Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo w/attach.	Chris Jennings to Hillary Clinton Re: Bipartisan Senators Meeting (54 pages)	4/29/93	P5

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

FOLDER TITLE:
April 1993 [5]

gf80

RESTRICTION CODES

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April 29, 1993

MEMORANDUM FOR Hillary Rodham Clinton

FROM: Chris Jennings, Christine Heenan

RE: Congressional Briefing Book

CC: Ira, Melanne, Steve, etc.

Attached is a list of suggested materials for inclusion in the briefing book on health care reform for members of Congress. We are underway with this project, and wanted to be sure this is what you had in mind.

SECTION I: OVERVIEW OF THE PLAN

This section would have simple descriptions of the plan. They would vary in length and format, so that Members could use the one(s) they felt most comfortable with. Included in this section would be:

IA. 1-page outline on plan (attached)

IB. 5 8-page description with charts (attached)

IC. Slides from the decision memo outlining problem in current system/solution in new system (attached)

SECTION II: HOW THIS PLAN EFFECTS IMPORTANT CONSTITUENCIES

This section will be constituency-specific, and will, for each constiuency, have four parts:

IIA. • **Problem/status quo**
A one page description of the current system as it impacts this group, with a focus on the particular problems in the system from the point of view of this constituency

IIB. • **Description of the plan from the constituency's perspective**

This section would also be no more than one page, and would describe the new system from the point of view of each constituency. For example, in the section on consumers, the system would be described in terms of how individuals get coverage, how they choose their doctor, etc. In the section on labor, it would focus on how the new plan will effect employer/employee contracts, etc.

IIC. • **Talking Points**

Basically a summary of the above issues in capsulized, sound-bite language.

IID. • **Q & A**

For the most part this section will contain much of the same information from section IIB, but will be written as questions we anticipate will be frequently asked, with answers.

This section will have write-ups for at least these constituencies:

Consumers
(this section will also have a page on costs: now and in the new system)

Providers
- Generalists/Primary Care Doctors
- Specialist Doctors
- Nurses and other health care professionals
- Hospitals

Employers
-Big Business
-Small Business
(this section will also have a page on costs: now and in the new system)

Labor
Seniors
Veterans
Insurance Industry
Disabled Americans
Children + Families

SECTION III: POLICY COMPONENTS OF THE PLAN

Unlike the above section, which breaks the whole plan down from the point of view of given constituencies, this section will focus on different policy components of reform. In some cases, there will be natural links to constituencies, e.g. seniors/long-term care. The main purpose of this section would be for Members to be able to quickly reference how this plan deals with certain issues, and how to talk about them.

This section will include write-ups on:

- Costs/Financing
- Controlling Spending
- Physician Choice
- Simplicity
- Managed Competition
- Long term Care
- Medicare
- Medicaid
- State/Federal Role
- Malpractice
- Mental Health
- Underserved Populations
- Rural Health Care
- Undocumented Persons
- Fraud and Abuse
- Prescription Drugs
- Native Americans/Indian Health Service

Single payer

Section II Jump Search

SECTION ~~IV~~: GLOSSARY OF TERMS

This will be a listing of frequently used health care policy jargon broken down into easy-to-grasp definitions. This glossary will be an expanded version of the one we prepared for the Members' briefing book during the recess.

SECTION VI CHARTS AND GRAPHS

Building on the advice that Members love to use simple graphs and charts, we will produce a series of straightforward charts for presentation materials.

OVERVIEW OF HEALTH REFORM:

ALL AMERICANS ARE GUARANTEED:

- COMPREHENSIVE BENEFITS
- SECURITY AND PORTABILITY OF COVERAGE
- CHOICE OF PLANS AND PROVIDERS
- HIGH QUALITY CARE

FEDERAL GOVERNMENT WILL:

- DEFINE BENEFITS
- DEVELOP QUALITY, ACCESS, INSURANCE STANDARDS
- REFORM MALPRACTICE
- ESTABLISH FRAMEWORK FOR STATE-RUN SYSTEMS
- SET BUDGETS

STATES WILL:

- SET UP ALLIANCE TO REPLACE FRAGMENTED INSURANCE MARKET
- GUARANTEE AFFORDABLE COVERAGE THROUGHOUT STATE
- ENFORCE QUALITY, ACCESS AND INSURANCE STANDARDS
- ENFORCE BUDGETS

HEALTH ALLIANCES WILL:

- ENSURE AVAILABILITY OF VARIETY OF HEALTH PLANS
- NEGOTIATE PREMIUMS WITH HEALTH PLANS
- MANAGE ENROLLMENT
- PROVIDE CONSUMER EDUCATION AND PROTECTION

HEALTH PLANS WILL:

- ACCEPT ALL APPLICANTS AT COMMUNITY RATE
- PROVIDE GUARANTEED BENEFITS WITHIN AGREED-UPON RATE

OVERVIEW OF HEALTH REFORM

TODAY'S SYSTEM:

AMERICAN HEALTH CARE IS A PATCHWORK "NONSYSTEM". PEOPLE'S ACCESS TO INSURANCE AND CARE DEPENDS ON WHERE THEY WORK AND HOW MUCH MONEY THEY HAVE. EVEN WELL-INSURED AMERICANS INCREASINGLY FEAR THAT COVERAGE WON'T BE THERE WHEN THEY NEED IT.

WITH NO ACCOUNTABILITY AND NO GUARANTEES, CARE IS DISJOINTED, ACCESS IS UNEVEN, QUALITY VARIES, COSTS ARE SHIFTED FROM ONE PAYER TO ANOTHER AND OVERALL SPENDING RISES UNCHECKED.

UNDER HEALTH REFORM:

WE WILL BUILD AN AMERICAN HEALTH CARE SYSTEM BASED ON A SERIES OF GOVERNMENT GUARANTEES: ALL AMERICANS GET COVERAGE; NO ONE CAN BE DENIED INSURANCE; EVERYONE HAS ACCESS TO THE SAME COMPREHENSIVE BENEFITS PACKAGE; AND PEOPLE CAN CHOOSE THEIR OWN DOCTOR WITHIN A SYSTEM OF HIGH QUALITY MEDICAL CARE.

THE FEDERAL GOVERNMENT WILL ESTABLISH AND OVERSEE THE OVER-ALL FRAMEWORK OF THE AMERICAN HEALTH CARE SYSTEM.

IT WILL DEFINE THE BENEFITS PACKAGE THAT EVERY AMERICAN WILL HAVE.

IT WILL SPELL OUT INSURANCE REFORMS THAT WILL PROHIBIT DISCRIMINATION BASED ON HEALTH STATUS OR OTHER FACTORS.

IT WILL SET AND ENFORCE HEALTH CARE BUDGETS.

WITHIN THE FEDERAL FRAMEWORK, STATES WILL RUN THE SYSTEM, TAILORING ITS DESIGN TO THE HEALTH CARE NEEDS OF LOCAL COMMUNITIES. IN EVERY STATE, PEOPLE WILL BUY THEIR INSURANCE FROM LARGE HEALTH CARE BUYING GROUPS CALLED "HEALTH ALLIANCES" THAT OFFER A NUMBER OF HEALTH CARE PLANS TO ALL PEOPLE IN A COMMUNITY. SOME STATES MAY RUN THE HEALTH ALLIANCES THEMSELVES, WHILE OTHER STATES MAY SIMPLY OVERSEE THEM.

HEALTH PLANS WILL REPLACE INSURANCE PLANS. WHETHER HMOS, FEE-FOR-SERVICE PLANS, OR SOMETHING IN-BETWEEN, THEY WILL TAKE ALL COMERS AND ASSUME RESPONSIBILITY FOR EFFICIENT DELIVERY OF QUALITY CARE FOR A SET AMOUNT.

HOW DO PEOPLE GET COVERAGE?

TODAY:

- ACCESS TO COVERAGE DEPENDS ON EMPLOYMENT STATUS, HEALTH, AND ECONOMIC CIRCUMSTANCES. CLOSE TO 40 MILLION AMERICANS HAVE NO HEALTH INSURANCE.

- IN MOST CASES EMPLOYERS, NOT EMPLOYEES, CHOOSE HEALTH PLANS

REFORM:

- ALL AMERICANS WILL BE GUARANTEED A COMPREHENSIVE NATIONAL BENEFIT PACKAGE -- WHETHER WORKING, NONWORKING; RICH, POOR; OLD, YOUNG; SICK, OR WELL

- INDIVIDUALS--NOT EMPLOYERS--CHOOSE FROM A VARIETY OF PLANS -- RANGING FROM OPEN FEE-FOR-SERVICE THROUGH HMOS.

WHERE DO PEOPLE GO TO GET HEALTH INSURANCE?

TODAY:

- SOME GET INSURANCE FROM THEIR EMPLOYER, SOME BUY INDIVIDUAL POLICIES FROM INSURANCE AGENTS OR AGENCIES, SOME GET HEALTH INSURANCE FROM THE GOVERNMENT, SOME PEOPLE DON'T HAVE INSURANCE.

REFORM:

- HEALTH INSURANCE WILL BE SOLD THROUGH HEALTH ALLIANCES-- GROUP PURCHASERS THAT OFFER A RANGE OF HEALTH PLANS TO PEOPLE IN THE COMMUNITY. IF YOU ARE WORKING, YOU MAY GET BROCHURES AND INFORMATION ABOUT YOUR CHOICE OF PLANS AT YOUR WORKPLACE. IF YOU WORK FOR A LARGE EMPLOYER, IT MAY BE THAT YOUR EMPLOYER PROVIDES THEIR OWN PLANS.

  BUT WHETHER YOU WORK OR NOT, YOU CAN ALWAYS GO TO THE HEALTH ALLIANCE TO LEARN MORE ABOUT DIFFERENT PLANS, GET INFORMATION ABOUT COSTS AND QUALITY, OR RESOLVE PROBLEMS WITH YOUR HEALTH COVERAGE.

HOW DOES THE INSURANCE MARKET CHANGE?

TODAY:

- SMALL FIRMS AND INDIVIDUALS ARE DISADVANTAGED IN NEGOTIATING WITH LARGE INSURANCE COMPANIES.

  THERE ARE THOUSANDS OF HEALTH INSURANCE COMPANIES

REFORM: - FIRMS AND INDIVIDUALS BAND TOGETHER INTO HEALTH ALLIANCES

FEWER, LARGER POOLS SPREAD RISK OVER A LARGER GROUP AND REDUCE ADMINISTRATIVE COSTS

CONSUMERS IN DRIVERS' SEAT IN NEGOTIATING PREMIUMS FOR GUARANTEED BENEFITS

WHERE DO PEOPLE GO TO GET THEIR HEALTH CARE?

TODAY: - PEOPLE WITH INSURANCE GO TO DOCTORS, HOSPITALS, PHARMACIES, HMOs, OR OTHER CARE PROVIDERS COVERED BY THEIR INSURANCE.

PEOPLE WITHOUT INSURANCE OFTEN GO TO EMERGENCY ROOMS, COMMUNITY CLININCS, AND OTHER PROVIDERS WILLING TO PROVIDE CARE WITHOUT BEING PAID, OR BEING PAID VERY LITTLE.

REFORM: - PEOPLE WILL GO TO THE SAME DOCTORS, HOSPITALS, PHARMACIES, HMOs, OR OTHER CARE PROVIDERS THEY'VE ALWAYS GONE TO. THESE PROVIDERS MAY ORGANIZE INTO "NETWORKS"-- WHERE THEY WORK CLOSELY TOGETHER TO MANAGE ALL THE CARE NEEDS OF THEIR PATIENTS AND WORK TO KEEP COSTS UNDER CONTROL. THERE MAY BE MORE HMO-TYPE NETWORKS, BUT THERE WILL ALSO BE LOOSELY FORMED NETWORKS OF DOCTORS IN INDIVIDUAL OFFICES THROUGHOUT A COMMUNITY.

HOW DO HEALTH PLANS CHANGE?

TODAY: - HEALTH INSURANCE PLANS COMPETE TO AVOID RISK; AND DISCRIMINATE BASED ON HEALTH STATUS AND OCCUPATION. OFTEN INSURANCE PLANS WON'T PAY FOR TREATMENT FOR PEOPLE'S "PRE-EXISTING CONDITIONS"-- HEALTH PROBLEMS, FOR EXAMPLE ALLERGIES OR DIABETES, THAT WERE ALREADY DIAGNOSED BEFORE YOU JOINED THIS HEALTH PLAN. SOMETIMES, INSURANCE COMPANIES WON'T EVEN TAKE PEOPLE BECAUSE OF PRE-EXISTING CONDITIONS.

- NO PLANS OR PROVIDERS AVAILABLE IN SOME AREAS (RURAL AREAS, INNER CITIES)

REFORM: - ALL PLANS REQUIRED TO TAKE ALL APPLICANTS (OPEN ENROLLMENT) AT SAME PREMIUM (COMMUNITY RATE)

- STATES/HEALTH ALLIANCES GUARANTEE THAT PLANS ARE AVAILABLE THROUGHOUT THE STATE (MAY MEAN STATE-RUN, SINGLE PAYER-TYPE PLANS)

WHAT HEALTH CARE SERVICES DO I GET FROM MY PLAN?

TODAY: - BENEFITS PACKAGES VARY IN WHAT THEY COVER: FOR EXAMPLE SOME COVER MORE MENTAL HEALTH SERVICES THAN OTHERS; SOME OFFER DENTAL CARE, SOME DON'T; SOME PAY PART OF THE COST FOR PRESCRIPTION DRUGS, SOME DON'T.

REFORM: THE NATIONAL HEALTH CARE PLAN WILL GUARANTEE A COMPREHENSIVE SET OF BENEFITS, WHICH WILL INCLUDE IN-PATIENT AND OUTPATIENT MEDICAL CARE, MENTAL HEALTH SERVICES, PRESCRIPTION DRUGS, SPECIALTY CARE, ETC. IN ADDITION, THE BENEFITS PACKAGE WILL OFFER MORE IN THE WAY OF PRIMARY AND PREVENTIVE CARE-- THINGS LIKE IMMUNIZATIONS, CHOLESTEROL SCREENINGS, MAMMOGRAMS -- THAN IS TYPICALLY OFFERED BY MOST OF TODAY'S PLANS.

HOW ARE COSTS CONTROLLED?

TODAY: - COSTS HAVE CONSISTENTLY RISEN AT A RAPID AND UNSUSTAINABLE RATE IN THIS COUNTRY. COSTS HAVE BEEN DRIVEN BY:

HIGH ADMINISTRATIVE COSTS:

HIGH CLAIMS PROCESSING/BILLING COSTS BASED ON MORE THAN 2,400 PAYERS FOR HEALTH CARE IN THE U.S. - - ALL WITH THEIR OWN REPORTING REQUIREMENTS.

HIGH ADMINISTRATIVE COSTS FOR SMALL FIRMS WITH FEW EMPLOYEES, OR FOR INDIVIDUAL POLICYHOLDERS.

HIGH INSURANCE ADMINISTRATION COSTS DUE TO UNDERWRITING PRACTICES.

UNNECESSARY UTILIZATION AND INTENSITY OF SERVICES BY PROVIDERS AND CONSUMERS INSULATED FROM COSTS.

FEE-FOR-SERVICE MEDICINE THAT, WITHOUT ATTENTION TO OVERALL SPENDING, ENCOURAGES PROVIDERS TO DO MORE TESTS AND PROCEDURES IN ORDER TO INCREASE THEIR PAY.

USE OF HIGH COST SETTINGS (I.E. HOSPITAL EMERGENCY ROOMS) BY PEOPLE WHO DON'T HAVE ACCESS TO CARE OR DON'T HAVE A PRIMARY CARE DOCTOR.

REFORM: - ADMINISTRATIVE COSTS GREATLY REDUCED BY:

ELIMINATION OF INSURANCE UNDERWRITING.

SIMPLIFICATION OF CLAIMS AND REIMBURSEMENT BY MOVING TO LUMP-SUM PAYMENTS PER PERSON AND BY SIMPLIFYING AND STANDARDIZING BILLING FORMS.

REDUCTION IN COSTS FOR SMALL GROUPS WHO USED TO BUY SEPARATELY AND NOW BUY AS PART OF A BIG GROUP.

COSTS FROM UNNECESSARY TESTS AND PROCEDURES REDUCED BY:

HEALTH PLANS ARE ACCOUNTABLE FOR DELIVERING THE GUARANTEED BENEFITS FOR A SET AMOUNT OF MONEY, SO THERE IS INCREASED INCENTIVE FOR THEM TO DELIVER CARE AS EFFICIENTLY AND COST-EFFECTIVELY AS POSSIBLE.

NATIONAL TECHNOLOGY ASSESSMENT AND BETTER INFORMATION ON PRACTICE PATTERN DIFFERENCES AND EFFECTIVENESS OF TREATMENT WILL ENHANCE COST CONSCIOUS/HIGH QUALITY PRACTICES.

BECAUSE PLANS WILL ONLY GET A SET AMOUNT OF MONEY, THEY WILL MAKE MORE PRUDENT DECISIONS ABOUT USE OF TECHNOLOGY AND MORE COST-EFFECTIVE CAPITAL INVESTMENTS.

THROUGH PRICE COMPETITION, INDIVIDUALS WILL SEE THE DIFFERENT PRICES PLANS CHARGE FOR OFFERING THE SAME BENEFITS, AND WILL MAKE MORE COST-EFFFECTIVE CHOICES.

AS A "SAFETY NET" -- THERE WILL BE A NATIONALLY SET BUDGET THAT LIMITS THE AMOUNT INSURANCE PREMIUMS CAN GO UP EACH YEAR.

WHO	WHAT
Federal Government	Guarantees all Americans coverage
Federal Government	Defines comprehensive benefits package
Federal Government	Sets rules for health alliances and health plans
Federal Government	Establishes and enforces budget
Federal Government	Creates national system of quality assurance
National Board	Examines benefits package and spending patterns to accommodate changing circumstances
National Board	Examines and addresses different spending patterns among states
National Board	Disseminates information about practice patterns and outcomes to different health alliances and plans

States	Set up health alliances, oversee their operation
States	Enforce budgets
States	Ensure that plans comply with federal requirements for coverage, quality, and service to low-income populations
Health Alliances	Ensure availibility of health plans
Health Alliances	Negotiate premiums with health plans
Health Alliances	Manage enrollment in plans and provide consumers with informations about plans
Health Alliances	Ensure equitable access to plans and service for low-income and vulnerable populations
Health Alliances	Oversee access and quality
Health Plans	Contract with providers and institutions
Health Plans	Provide health care to enrolled population

ADDRESSING THE PROBLEMS: THE WORK TEAM PROPOSALS

PROBLEM	SOLUTION
LACK OF SECURITY	• ALL AMERICANS ARE INSURED • INSURANCE CANNOT BE DENIED OR TAKEN AWAY REGARDLESS OF HEALTH STATUS • BENEFITS AT A COMPARABLE LEVEL CONTINUE REGARDLESS OF EMPLOYMENT OR INCOME STATUS • ALL AMERICANS AND THEIR EMPLOYERS PAY INTO THE SYSTEM AT THE SAME RATE REGARDLESS OF THEIR HEALTH STATUS
CONSUMER CONFUSION	• GREATER CHOICE OF PLANS FOR MANY AMERICANS • SIMPLE UNDERSTANDABLE BENEFITS PACKAGE • ONE COVERAGE PACKAGE FOR A FAMILY • NO COVERAGE BATTLES AMONG INSURERS • GUARANTEED ACCESS TO PLANS • CONSUMER COMPLAINT MECHANISM IN PLANS AND ALLIANCE • SIMPLE REIMBURSEMENT AND CLAIMS FORMS • PUBLISHED QUALITY INFORMATION

ADDRESSING THE PROBLEMS: THE WORK TEAM PROPOSALS (CONT'D)

PROBLEM	SOLUTION
PROVIDER HASSLE	• STANDARD REIMBURSEMENT AND ENCOUNTER FORM • SIMPLIFICATION OF REGULATIONS
HIGH ADMINISTRATIVE COSTS	• ELIMINATION OF INSURANCE UNDERWRITING AND MULTIPLE RISK PRODUCTS • SIMPLIFICATION OF CLAIMS AND REIMBURSEMENT – MOVE TOWARDS CAPITATED PAYMENT SYSTEMS – SIMPLE UNIVERSAL CLAIMS AND REIMBURSEMENT FORMS DRIVEN BY UNIVERSAL ENCOUNTER FORMS • ELIMINATION OF DUAL COVERAGE AND COVERAGE DETERMINATION PRACTICES • SIMPLIFICATION OF PRODUCT REDUCES NEED FOR AGENT TO ASSIST CONSUMERS • REDUCTION IN COSTS OF SMALL GROUP ADMINISTRATION • REDUCTION IN REGULATORY REQUIREMENTS -- FORM FILLING • REDUCTION IN MALPRACTICE PREMIUMS • REDUCTION IN TIME SPENT BY PROVIDERS AND INSURERS INVESTIGATING OR DEBATING REIMBURSABILITY

ADDRESSING THE PROBLEMS: THE WORK TEAM PROPOSALS (CONT'D)

PROBLEM	SOLUTION
UNNECESSARY TESTS AND PROCEDURES	• BUDGETED/CAPITATED SYSTEMS DISCOURAGE UNNECESSARY UTILIZATION AND INTENSITY OF SERVICE BY PROVIDERS • GATEKEEPERS (IN HMOs OR PPOs), SOME USE OF COPAYS IN FEE FOR SERVICE PLANS AND PRICE COMPETITION WILL DISCOURAGE UNNECESSARY CONSUMER USAGE • NATIONAL TECHNOLOGY ASSESSMENT AND BETTER INFORMATION ON PRACTICE PATTERN DIFFERENCES AND EFFECTIVENESS OF TREATMENT WILL ENHANCE COST CONSCIOUS/HIGH QUALITY PRACTICE • BUDGETED/CAPITATED SYSTEMS ENCOURAGE MORE PRUDENT USE OF TECHNOLOGY AND MORE COST EFFECTIVE CAPITAL INVESTMENT • MALPRACTICE REFORMS WILL CUT THE COSTS OF MALPRACTICE INSURANCE AND DEFENSIVE MEDICINE
UNDERSERVED POPULATIONS	• UNIVERSAL COVERAGE • INCREASED INVESTMENTS IN INFRASTRUCTURE IN POOR URBAN AND RURAL AREAS AND IN PUBLIC HEALTH • PREVENTION OF "RED LINING" OF HEALTH ALLIANCES • RISK ADJUSTMENT OF POOR POPULATIONS • HEALTH ALLIANCE RESPONSIBILITY FOR BUILDING HEALTH NETWORKS WHERE NONE EXIST

ADDRESSING THE PROBLEMS: THE WORK TEAM PROPOSALS (CONT'D)

PROBLEM	SOLUTION
INADEQUATE LONG-TERM CARE	• EXPANDED OPPORTUNITIES FOR HOME CARE AS BEGINNING OF SOCIAL INSURANCE PLAN • RAISING MEDICAID SPEND DOWN LIMITS • INCENTIVES/REGULATION FOR PRIVATE INSURANCE MARKET

HOW THE NEW SYSTEM MAINTAINS WHAT PEOPLE LIKE IN THE CURRENT SYSTEM

MAINTAIN NEGOTIATED BENEFITS	• LARGE EMPLOYERS AND EMPLOYEES CAN MAINTAIN THEIR CURRENT PLANS AS LONG AS THEY MEET FEDERAL STANDARDS – EMPLOYERS CAN CONTINUE TO PAY MORE GENEROUS PREMIUM SHARES AND COST-SHARING THAN NATIONALLY GUARANTEED BENEFITS PACKAGE IN A TAX SUBSIDIZED MANNER
MAINTAIN HIGH QUALITY SYSTEM	• QUALITY OF SYSTEM WILL IMPROVE WITH BETTER PRACTICE GUIDELINE INFORMATION, QUALITY REPORT CARD, CONSUMER SURVEYING • QUALITY INFORMATION WILL BE MORE AVAILABLE TO CONSUMERS
MAINTAIN CHOICE OF DOCTOR	• BUDGETED FEE FOR SERVICE NETWORK ALLOWS ALL AMERICANS TO CHOOSE THEIR DOCTORS AS THEY CAN TODAY • AVAILABILITY OF MULTIPLE PLANS OF DIFFERENT TYPES ALLOWS CONSUMERS GREATER CHOICE OF TYPE OF CARE THAN MANY HAVE TODAY

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