Court has consistently declined to consider other, similar caps, such as California's MICRA, which caps non-economic damages at $250,000 and has been upheld by the state supreme court. Maryland's cap of $350,000 on non-economic damages was upheld by the court of appeals in 1992.

Other state courts have judged differently, however:

Overturned:

Alabama $400,000 limit on non-economic damages was overturned on state constitutional grounds in 1991. The $1 million limit on damages in wrongful death actions is indexed to inflation.

Hawaii $375,000 limit on "pain and suffering" has been repealed effective October 1, 1993

Kansas $250,000 limit on non-economic damages, scheduled to expire on July 1, 1993, was struck down by the state supreme court in 1988.

Minnesota $400,000 limit on intangible loss awards was repealed in 1990

New Hampshire $875,000 limit on non-economic damages overturned on state constitutional grounds.

Awards Increases:

Nebraska $1 million limit on total damages has been increased to $1,250,000 for events occurring after December 1, 1992

New Mexico Effective April 1, 1995 limits on damages have been modified to $600,000 maximum for non-economic and $600,000 for medical care, and damages for "future medical care" have been prohibited. The maximum amount for which providers may be liable before recourse to the state patient compensation fund has been increased to $200,000

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo	Chris Jennings to Hillary Clinton Re: Tomorrow's Finance Committee Meeting (19 pages)	4/19/93	P5

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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

FOLDER TITLE:
April 1993 HSA [2]

gf77

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE UNDOCUMENTED PERSON

IN THE NEW

HEALTH CARE REFORM SYSTEM

Submitted by: Cluster 1 Task Group 2

Special Issues in Purchasing
Cooperatives for
Underserved Populations

Contact: Chair: Claudia Baquet
(202) 690-6020

Date: April 19, 1993

THE UNDOCUMENTED PERSON IN THE NEW HEALTH CARE REFORM SYSTEM

RECOMMENDED OPTIONS

OPTION 1.--Given the characteristics of the undocumented, the easiest option for covering this population within the NEW SYSTEM would be to acquiesce about any restrictions of coverage due to citizenship and treat the undocumented as low-income workers or as homeless people within the HIPC and Plans requirements. For those working as migrant and seasonal farmworkers, another option may be to establish a national purchasing cooperative for mobile populations.

- Based on the Omnibus Reconciliation Action of 1989, the Medicaid program was expanded to include pregnant women with incomes falling at or below 200% of federal poverty levels without a test of citizenship. Also, it has been the general practice of Community and Migrant Health Centers not to inquire about citizenship for persons seeking care. Therefore, it is not unprecedented for the U.S. Government to ignore citizenship requirements when it provides a health service benefit.

- This OPTION responds to the failure of employer sanctions as a means of controlling the flow of undocumented persons. Once a Plan enrolls an employer with a workforce that may include undocumented persons, it will be difficult for the Plan to police the citizen status of each worker that is covered. Also, the employer may be put at-risk if such workers are uncovered in this process. This is especially critical for such industries that use "cheap labor" such as the hospitality industry and agriculture. Depending on what the risk is to the employer, he may decide to somehow get around the provisions of the NEW SYSTEM and thus weaken it.

- Besides economic incentives in promoting this OPTION, there are also public health reasons for facilitating the identification of medical conditions to persons living and working in U.S. communities. Communicable diseases such as tuberculosis are on the rise and a significant portion of the new cases are immigrants who come from countries where TB is highly prevalent. Included in these immigrants could be and (most likely are) undocumented persons that may be actively infected with TB or other communicable diseases. Therefore, to limit the undocumented persons access to the health delivery systems will drive them to get "underground" medical services and not allow the public health system to

work toward eliminating the communicable diseases that may be present. Given the types of work the undocumented perform, they could inadvertently expose the general population to these risks as well. Unfortunately, this argument may perpetuate xenophobia and the view that immigrants are a drain on the U.S. economy.

- About citizenship, the NEW SYSTEM could avoid the xenophobic discourse about health care in the U.S. and non-U.S. citizen that is here "legally" whether they are tourists, students, or temporary workers can be considered through the HIPC and Plans as covered workers or as subsidized populations. These populations are of significant size to make it important to facilitate the processes for providing needed health care.

OPTION 2.--If there are set aside funds for special populations, then the undocumented population could be included in such special funding arrangements.

- This option would need to be Federally administered since stateS have a much harder time with the undocumented populations due to the perspective that the states see the undocumented as a Federal responsibility. Nevertheless, since identifying and estimating undocumented person could be very difficult, it may not be possible to provide the funding in an informed manner.

- Experience with the Federal SLIAG program, which was set up to reimburse states who have a significant number of IRCA (Immigration Reform and Control Act) amnesty person seeking public services, was non-productive for the states because the funding mechanism that was established was used by the Congress for other purposes. Thus, any special fund that might be considered for the undocumented may be more vulnerable and would need to have "protection and guarantees" in order to be secure for the states to use.

- Within this OPTION special payment subsidies or grants might be provided to Essential Service Providers (public health hospitals, local and state health departments, community and migrant health centers, and other local community clinics, individual practice providers, and other community based organization) to assure that services are provided without the risk of arrest.

OPTION 3. -- Establish that enrollment in the New System is blind to immigration status. Establish that the Federal Government will subsidize costs for those who are not working. Establish through treaty with Mexico a Binational Border Health Commission and general agreement that Mexico will reimburse the U.S. Government for at least a portion of costs incurred by providing subsidized care to undocumented persons. Direct the Binational Border Health Commission to establish a fair and equitable method of reimbursement.

- Since it would be difficult to identify undocumented persons, Federal funding might have to be provided to essential service providers in an uniformed manner, and subsequent reimbursement by the Mexican government would be similarly uniformed. Another option is to have the PC (not the providers) collect immigration status information and bar them from sharing it with other agencies.

OPTION 4. -- Do not include undocumented workers in health care reform. If undocumented workers are excluded, the costs associated with subsidized care that is part of the health care reform will be reduced, but the following issues need to be considered:

- Areas of the United States (i.e., the Southwest) will continue to absorb the costs of uncompensated medical care for undocumented workers. While some of this care is provided in publicly funded health centers, care also is given by private practitioners and institutions. State premiums/subsidies will need to be adjusted to absorb dollars spent on the medical care of these individuals.

- Families can be composed of legal United States residents and undocumented workers. How will employer-based insurance cover those member of families who are undocumented workers? How will undocumented parents of U.S. citizen children receive treatment?

Characteristics of the Undocumented

Immigrant Status

The Immigration Reform and Control Act (IRCA) divides immigrants into two categories: "Residents since 1982" and the "Special Agricultural Workers" who had to demonstrate employment in agriculture in the U.S. for at least 90 days between May 1, 1985 and May 1, 1986. In addition, other non-IRCA legalization categories have "numerical limitation" that include nine orders of "exempt from limitations" that have ten different categories of exemptions. Non-immigrants who come to the U.S. temporarily are divided into ten classes. Included in the nonimmigrant group are "temporary workers and trainees" which include agricultural workers.

Estimate of Undocumented

In a recent report (November 1992) to the Los Angeles County Board of Supervisors on the "Impact of Undocumented Persons and other Immigrants on Costs, Revenues, and Services in Los Angeles County", undocumented persons is defined as, "Foreign-born persons who are not in the country under a lawful immigration tus and who are not permanently residing in the United States er color of law..." The Report uses two different models to estimate the number of undocumented persons--one results in 1.6 million and the other in 2.1 million. The INS statistics estimate between 2.0 million and 3.5 million undocumented persons in 1990 in the U.S. This is the same range that the Urban Institute and Rand Corporation estimated in 1980. About 3.0 million undocumented persons were identified under the IRCA legalization program between 1987 and 1989. Therefore, the current INS estimate suggests that the number of undocumented continues to increase notwithstanding IRCA provision such as employer sanctions. The November 1992 Report of the Commission on Agricultural Workers stated, "A reasonable mid-range estimate based on these case studies is that 25 percent of the 1991 non-supervisory SAS (seasonal agricultural service) labor force is made up or unauthorized workers." They estimate about 2.5 million hired agricultural workers in the U.S.

Economic Issues

The L.A. County Report calculated that there were 700,000 undocumented immigrants in the County, 720,0900 persons under amnesty, 630,000 recent legal immigrants, and 250,000 citizen

20 April 1993

TO: Judy Feder, Ira Magaziner, Chris Jennings

FROM: Robert Valdez

SUBJECT: OPTIONS FOR DEFINING UNIVERSAL COVERAGE

This memo provides a political and economic analysis of options for defining universal coverage as outlined in my 16 April memo.

ISSUE: Publically members of the task force have indicated that citizens and probably permanent residents would be included under the universal coverage provisions of the reform initiative. Recognition of the need to support current efforts that provide services to disenfranchised groups such as the undocumented were vaguely identified in the form of a "set aside" or special fund.

Unfortunately, this narrow definition for participation leaves out numerous "types" of immigrants that are distinguished by immigration officials. Furthermore, it suggests that groups of individuals currently served by programs would no longer be eligible for assistance. The political and economic implications of defining univeral coverage in this way in the wake of a comprehensive redesign of U.S. immigration policy during the 1980s may not be readily apparent. The major implications include:

o Requires a costly and burdensome adminstrative structure to police participation

o Encourages fraud and abuse at all levels

o Creates financial hardship on states and local communities with large immigrant populations

o Perpetuates expensive approach to caring for ill individuals

o Reduces or eliminates benefits currently enjoyed by some U.S. residents

o Some 4 to 6 million U.S. residents remain "uninsured," concentrated in the large and rapidly growing Latino and Asian communities across the country.
  - These communities are highly concentrated in key mid-term election states and metropolitan communities.
  - Several metropolitan areas would experience serve financial impacts. These communities include Los Angeles, New York City, Chicago, Houston, and Miami but the effects are certainly not confined to these large metropolitan areas. Many smaller communities will also be affected.
  - These communities, largely composed of immigrants - both documented and undocumented - have the highest levels of labor force participation and economic activity in the

country.

- o Complicates system reform in a number of ways
  - As employers will the disenfranchised be allowed or required to participate?
  - If employers do not have to cover some workers such as undocumented or temporary workers or students then we create adverse hiring and immigration incentives.

The impact on the health care system of defining participation narrowly include:

- o Uncompensated care for catastrophic events and the wasteful use of emergency rooms for non-life threatening care will continue unabated.
- o Non-participation by large segments of community residents increases the risk and costs of preventable and communicable diseases such as tuberculosis.
- o Maintence of effort funds for the new system may not be available as result of local and state demands to care for the medically disenfranchised.

Current statutes assure the expansion of opportunities for immigration and undocumented immigration is likely to continue unchecked. As a consequence, we can expect immigration to reach one million a year or more during the 1990s.
The largest demands on local jurisdictions are for education and health care. Two recent Supreme Court rulings have broadened state/local responsibility in the area of education, first by mandating equal access to K-12 education for the children of undocumented immigrants (Plyler v. Doe,1982) and second by requiring greater state and local attention to language-minority students (Lau v. Nichols, 1974). Recent U.S. Appeals Court rulings (i.e., Crespin v. Coye) stated that county welfare departments and others are enjoined from denying Medicaid coverage upon verification of immigration status. Extension of Medicaid coverage to immigrants, documented and undocumented require a careful examination of alternative ways of defining "universal coverage."

OPTION 1: DEFINE ELIGIBLES BASED ON ESTABLISHED RESIDENCY

PRO: Many programs currently define eligibles based on residency rather than citizenship.
Creates universal coverage system.
Provides greater control of health care budget.
Reduces financial stress on states and locales.
Reduces political opposition by major states, county, and city officials, immigrant advocacy groups, and the Latino and Asian communities.

CON: Perceptions by vocal minority will oppose and use zenophobic arguments to arouse deepseated fear in the general public.

Potentially increases subsidies for lower income populations (but current data estimates probably already include immigrants because they are indistinguishable)

OPTION 2: RESIDENTS PARTICIPATE BUT ONLY CITIZENS AND PERMANENT RESIDENTS ARE ELIGIBLE FOR FEDERAL SUBSIDIES

Residency could be used to define eligibility to participate in the new system. However, a more severe test such as citizenship or permanent legal residency could be used to establish elibility for the range of subsidies funded by the federal government. States could choose to provide these subsidies for special populations such as immigrants or visitors.

PRO: Maintains a universal program
Reduces funds needed for federal subsidy
Reduces political opposition by potential allies

CON: Anti-immigrant groups would not be mollified
Some poor families and individuals would be denied options within the system because they cannot afford them.
Administrative structure would be required to determine citizenship or permanent residence

OPTION 3: REMAIN SILENT ON PARTICIPATION REQUIREMENTS

A number of program statutes are silent with regard to citizenship or residency. States vary in how they determine who is or is not included in their programs. In general, groups with legitimate claims excluded from the programs have pressed their case in the courts.

PRO: Program eligibility reflects the individual community values and concerns.
Status quo would be maintained for most programs
States would reduce political pressure but not locales

CON: Highly variable state and local approaches
Costly patterns of care and neglect would continue
Less budgetary control

OPTION 4: INCLUDE SET ASIDE FUNDS FOR SPECIAL POPULATIONS, SUCH AS IMMIGRANTS, STUDENTS, TOURISTS, AND OTHERS

PRO: Provides some certainty that funds will be available.
Maintains role of public health in care of disenfranchised.

CON: Set asides are extremely vulnerable to political whim.
Difficult to target and budget for funds to high impact areas.
Anti-immigrant opposition would be vocal and organize mass opposition.
Requires safety net provides to continue to provide personal medical services.

16 April 1993

TO: Judy Feder and Ira Magaziner

FROM: Robert Valdez, Henry Montez, Ciro Sumaya, Richard Veloz, Elena Rios

SUBJECT: Options for defining UNIVERSAL COVERAGE

In response to your request we have put together the following options for defining univeral coverage that address several issues regarding the treatment of immigrants and visitors. Valdez's 13 April memo provided background information for reconsidering the publicly stated position by you and Mrs. Clinton that only citizens and permanent residents would be included in the new system. The implications of defining univeral coverage in this way in the wake of a comprehensive redesign of U.S. immigration policy during the 1980s may not be readily apparent. The major implications include:

- A large number of U.S. residents remain "uninsured," especially in the large and rapidly growing Latino and Asian communities across the country. Dr. Valdez's February 17 JAMA article documents the extraordinary increase in the number of uninsured in these communities despite their extremely high rate of participation in the labor force.

- A two-tiered system for citizens and "second-class" immigrants will be created, especially if the reforms must be phased in over a number of years. Uncompensated care for catastrophic events and the wasteful use of emergency rooms for non-life threatening care will continue the pattern of costly care we wish to eliminate. Eligible children may not fully participate in the system because their parents' fear deportation.

- Cities and counties will bear an unusually heavy fiscal burden in maintaining personal health care services for a large number of immigrants and other disenfranchised individuals. Maintence of effort funds for the new system may not be available as result of these demands.

- Numerous states, especially California, Texas, New York, Florida, Illinois, New Jersey, Connecticut, Washington, and Michigan, will bear the brunt of federal policies on health care reform and immigration policy.

Among the 37 million or so uninsured residents of the United States (Mrs. Clinton apparently does not know that our estimates of the uninsured include non-citizens and citizens alike.), include about 6 million blacks and about 7.1 million Latinos. It is important to keep in mind that no matter what strategy the President chooses Latinos may still face major health care access difficulties. Ensuring adequate medical care services to the Latino community and immigrant communities requires attention to

both the financing mechanisms and the structure of the medical care and public health delivery systems. Even Latinos who are currently covered by health insurance cannot find an adequate supply of providers in their communities.

EXPECTED: 10 MILLION IMMIGRANTS IN THE 1990s

Current statutes assure the expansion of opportunities for immigration and undocumented immigration is likely to continue unchecked. As a consequence, we can expect immigration to reach one million a year or more during the 1990s. For more than a century, formulating and enforcing immigrant policy have been the exclusive prerogative of the Congress and the federal executive branch. But today, as in the past, the effects of immigration policy are felt mainly at the local level, a fact that has yet to be fully recognized by Congress, by immigration advocacy groups, or even by analysts. The largest demands on local jurisdictions are for education and health care. Two recent Supreme Court rulings have broadened state/local responsibility in the area of education, first by mandating equal access to K-12 education for the children of undocumented immigrants (Plyler v. Doe,1982) and second by requiring greater state and local attention to language-minority students (Lau v. Nichols, 1974). These rulings and the extension of Medicaid coverage under state option to immigrants, documented and undocumented require a careful examination of how "universal coverage" will be defined.

OPTION 1: DEFINE ELIGIBLES BASED ON ESTABLISHED RESIDENCY

Many programs currently define eligibles based on residency rather than citizenship. These programs have largely followed the basic American principle, "justice and liberty for all." Under the Equal Protection Clause of the Fourteenth Amendment as set forth in Plyer v. Doe, 1982 the Supreme Court said that undocumented students have a right to a public education. A permanent injunction by the U.S. Court of Appeals in California in Crespin v. Coye specifically stated that county welfare departments and others are enjoined from denying Medicaid coverage upon verification of immigration status.

The major objection to defining eligibility by residency reflects fear of immigrants and the notion that some individuals espouse that immigrants are a drain on the public coffers. Numerous Presidential Blue ribbon panels and policy analyses including those by Dr. Valdez have demonstrated that nationally immigrants add to the economic and social fabric of American society. The negative effects, as Dr. Valdez points out fall on local jurisdictions largely in the form of demands on the education and health care systems.

Provisions for the many populations who do not fit the narrow definition of citizen or permanent resident must be given renewed consideration if adopted. These populations include, many categories of immigrants, foreign students and other visitors who

live in the U.S. for extended periods of time, and guest workers.

OPTION 2: RESIDENTS PARTICIPATE BUT ONLY CITIZENS AND PERMANENT RESIDENTS ARE ELIGIBLE FOR FEDERAL SUBSIDIES

Residency could be used to define eligibility to participate in the new system. However, a more severe test such as citizenship could be used to establish elibility for the range of subsidies funded by the federal government. States could choose to provide these subsidies for special populations such as immigrants or visitors.

OPTION 3: REMAIN SILENT ON PARTICIPATION REQUIREMENTS

A number of program statutes are silent with regard to citizenship or residency. States vary in how they determine who is or is not included in their programs. In general, groups with legitimate claims excluded from the programs have pressed their case in the courts. Program eligibility reflects the individual community values and concerns.

Programs funded in large by federal monies have largely included citizens, permanent residents, and other residents (many of whom are technically undocumented immigrants). Others individuals are included in medical care programs on an emergency basis.

OPTION 4: INCLUDE SET ASIDE FUNDS FOR SPECIAL POPULATIONS, SUCH AS IMMIGRANTS, STUDENTS, TOURISTS, AND OTHERS

Set asides are extremely vulnerable to political whim. For example, a set aside for states with large numbers of newly documented immigrants under the Immigration Control and Reform Act of 1986 with the exception of the first year has never been funded by Congress.

If such a set aside were to be developed it is extremely important that major metropolitan areas directly be identified for funds as well as providing state level relief.

After your presentations and Mrs. Clinton's recent meeting with Latino health care professionals in which it was stated that the undocumented would not be included in the new system, we have received indications that Congressional leaders, state legislators, and local county officials are extremely concerned. We look forward to working with you in finding a workable resolution to this and the related issues. Defining who is part of the universe under "universal coverage" is a key parameter in the reform initiative.

We should probably meet to discuss how best to address this issue and to consider how best to respond to the concerns of the national, state, and local representatives.

13 April 1993

To: Judy Feder and Ira Magaziner

From: Robert Valdez

Subject: Impact on Local communities - Immigration & Health Care Reform

Copies: Latino Work Group Members

FEDERAL POLICY IN THE 1980s WILL INCREASE AND DIVERSIFY IMMIGRATION STREAM IN THE 1990S AND EARLY 2000

The 1980s was marked by a wave of immigration nearly equal to the peak number who arrived in the first decade of the century. With an acceleration of immigration since the 1960s, the proportion of immigrants in the total population has reached 8 percent in 1990. Nearly one of every two foreign born persons now residing in the country entered within the last decade. They account for 40 percent of the 22 million 1980-1990 population growth in the nation and for more than half of the growth if the U.S.-born children of immigrants are included.

During the last decade we witnessed a comprehensive redesign of the U.S. policy towards refugees, undocumented immigrants, temporary immigrants, and those gaining permanent immigrant status. Three new statutes - the Refuge Act of 1980, the Immigration Control and Reform Act of 1986 (IRCA), and the Immigration Act of 1990.- are the most important components of this redesign. Together they will increase the number of immigrants - documented and undocumented - coming to the United States. The key expansionary provisions include:

* number of documented immigrants allowed entry increased from 500,000 to 675,000 or more.

* Refugees and asylees will remain outside the limit.

Conservatively they can be expected to add 150,000 to 200,000 entries every year, up from about 100,000 in the 1980s.
In light of the profound international geopolitical changes and growing incidence of regional conflicts throughout the world, we can expect increased pressures to admit refugees and asylees.
(In June 1993, the President must decide the fate of the Salvadorean immigrant community because their temporary status expires again. Many Salvadoreans live in the D.C. area. and many have lived in the United States for over 10 years and raised their children here.)

IMMIGRATION IS MORE THAN A BORDER ISSUE

In addition the new laws provide for four new categories of immigrants that will profoundly affect the size and composition

of immigration in the United States. First, the largest amnesty program for undocumented immigrants will move more than 3 million from the underground to the mainstream of American life. The majority of applicants were Mexicans (75%) living in four states along the U.S.-Mexico border. As amnestied immigrants become permanent residents and citizens they will be able to sponsor additional family members. Second, each country's quota for documented immigrants increased from 20,000 to 47,000. Countries most likely to benefit are those with long waiting lists, including the Philippines, Mexico, India, China, Korea, and Vietnam. Third, creation of a diversity visa (55,000 annually) to be granted to nationals from counties sending few documented immigrants to the U.S. This is likely to increase immigration from some European countries (e.g., Ireland and Eastern Europe) and Africa. Lastly, establishment of a "temporary protected immigration status" for a selected group of undocumented immigrants provides beneficiaries protection against deportation and authorization to work. Currently two groups are so covered: spouses and children of the amnestied immigrants and nationals from El Salvador and a few other counties.

MANY IMMIGRANTS CAN PARTICIPATE IN SOCIAL PROGRAMS

Because immigration is expected to continue at peak levels throughout the 1990s, the local effects of immigration and the fiscal capacity of local areas and of individual communities to integrate successive waves of immigrants has emerged as a significant policy issue. Considerable confusion exists regarding what programs and services are available to immigrants - documented and undocumented. (This distinction is not very useful from a practical point of view, particularly at the local level. It is virtually impossible to separate out the document from the undocumented. Families are often composed of a complex mixture of immigration statuses - citizens, residents, undocumented.) The following chart provides a quick look at the status quo.

Program	LPR	Refugee	PRUCOL	PRE-82	SAW	Family	TPS	Undoc
AFDC	Y	Y	Y	-5 YR WAIT FROM '86-			N	N
SSI	Y	Y	Y	Y	Y	Y	N	N
UNEMPLOY	Y	Y	Y	Y	Y	Y	Y	N
MEDICAID	Y	Y	Y	-CHILD/ELDERS FULL OTHERS EMERGENCY for 5yrs from '86			MCH&Preg Emergency	
FOOD STAMP	Y	Y	N	-5 YR WAIT FROM '86-			N	N
WIC	Y	Y	Y	Y	Y	Y	Y	Y
SCHOOL LUNCH	Y	Y	Y	Y	Y	Y	Y	Y

(LPR - Legal permanent resident; PRUCOL - Permanently Residing Under the Color of Law; SAW - Special Agricultural Worker; TPS - Temporary Protected Status)

As you can see there are numerous Federally funded programs that do not discriminate immigrants based on their immigration status. It is important to note that the PRUCOL are technically undocumented immigrants who have established themselves as if they are documented residents. This can be done in a variety of ways including filing a regular tax form 1040 rather than a form for non-permanent residents.

FEDERAL POLICIES GREATLY STRESS LOCAL COMMUNITIES ALREADY

Immigration affects most of the countries major cities and local communities. The twenty-five largest communities in the country have experienced large growth in their immigrant communities. Local communities with large immigrant populations were promised federal financial assistance with IRCA but SLIAG funds were never made available because they were politically vulnerable as set aside funds.

CONCENTRATION OF IMMIGRANTS IS INCREASING

Between 1980 and 1990, 8.7 million new immigrants (documented and undocumented) entered and remained in the country. Most (71%) reside in just five states: California, New York, Illinois, Florida, and Texas. The remaining quarter are spread throughout but generally in specific local communities.

RELATIVE CONCENTRATION INCREASES AS SIZE OF JURISDICTION DECREASES

Within a state, about 80 percent of immigrants concentrated in the largest metropolitan areas. With the exception of New York and Chicago, these metropolitan areas have been among the fastest growing areas of the country, expanding at 2 to 3 times the national average. In these areas, immigration in the last decade accounted for 60 to 100 percent of population growth.

IMPLICATIONS FOR HEALTH CARE REFORM

- Increased diversity of metropolitan area consumers creates demand for culturally competent health care delivery systems
- Creates a two-tiered system if immigrants left out
- Increased needs for public health and community development and health promotion perspectives that go beyond medical care delivery reform
- Tremendous fiscal stress on local communities due to Federal policies.
- System could collapse in major metropolitan areas under weight of the transition to the new system and rapid population growth.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. memo	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Legislative/Congressional Distribution List (2 pages)	4/20/93	P5

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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

FOLDER TITLE:
April 1993 HSA [2]

gf77

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

HOUSE LEADERSHIP DEMOCRATIC RELIABLES

Member	Background Information
ARIZONA:	
Coppersmith	
English	Education and Labor, Caucus for Women's Issues, Mainstream Forum, Freshman
Pastor	Hispanic Caucus
ARKANSAS:	
Lambert	Energy and Commerce, Caucus for Women's Issues, Rural Health Care Coalition, Freshman
Thornton	Mainstream Forum
CALIFORNIA:	
Fazio	Rural Health Care Coalition
Matsui	Ways and Means
Mineta	
Pelosi	Caucus for Women's Issues, McDermott Cosponsor
Stark	Ways and Means, Subcommittee on Health, Chair; Rural Health Care Coalition; McDermott Cosponsor
Waxman	Energy and Commerce, Subcommittee on Health, Chair
CONNECTICUT:	
DeLauro	Caucus for Women's Issues
Gedjenson	McDermott Cosponsor
Kennelly	Ways and Means, Health Subcommittee; Caucus for Women's Issues

FLORIDA:	
Bacchus	
Deutsch	
Johnston	
GEORGIA:	
Lewis	Ways and Means, Health Subcommittee; Congressional Black Caucus; McDermott Cosponsor
HAWAII:	
Abercrombie	McDermott Cosponsor
IDAHO:	
LaRocco	Rural Health Care Coalition, Mainstream Forum
ILLINOIS:	
Collins	Energy and Commerce, Caucus for Women's Issues, Congressional Black Caucus, McDermott Cosponsor
Costello	Rural Health Care Coalition, Mainstream Forum
Evans	Rural Health Care Coalition, McDermott Cosponsor
Rostenkowski	Ways and Means
INDIANA:	
Sharp	Energy and Commerce
KENTUCKY:	
Mazzoli	Judiciary
Natcher	
MARYLAND:	
Cardin	Ways and Means, Subcommittee on Health
Hoyer	

MASSACHUSETTS:	
Frank	Judiciary, McDermott Cosponsor
Kennedy	McDermott Cosponsor
Markey	Energy and Commerce
Olver	McDermott Cosponsor
Studds	Energy and Commerce, Health Subcommittee; Rural Health Care Coalition, McDermott Cosponsor
MICHIGAN:	
Bonior	
Carr	Mainstream Forum, McDermott Cosponsor
Dingell	Energy and Commerce
Ford	Education and Labor
Levin	Ways and Means, Subcommittee on Health
Kildee	Education and Labor
MINNESOTA:	
Sabo	McDermott Cosponsor
MISSOURI:	
Danner	Caucus for Women's Issues, Rural Health Care Coalition, Freshman
Gephardt	
Wheat	Rules, Congressional Black Caucus
MONTANA:	
Williams	Education and Labor, Rural Health Care Coalition
NEBRASKA:	
Hoagland	Ways and Means, Health Subcommittee; Rural Health Care Coalition; Mainstream Forum

NEW YORK:

Ackerman	McDermott Cosponsor
Engel	Education and Labor, McDermott Cosponsor
Lowey	Caucus for Women's Issues, Mainstream Forum
Manton	Energy and Commerce, McDermott Cosponsor
Schumer	Judiciary, McDermott Cosponsor
Slaughter	Rules, Caucus for Women's Issues, Rural Health Care Coalition, Mainstream Forum

NORTH DAKOTA:

Pomeroy

OHIO:

Brown	Energy and Commerce, Health Subcommittee; Freshman
Sawyer	Education and Labor
Strickland	Education and Labor, Rural Health Care Coalition, Freshman

OKLAHOMA:

Synar	Energy and Commerce, Health Subcommittee; Judiciary, Rural Health Care Coalition

OREGON:

Kopetski	Ways and Means
Wyden	Energy and Commerce, Health Subcommittee; Rural Health Care Coalition

RHODE ISLAND:

Reed	Education and Labor, Juciciary

SOUTH CAROLINA:

Clyburn	Congressional Black Caucus, Single Payer, Freshman
Derrick	Rural Health Care Coalition

TEXAS:	
Bryant	Energy and Commerce, Health Subcommittee; Judiciary
Frost	Rules
Geren	Mainstream Forum
Lauglin	Rural Health Care Coalition
VIRGINIA:	
Byrne	Caucus for Women's Issues, Freshman
Moran	Mainstream Forum
Scott	Education and Labor, Judiciary, Congressional Black Caucus, McDermott Cosponsor, Freshman
WASHINGTON:	
Cantwell	Caucus for Women's Issues, Freshman
Kreidler	Energy and Commerce, Health Subcommittee; Freshman
McDermott	Ways and Means, Health Subcommittee; Rural Health Care Coalition; Sponsor of Single Payer Bill
Swift	Energy and Commerce, Rural Health Care Coalition
Unsoeld	Education and Labor, Caucus for Women's Issues, Rural Health Care Coalition
WEST VIRGINIA:	
Mollohan	Rural Health Care Coalition
Rahall	Rural Health Care Coalition
Wise	Rural Health Care Coalition
WISCONSIN:	
Kleczka	Ways and Means, Subcommittee on Health
Obey	Rural Health Care Coalition