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001. memo	Chris Jennings to Hillary Clinton Re: Dole, Chafee Visit Following Senate Democrats Meeting (1 page)	2/4/93	P5

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- b(1) National security classified information [(b)(1) of the FOIA]
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- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

MEMORANDUM

TO: Hillary Rodham Clinton January 23, 1993
FR: Chris J.
RE: Tomorrow's Congressional Leadership Meeting
cc: Melanne

Pat Griffin and Steve asked me to draft up the memo that they are providing for the President in preparation for tomorrow's meeting with Speaker Foley and Majority Leader Mitchell. In case you have not yet seen it, I am attaching a copy of it for your use.

Late Breaking News: Based on my conversation with Senator Mitchell's Chief of Staff today (John Hilley), it is my hunch that Senator Mitchell may say that our desire for something close to simultaneous action on the legislation from the two chambers may be desirable, but may not be overly realistic. (If he does not say it, he probably believes it.) There are at least a few reasons why Senator Mitchell might come to this conclusion:

(1) the Senate almost always acts after the House and he may feel he cannot deliver on such a commitment;

(2) the Finance Committee does not have the staff capability to produce a product without a House version to work off of; and

(3) the fact that, unlike the House, the Senate will need significant Republican support to pass a bill will slow down the process beyond what is necessary for the House.

Regardless, it is still important to explore this option and the other coordination issues the memo raises with the Leaders. It will give you an idea as to how much they, and particulary the Speaker, will get engaged and want to press (and coordinate with) his Chairmen in the upcoming legislative process.

You may also want to take this opportunity to get a read from Senator Mitchell as to where he believes Senator Dole is (and, more importantly, will be) over the next several months on the health care issue. Understanding that politics complicates all of this with regard to Dole, does Senator Mitchell have any suggestions as to how to interact with the Minority Leader for the early part of the Senate deliberations?

On a related note, because of the need for Republican Senate support, you may wish to ask Senator Mitchell (or he may ask you and the President) about how soon we should re-engage our visible bipartisan outreach effort with Republicans. (As you may know, we have been conducting numerous separate briefings with the Senate Finance and Senate Labor Committee staff; at our request, and that of the Committees, they have all been bipartisan.) More specifically, when you discuss the proposal for a meeting with the Committee Chairs, Senator Mitchell may suggest that we start thinking about integrating the Republican Ranking Members for these discussions. (The House Chairs probably won't like this at least right away, but I agree that we must get Dole, Chafee, Packwood and Kassebaum in here very soon.)

On a somewhat unrelated matter, I am also attaching a draft of our latest analysis of the impact of the Health Security Act on the State of New York. As you will note, we come to the conclusion that New York does quite well under reform.

We plan to brief Senator Moynihan's staff on our findings tomorrow afternoon at 4:00. (While Governor Cuomo's office will almost assuredly dispute our findings, we believe that at least Senator Moynihan's staff will be a bit more receptive; I will be at that meeting and will give you and Melanne a reaction assessment.) This type of information will not be available for every State prior to the NGA meeting, but we will have an overall impact assessment on the States, as well as some internal analysis on some key States that John Hart anticipates that you and the President would like to have on hand.

THE WHITE HOUSE

WASHINGTON

January 22, 1994

MEETING WITH SPEAKER FOLEY AND MAJORITY LEADER MITCHELL

DATE: January 24, 1993
LOCATION: Oval Office
TIME: 3:00 pm
FROM: Pat Griffin

I. PURPOSE

- To refocus the Congressional Leadership on health care.

- To jointly develop a specific legislative action timetable and strategy that, while somewhat flexible, will provide the Administration, the Leadership and the Committee Chairmen the guidance and discipline necessary to pass a signable bill.

- To attempt to get the Leadership to agree to establish a mechanism that simultaneously coordinates ongoing policy and strategic modifications between Committee Chairs.

- To outline the role the Administration currently plans to play in the legislative process and to seek feedback to it.

- To obtain guidance about how we can best ensure a successful follow-up meeting with the Leadership and the five Committee Chairs of primary jurisdiction over health legislation.

II. BACKGROUND

Looking at the constrained legislative calendar, noting that Members are diversely positioning themselves as it relates to health care, and keeping in mind the politics of any election year, it is clear that the Congress must be kept on a tight and well orchestrated timetable in order to produce a product that achieves the universal coverage/affordability marker that has been laid out by you and the First Lady. The Congress will not be responsive to this challenge unless the Leadership is invested and has agreed upon a reasonable timetable and strategy that, while somewhat flexible to currently unforeseen developments, serves to discipline the process. This meeting has been designed to facilitate this outcome.

AGENDA ITEMS

1. Timetable. Develop an agreed upon and fairly specific (but internal) timetable for Congressional actions (i.e, Committee mark-ups, floor schedule, conference, etc.) and a strategy about how best to stick to the schedule. (Inherent in this discussion is an understanding that, even if you, the Speaker and the Majority Leader are in agreement, the strategy must also be sold to -- and accepted by -- the five Chairmen as well.)

   The easiest way to get a timetable agreed upon is to work backward with the Speaker and the Majority Leader. While the best outcome would be to have a bill to your desk by the August recess, a much more realistic goal is to have it pass both chambers and be in conference by that timeframe. (Attached is a one page legislative calendar that outlines such a scenario.)

   Although finalizing a conference agreement and passing it through both Houses will be extremely challenging, the most difficult hurdle will be getting the bills into conference. As such, the primary focus of your conversation should be on how best to get the bills out of the Committees and onto the respective chamber floors for a vote on an acceptable legislative product. (A background on this process is attached for your review.) Any significant delay in this process will serve to either make it impossible to complete Congressional action prior to adjournment or will produce a substandard product (because opponents will have greater leverage in undesirably modifying the bill.)

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2. Process Strategy to Work Within Timetable. There is no question that many House Members live in fear of being whip-sawed by the Senate if they are forced to move first and take a tough political vote on health care, particularly in this election year. They have no interest in witnessing a repeat of what they feel they went through in last year's budget process.

   To be responsive to the understandable concerns of the House, we recommend that you push the idea of a simultaneous, bicameral Committee and floor vote strategy. If the Senate Finance Committee, and thus the Senate as a whole, delays their action well beyond House Committee/floor action, we fear that there is a realistic possibility that the House will report out bills that they believe will not place them in a political vulnerable position (i.e., a significantly and unacceptably watered down bill).

There is little doubt that our simultaneous Congressional action recommendation conflicts with the institutional history of the Senate and the make-up of the Finance Committee, and it will be difficult to implement. Having said this, we believe it is still essential to attempt this because (1) we believe that a bill you are satisfied with might not be produced without this approach and (2) even suggesting it at least signals to the House that we are sensitive to their legitimate concerns.

Consistent with the concept of working concurrently with the Committees is a need to coordinate substantive policy modifications with the Committee Chairmen. If Committees report out completely opposite approaches, marrying the policy within the Rules Committee (and on the floor in the Senate) will be made extremely difficult. The only people who have a chance to even raise this Committee coordination concept with the Chairmen are their Leaders. We recommend that you raise this concept with Speaker Foley and Majority Leader Mitchell as something that seems desirable and ask them whether they believe it is feasible. **The optimal outcome from this proposal would be an agreement to establish a bicameral, Committee Chairmen coordination mechanism.** A chamber specific coordination approach would still be a great step forward.

3. Administration Role. It is important that you and the First Lady define the role you feel would be best to play throughout the legislative process, with a particular emphasis on the next two months or so. In so doing, you may wish to describe how you feel that the most useful contribution you can make to the work of the Congress is to keep the public debate focused on the fact that there is a health care crisis and that employer-based universal coverage is the only viable solution.

We would recommend that you reiterate that you have no desire or intention to micromanage the process because you feel it would be counterproductive for the Administration to be involved in the day to day actions/decisions of Committees. This does not mean the Administration is not engaged in the work of the Committees; it does mean, however, that it is a role that is primarily technical and behind the scenes until later in the process. You want to make sure, as we suspect is true, that they agree with this strategy.

4. <u>Preparation for Chairmen's Meeting</u>. The meeting should not conclude until you discuss how best to prepare for the next meeting with the Committee Chairmen. We would recommend that you seek their advice about the most appropriate timing, setting, and agenda of the Chairmen's meeting. You may also wish to solicit Leadership's assessment of where the Chairmen stand on the ability to report out comprehensive health reform bills.

IV. PARTICIPANTS

The President
The First Lady
Speaker Foley and his staff, George Kundanis
Majority Leader Mitchell and his Chief of Staff, John Hilley
Pat Griffin
Harold Ickes
Ira Magaziner
Steve Richetti
George Stephanopoulos
Melanne Verveer

V. SEQUENCE OF EVENTS

Members and staff arrive at 3:00.

The President opens up meeting and calls on the First Lady to make a few remarks about how appreciative she has been for all the past advice and how much we will need the Leadership's assistance throughout the upcoming challenging process.

The President briefly outlines the four agenda items that he would like to discuss and opens up the discussion with the Speaker and the Majority Leader.

VI. PRESS PLAN

Closed press. (White House photographer will be present.)

POSSIBLE HEALTH CARE TIMETABLE

January 1 to January 31

Activities:

- Committee Staff/Meetings with Administration (ongoing)
- **President convenes meeting with Leadership**
- State of the Union
- Hearings continue
- Meeting with Chairmen

February 1 to March 31

Activities: Recess: February 14 - February 22

- Hearings continue
- Subcommittee mark-up begins (House Committees)

April 1 to May 31

Activities: Recess: March 28 - April 10
May 27 - June 7

- House full Committee mark-ups
- Senate Finance and Labor Committee mark-ups
- Leadership reconciliation of different bills (if bills reported out)
- House Rules Committee mark-up

June 1 to June 30

Activities:

- House and Senate/House Rules mark-ups (if not done already)
- House floor consideration and final vote
- Senate floor amendment marriage (between Labor & Finance)
- Senate floor consideration

July 1 to August 14

Activities: Recess: July 1 - July 10
August 15 - September 6

- Senate floor vote no later than mid July
- House and Senate conference commences no later than late July

August 15 to October 7 (Target Adjournment Date)

Activities:

- Conference Report/House and Senate floor vote
- Final passage

CONGRESSIONAL ACTION PROCESS FOR HEALTH REFORM

Since health care legislative jurisdiction is divided among several committees in both the House and the Senate, it will be necessary for different, and perhaps conflicting approaches to be stitched together before legislation is brought to the full House and Senate for a vote in the spring. This process will require several weeks after the bill is reported from the committees. The process will require leadership both from the Administration and from Congressional leaders, but the Committees must also be permitted enough room to work out issues independently, and to win a majority in each committee. The Administration must avoid attempting to micro-manage at each Committee, while at the same time providing the technical support and prodding without which the process is likely to bog down.

In the Senate, Majority Leader Mitchell has the authority and responsibility to schedule the timing and substance of what is brought to the floor before the full Senate. In so doing, he (working closely with the Administration, Chairman Moynihan and Chairman Kennedy, as well as -- hopefully -- Republican Leader Dole) must decide what provisions will go into a Leadership amendment to the bill (S. 1757) pending on the Senate calendar.

As of this writing, it is unclear whether the Finance Committee and the Labor and Human Resources Committee will be able to work out an amicable agreement on a division of jurisdictional responsibilities. Regardless, the advantage we have going in is that the Majority Leader has very good working relationships with the two Committees and can be counted on to push the Chairmen and the Committees, to the degree necessary, to report out their versions of the legislation in a timely manner.

Should there be an unacceptable delay in reporting out the bill, the Majority Leader can always call up the bill directly off the Senate calendar, amend the bill himself and call it up for Senate consideration. (Obviously, this would not be the most preferable action because it would bypass the Committee process and signal a significant lack of consensus.) Under any scenario, at some point during Senate floor deliberation, Republicans will engage in a fillibuster. As a result, a 60 Member vote will be necessary to get to get final passage through the Senate.

In the House, the process will be managed by the leadership through the Rules Committee, which will determine what version goes to the floor, as well as the content and order of amendments that will be permitted on the floor. In the event that any one Committee is unable to report out a full version of the health care plan, the version going to the floor could reflect the high water mark rather than the least common denominator, with the burden then on the opposition to muster a majority to amend the package.

It would be ideal for the Committees to track each other closely, but if they are unwilling or unable to coordinate, the Rules Committee can still fashion a single new bill representing a negotiated agreement, if the leadership is willing to use the powers of the Rules Committee. Since the leadership has firm control over the Rules Committee, provided we maintain a majority in the full House, a bill could not be held hostage even if a problem develops in one or another committee. In the event that a Committee is unable to muster a majority to report the bill to the floor, the Rules Committee could report out a rule that would discharge the Committee from further consideration and clear the bill for floor consideration nonetheless.

Since a rule only requires a majority of votes, not unanimous consent or a supermajority, even substantial opposition would not present an insurmountable obstacle to floor consideration.

The process of reassembling a bill at the Rules Committee will involve many of the most significant decisions and the Administration will want to play a substantial role in the negotiations. To preserve our ability to help shape the final product sent to the House floor, it would be preferable to avoid making unnecessary commitments during earlier committee consideration. It is inevitable that many issues will be revisited when the bills are stitched together again by the leadership at the Rules Committee. At the same time, the Administration will need to provide constant prodding to keep the process moving along, and on many occasions, we will need to help committees develop alternatives to keep the process moving along.

Once the bills pass both Houses, the conference will represent another test for the Congress and the Administration. It is our expectation that the conference will last through the summer and into most of September. And, as is typical with the Congress, only the prospect of the end of the session and the pressure from Members desiring to adjourn to attend to reelection efforts will produce the conference agreement.

Our success in influencing the conference process will depend on the degree to which we were able to establish productive working relationships with the Committee Chairmen and the Leadership earlier in the legislative process. To the degree this occurs, the Chairmen will call on us to referee conflicting opinions and positions. It will also open the door for us to put pressure on the conferees to conclude the agreement prior to Congress going out of session.

MEMORANDUM

TO: Clinton Administration Health Team
FR: Chris Jennings and Steve Edelstein, Health Transition Staff
RE: Meetings/Outreach Report

DATE: January 24, 1993

During the last two months, the Health Policy Transition Team reached out to as many individuals and groups as possible who are interested in contributing to or affecting President Clinton's health care reform initiative. The outreach effort that I chaired was aimed at the various and multiple interests of the Members of Congress, the Governors and non-executive branch state and local governments, aging/long term care/prescription drug coverage advocates, small businesses, and pharmaceutical interests. Bruce Fried met with virtually every other interest group that does not fall under these categories. His report is being forwarded under separate cover.

Meetings were held with numerous individuals and/or organizations, either individually or in groups. The meetings had several purposes:

1. Informing individuals and/or groups about the structure and personnel of the Transition and the Health Policy Team.

2. Informing them about the President-elect's position on health care reform, basically a reiteration of the Campaign position.

3. Obtaining the views of the participants & making specific requests for their advice and recommendation on various policy issues. In all cases, those who expressed a concern about a particular issue were requested to provide their position and any alternative policy recommendation, in writing, to the Transition Team. Policy recommendations submitted by groups were forwarded to the group within the Health Policy Team for their consideration.

4. Focusing participants on high priorities, rather than laundry lists. Discussing the need for everyone to make contributions/sacrifices for health care reform to get enacted. In that regard, asking them to be part of the solution and not part of the problem. (Almost without exception, this message was heard and well received).

Files containing any pertinent notes on these meetings, or containing written materials submitted by the individuals or groups, are being transferred to appropriate offices within the Administration. A listing of the individuals and/or groups we met with, along with a brief summary of their general health care position, can be found on the following pages.

CONGRESSIONAL OUTREACH:

1. Congressional Leadership

Senate

George Mitchell, Senate Majority Leader
Bob Dole, Senate Minority Leader (through staff)
Senator Moynihan, Finance Committee Chairman
Senator Bob Packwood, Finance Ranking Republican Member (through staff)
Senator Kennedy, Labor and Human Resources Chairman
Senator Nancy Kassebaum, Labor Ranking Republican (through staff)
Senator Jay Rockefeller, Finance Medicare Subcommittee Chairman
Senator Dave Durenberger, Finance Medicare Subc. Ranking Republican
Senator John Chafee, Finance Medicaid Subc. Ranking Republican (through staff)
Senator David Pryor, Aging Committee Chairman and Secretary of the Senate

House

Speaker Foley (through staff)
Minority Leader Michels (through staff)
Richard Gephardt, House Majority Leader (through staff)
Newt Gingrich, Republican Whip (through staff)
Congressman Dan Rostenkowski, Ways and Means Chairman
Congressman Bill Archer, Ways and Means Ranking Republican (through staff)
Congressman John Dingell, Energy and Commerce Chairman
Congressman Norman Lent, E&C Ranking Republican (through staff)
Congressman Pat Ford, Labor and Education Chairman (through staff)
Congressman Pete Stark, Ways and Means Health Subcommittee Chairman
Congressman Henry Waxman, Energy and Commerce Health Subc. Chairman
Congressman Pat Williams, Labor and Education Subcommittee Chairman
(through staff)

Policy Positions: First, as it relates to the Democratic Leadership, there was a very encouraging willingness and desire to work in concert with the new Administration to develop a health reform proposal. As a sign of this cooperation, with the exception of one representative (Pete Stark), all agreed to hold off on introducing initiatives that could potentially signal that the Democrats were heading in conflicting directions.

The Democrats mentioned above, most particularly the two Majority Leaders, felt that the only way an inevitably controversial and complex health care reform bill could make it through the Congress would be for all or most of the Democratic Leadership

to get behind a relatively detailed and unambiguous health care proposal pushed by the new President. A process by which this could be achieved was established by the Transition Team. An agreement to have regular and substantive meetings was reached and, at the conclusion of the Transition, many of these meetings were deferred until the major health care players of the new Administration were in place.

Although there are widely varying opinions on how to proceed with health care reform, the likelihood of success in achieving a sufficient amount of support in the Congress for a Clinton health reform plan seems good as long as careful and consistent consultation takes place among the members and particularly the leadership. In preparation for the Committee Chairman's meeting with the then President-elect, a brief memo on their current reform positions was drafted and is attached for your review. In addition, a detailed summary of the Senate Finance Committee members background in the health care area, which was produced for Secretary Shalala for her confirmation hearing is also attached for your use.

2. Outreach to Rest of the Congress:

Senator Max Baucus (Dem. - Montana)
Senator Jeff Bingaman, (Dem. - New Mexico)
Senator David Boren, (Dem. - Oklahoma) through staff
Senator John Breaux (Dem. - Louisiana) through staff
Senator Tom Daschle (Dem. - South Dakota)
Senator Bob Kerrey (Dem. - Nebraska)
Senator Howard Metzenbaum, (Dem.- Ohio)
Senator Donald Reigle (Dem. - Michigan) through staff
Senator Paul Wellstone, (Dem. - Minnesota)
Senator Harris Wofford (Dem. - Pennsylvania)

Congressman Mike Andrews (Dem. - Texas)
Congressman Xavier Becera (Dem. - California)
Congresswoman Cardiss Collins (Dem. - Illinois)
Congressman John Conyers (Dem. - Michigan)
Congressman Jim Cooper (Dem. - Tennessee)
Congressman Kika de la Garza (Dem. - Texas)
Congressman Harry Johston (Dem. - Florida)
Congressman Jim McDermott (Dem. - Washington)
Congressman Robert Menendez (Dem. - New Jersey)
Congressman Solomon Ortiz (Dem. - Texas)
Congressman Bill Orton (Dem. - Utah)
Congressman Bill Richardson (Dem. - New Mexico)
Delegate Carlos Romero-Barcelo (Dem. - Puerto Rico)

Congresswoman Lucille Roybal-Allard (Dem. - California)
Congresswoman Louise Slaughter (Dem. - New York)
Congressman Charles Stenholm (Dem. - Texas) through staff
Congressman Louis Stokes (Dem. - Ohio)
Congressman Mike Synar (Dem. - Oklahoma)
Congresswoman Nydia Velasquez (Dem. - New York)
Congressman Ron Wyden (Dem. - Oregon)

Congressional Black Caucus
Congressional Hispanic Caucus
Senate Rural Health Caucus

Policy Positions: Obviously there is and there will continue to be a wide range of opinions relating to national health reform amongst this group. Almost without exception, however, these particular members are committed to achieving the goals of cost containment and universal access. In attempt to reach out to all members of Congress, regardless of their past or current positions, the Transition Team sent a memorandum to every member soliciting . suggestions and the names of key staff contacts.. This communication was extremely well received, particularly among the Republicans.

STATE AND LOCAL INTERESTS:

1. Governors

National Governors' Association

Governor Lawton Chiles (Dem. - Florida)
Governor Howard Dean (Dem. - Vermont)
Governor Jim Florio (Dem. - New Jersey)
Governor Roy Roemer (Dem. - Colorado)
Governor John Waihee(Dem. - Hawaii)
Governor David Walters (Dem. - Oklahoma)

Policy Positions: Governors have a great interest in working collaboratively with President Clinton in the development of a health care reform proposal. Their priorities are that any proposal contain significant state flexibility in terms of state administration, cost containment, and personnel and technology distribution. Those states who have comprehensive state-wide reform proposals in place consistently argued that efforts aimed at passing a national reform initiative should not hinder the development of state plans. The transition team, in consultation with the NGA, incorporated the governors and their representatives into the policy work groups that were established. Lastly, although not related to comprehensive reforms, almost all Governors would also like to see immediate Medicaid financial and administrative relief provided to the states.

2. **Other State and Local Officials**

Association of Attorneys General
American Public Welfare Association
City Managers Association
National Association of Counties
National Association of State Treasurers
National Association of Towns and Townships
National Caucus of Black State Legislators
National Conference of State Legislatures
National League of Cities
U.S. Conference of Mayors

State Senator Robert Connor (Rep. - Delaware)
State Representative Art Hamilton (Dem. - Arizona)
State Representative Tom Mason (Dem. - Oregon)
State Representative Karen McCarthy (Dem. - Missouri)
State Senator Cindy Resnick (Dem. - Arizona)
State Representative David Richardson (Dem. - Pennsylvania)

Policy Positions: Policy positions extremely similar to the Governors. However, they strongly believe that they have an important and unique perspective, separate and apart from the Governors that should be incorporated into the policy development process.

AGING/LONG TERM CARE/PRESCRIPTION DRUG ADVOCATES:

1. **Consumer Groups**

Alzheimer's Association
American Association of Retired Persons
Consumers Union
Families USA
National Association of Area Agencies on Aging
National Committee to Preserve Social Security and Medicare
National Council of Senior Citizens
National Council on the Aging

In addition, met in group settings with:

The Leadership Council of Aging Organizations (32 national aging organizations)
The Long Term Care Campaign (representing 137 cooperating Organizations
Save Our Security (representing over 100 organizations)
Generations United (representing numerous aging and children's advocates)

Policy Positions: Almost without exception, all of these visible and potentially powerful interest groups are assuming that there will be a prescription drug benefit for both the under and the over 65 population. (They repeatedly cite Clinton campaign pledges to make this happen). They also are relatively confident, based on campaign rhetoric, that strong drug cost containment be applied to these benefits so that beneficiaries and taxpayers are not saddled with overwhelming premium costs. They are so certain that the drug benefit coverage and cost containment campaign pledges will be met that they did not even spend much time lobbying for them.

The primary two-pronged theme emerging from these meetings is that long term care cannot be forgotten, so don't assume that a drug benefit will suffice. Once again, they cite campaign pledges to meet the long term care need. The room for compromise in these groups' positions with regard to long term care is that it can be phased in over a period of time. In fact, it appears that most would be satisfied with a home health benefit, which includes personal care assistance services for the disabled, that sets up a process as to how to deal with the institutional (nursing home) long term care shortcomings in the current system.

2. Provider Groups

National Association for Home Care
American Health Care Association (Nursing Homes)
American Association of Homes for the Aging
National Institute on Adult Daycare

Policy Positions: The long-term care provider groups generally support health care reform. None are strongly wedded to a particular approach. Instead, they are looking to win points from their accommodating position on health care reform which they can parlay into the inclusion of some kind of long-term care program as part of the health care reform effort. Most would accept a less than comprehensive long-term care benefit if it contained some coverage for the services provided by their membership. The only significant exception to the above, is that home care providers are now strongly advocating the inclusion of home care services within any minimum benefit package for the under 65 population.

SMALL BUSINESS INTERESTS:

National Association of Life Underwriters (Insurance Agents)
National Federation of Independent Businesses
National Small Business Legislative Council
National Small Business United
U.S. Chamber of Commerce

Policy Positions: A sizable segment of the small business community will oppose any reform plan that includes a mandate. They view it as an unwarranted intrusion by government on the operation of their business. But the response of the majority of small businesses will hinge very strongly on the timing of the phase-in schedule, particularly the relation of the mandate to implementation of cost controls. Small businesses will complain most bitterly if the mandate precedes any significant effort to reign in private market insurance costs. They may offer grudging support for the plan if cost controls are in place prior to the mandate.

In a significant recent development, the National Small Business Legislative Council has signaled their willingness to consider a mandate if the cost issue is adequately addressed and small businesses are not unduly burdened (i.e. they receive sufficient subsidies). However, Small Businesses United, previously considered the more liberal small business group has not indicated any change of their position in opposition to a mandate, instead favoring a broad surtax on income to finance expanded access to health care. the most visible and influential small business advocacy group is without question the National Federation of Independent Business. Although our meetings with them have been non-confrontational and constructive, it is highly unlikely they will see it in their interest to support any health care plan that includes an employer mandate.

The National Association of Life Underwriters is particularly concerned with the role of independent insurance agents after the reform plan goes into effect. They fear that with health insurance purchasing cooperatives, the role of independent insurance agents will be obsolete and most will be forced out of business. They have suggested the purchasing cooperatives be permitted to contract out with agents to sell the approved policies.

PHARMACEUTICAL INTERESTS:

1. **Drug Manufacturers**
   Merck
   Johnson and Johnson
   Pfizer
   Schering Plough
   SmithKlineBeecham
   Syntex
   Eli Lilly
      Searle
      Marion Merrel Dow

Policy Positions: The industry has initiated conversations about a voluntary drug price agreement in which drug manufacturers would keep their price increases to at or below the general inflation rate. It is their desire to use this proposal as a substitute for much more intrusive and unappealing government cost containment intervention. They also have come out in support of the concept of managed competition as another market-based and acceptable approach to containing costs. Merck and a few other companies acknowledge that their remain outstanding issues on their voluntary price constraint proposal including a lack of an enforcement mechanism, an assurance that all companies would enter such an agreement, and the a concern that the price constraints would not be extended to all purchasers, particularly non-managed care purchasers. The industries infatuation with the voluntary agreement and managed competition does little or nothing to address and contain the prices of new drugs. This is particularly the case with new drug products that have no therapeutic alternatives and for which there can be no competition.

2. **Generics**
   Generic Pharmaceutical Industry Association
   National Association of Pharmaceutical Manufacturers
   National Pharmaceutical Alliance

Policy Positions: These associations, representing numerous generic companies, do not want to be singled out as the bad guys of the pharmaceutical industry. They argue persuasively the they are not contributing to drug price inflation. Their primary request is to insure that they be treated differently than the name brand manufacturers and, in fact, protected to insure that they continue to provide a cost-effective alternative to name brands. They obviously do not have major concerns about limitations on new drug prices.

3. **Biotech Interests**

Industrial Biotechnology Association
Roche Pharmaceuticals
T Cell Sciences, Inc.
Novo Nordisk
Genetech, Inc.
Synergen, Inc.

Policy Positions: The biotech industry has one primary concern related to drug prices: the regulation of prices of new drug products. They feel that any such regulation will not only constrict but may eliminate them as an industry because they live or die on their ability to produce new products over the next several years.

4. **Pharmacists**

American Pharmaceutical Association
American Society of Consultant Pharmacists
National Association of Chain Drug Stores
National Association of Retail Druggists

Policy Positions: These organizations represent a relatively diverse and comprehensive cross section of the nation's pharmacists. They have yet to agree on a unified position but in general all agree that a minimum benefit package should cover pharmacist services. they argue that such services are cost effective because they assure appropriate compliance and help guard against expensive adverse drug reactions. They also appear to be moving toward a position that at least on a temporary basis assures that all pharmacists who provide covered services are protected from being excluded by insurers attempting to contract with selected individual pharmacists.

5. **Purchasers**

Group Health Association of America
American Society of Hospital Pharmacists

Policy Positions: These groups, like other hospital or HMO based purchasers requested that any health reform protect their ability to continue to negotiate using manged competition methods, such as the use of drug formularies. They therefore oppose the use of a provision like the Medicaid "best price" law to contain the cost of any other purchaser such as Medicare (they fear that a requirement to provide the best price to the Medicare program wil harm their ability to negotiate freely with drug manufacturers). Lastly, one cannot have a discussion about prucahsers without mentioning consumers, please refer to aging/long term care/prescription drug advocates section above.

MENTAL HEALTH INTERESTS:

American Academy of Pediatrics; American Psychiatric Association
American Psychological Association
Child Welfare League of America
Mental Health Law Project
Mental Health Policy Resource Center
National Alliance for the Mentally Ill
National Association of Community Health Centers
National Association Psychiatric Treatment Centers for Children
National Association Social Workers
National Council of Community Mental Health Centers
National Mental Health Association

Policy Positions: The mental health groups (the Mental Health Liaison Group--a coalition of 25 plus groups, including the American Psychiatric and Psychology Associations, National Alliance for the Mentally Ill, National Mental Health Association--supports nondiscrimination between mental health and other health benefits for patients and are focused on eliminating what they feel are the artificial limits, e.g., 20 visits, etc, on counseling type services. Note that the National Alliance for the Mentally Ill believes that the health reform plan must focus first on the most needy and severely ill.

Groups insist on the importance of coordinating national reform with existing federal, state and local community health systems. To build capacity in communities to meet mental illness needs, they recommend: expanding mental health block and PATH grants, using community mental health block grants to enhance state integrated comprehensive service plans for individuals, improving community services with demo programs, and developing processes to assure coordination of CMHS services development and support.

MEMORANDUM

FROM: Bruce Fried

RE: Transition Health Policy Group Outreach Effort
Positions of Various Groups

DATE: January 24, 1993

During the Transition, the Health Policy Team aggressively reached out to virtually every sector interested in reform of the nation's health care system. Meetings were held with the following organizations, either individually or in groups. The meetings had several purposes:

1. Informing groups about the structure and personnel of the Transition and the Health Policy Team.

2. Informing groups about the President-elect's position on health care reform, basically a reiteration of the Campaign position.

3. Obtaining the views of the groups and making specific requests for their advice and recommendation on various policy issues. In all cases, groups which expressed a concern about a particular issue were requested to provide their position and any alternative policy recommendation, in writing, to the Transition Team. Policy recommendations submitted by groups were forwarded to the group within the Health Policy Team for their consideration.

Files containing notes on these meetings with additional materials are being transferred to appropriate offices within the Administration. Summary of interest group positions follow.

Chris Jennings has prepared a similar memorandum covering meetings he had with pharmacuetical interests, small employer groups, states, Congress, aging advocacy organizations and long term care groups.

LABOR

AFL-CIO
Service Employees International Union
AFSCME
United Auto Workers
National Education Association
International Ladies Garment Workers Union
Retail, Wholesale, and Department Store Union
Building Trades Department, AFL-CIO
Communications Workers of America
Teamsters
American Federation of Teachers
United Mine Workers of America

Policy position: Labors position is fairly straightforward. In order to secure labor support, the Clinton health plan must have a means of achieving a real, enforceable budget, must have a mechanism for achieving universal access, and must assure a high-standard for quality care. Union presidents advised that they are willing to go to their members for additional taxes, but advised that they will aggressively oppose the taxation of health care benefits.

Many unions have special concerns. For instance, the UAW and the Steelworkers are concerned about the problems of retiree health coverage both from the perspective of their retired members and from that of their employers who are being required to post unfunded health care obligations as liabilities.

DISABILITY GROUPS

The Arc
Epilepsy Foundation of America
United Cerebral Palsy Association
American Speech-Language-Hearing Association
American Psychological Association
National Association of Developmental Disabilities Councils
American Congress of Rehabilitation Medicine
AIDS Action Council

Policy Positions: The primary concern of disability groups in the design and details of the core benefit package. As they put it, health care reform should be "non-discriminatory," should have comprehensive benefits, provided in an appropriate manner, with financing and other burdens being equitable.

The focus on managed care is a particular concern, the fear being that in a managed care environment, the special needs of people with disabilities could be lost or ignored.

These groups are particularly concerned about and opposed to an Oregon style approach to resource allocation.

HEALTH CARE ADVOCATES

National Senior Citizens Law Center
National Health Law Program
Families USA
Health Care for America
National Leadership Coalition for Health Care Reform
Healthcare Leadership Council

Policy Positions: The two law groups have specialized expertise in the health care needs for low-income Americans, particularly with how the current system operates in the real world.

The National Leadership Coalition and Health Care for America are both coalitions committed to comprehensive health care reform. NLC is better established with business, labor, provider and consumer participation (including Families USA). Its position is close to that articulated during the Campaign. HCA is a vestige of the Kennedy health care effort. While not as well positioned as NLC, its has a large number of important groups among its members. HCA's position will allow it to be supportive of the President's efforts.

Families USA is an effective advocacy group with sophisticated grass roots and communications abilities. It will support the President's position with particular attention to the coverage issues.

The Healthcare Leadership Council is a coalition of large insurers, pharmaceutical companies and for-profit hospitals. The organization opposes global budgeting and supports a tax cap on benefits in excess of the core benefit package. They would use revenues from the tax cap to expand access. They are strongly in support of managed competition as articulated by the Jackson Hole Group.

SINGLE-PAYOR ADVOCATES

American Public Health Association
Church Women United
Citizen Action
Consumers Union
Graphic Artists Union
International Brotherhood of Teamsters
National Association of Social Workers
National Council of Senior Citizens
National Farmers Union
National Hispanic Council on Aging
Neighbor to Neighbor
NETWORK: A National Catholic Social Justice Lobby
Oil, Chemical, and Atomic Worker Union
Physicians for a National Health Program
Public Citizen
United Cerebral Palsy Associations
United Church of Christ, Office of Church in Society
United Electrical Workers

Policy Positions: The single-payor advocates basically wish that the President would support their position. Since he does not, they would like for their to be sufficient flexibility in the enacted reforms so that the states can adopt a single-payor system. Most of these groups recognize that they share the President's objectives and will set aside their ideology to support the President so long as those objectives are not abandoned.

RELIGIOUS

Interreligious Health Care Access Campaign
- National Council of Churches
- United Church of Christ
- United Methodist Church
- Evangelical Lutheran Church in America
- Church Women United

US Catholic Conference

Policy Position: These groups are very committed to universal access. While other issues (financing, quality, etc.) are important, universality is primary. The USCC is also fundamentally committed to progressive reform, but is also opposed to inclusion of abortion services in the core benefit package. The groups are not generally focused on the specifics of the President's position, though many in the IHCAC are single-payor advocates. The church groups have not been particularly effective as health care advocates, but might be helpful as the debate becomes more real.

CHILDREN'S HEALTH ADVOCATES

- Children's Defense Fund
- Child Welfare League
- Association of Maternal and Child Health Programs
- National Association of Children's Hospitals and Related Institutions
- National Commission to Prevent Infant Mortality
- March of Dimes Birth Defects Foundation
- Association for Care of Children's Health
- The Alan Guttmacher Institute
- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American Nurses Association
- American Public Health Association
- American Speech-Language-Hearing Association
- Association for Retarded Citizens
- American Association of University Affiliated Programs
- Health and Medicine Council of Washington
- National Association of Community Health Centers
- National Center for Clinical Infant Programs
- National Council of Community Hospitals
- U. S. Catholic Conference -- Department of Social Development
- Virginia Perinatal Association
- Women's Legal Defense Fund

Policy Position: These groups are primarily concerned with the inclusion on child specific health benefits (pre- and neo-natal care, well baby care, immunizations, etc.) in the benefit package. Other issues include universal coverage, access to medical care, and the problems in the Medicaid program.

MINORITIES

- NAACP
- National Urban League
- National Council of La Raza
- National Hispanic Advisory Committee on Health
- National Congress of American Indians
- Cherokee Nation
- National Indian Health Board

Policy Positions: All groups were primarily concerned with universal coverage, with other important issues being quality and cost containment. None of the groups were particularly focused on the President's plan, except that the Indian groups were concerned about the implications for the Indian Health Serviceand meeting the needs of very poor and very rural populations. Hispanic groups are concerned that a managed care model that does not address

the needs of a population that often shies away from contact with official offices will still not have access to care.

ALCOHOL AND DRUG ABUSE

National Association of Alcoholism and Drug Abuse Counselors
Coalition for the Prevention of Alcohol Problems
American Academy of Family Physicians
National Coalition to Prevent Impaired Driving
Center for Science in the Public Interest

Policy Position: These groups were focused on inclusion of alcohol treatment in the benefit package, and supportive of a major increase in taxes on alcoholic beverages dedicated to health care improvements.

EMPLOYERS -- LARGE

National Association of Manufacturers
    including Alcoa
Washington Business Group on Health
National Retail Federation (both large and small employers)
IBM
General Motors
Acme Steel
Bethleham Steel
Inland Steel
LTV
National Steel
Wheeling-Pittsburgh Steel
American Iron and Steel Institute
Erisa Industry Committee
Pepsico
Association of Private Pension and Welfare Plans
Johnson & Johnson

Policy Positions: Large employers are not monolithic in their position. The mature industries (auto, steel, etc.) are supportive of health care reforms which effective control costs, assure universal coverage, incent quality care. Others are opposed to the imposition of budgeting strategies. This opposition is essentially ideological, though real problems are presented in how an effective budgeting approach could be developed and implemented.

Most large employers are supportive of the managed competition strategies articulated by the President -- insurance reform, pooling for small purchasers, increased use of managed

care delivery systems. Many support a tax cap on benefits, but would protect the tax advantage for the employer, making excess benefits taxable as income for employees.

The vast majority of large employers self-insure and will want to protect their ability to self-insure in a reformed health care system. Several groups have been asked to make policy recommendations on how self-insurance could be maintained without damaging the President's plan. As of this date none have been received.

INSURERS

Health Insurance Association of America

Policy Position: After regularly opposing any kind of comprehensive reform, HIAA now has staked out what can be considered a negotiating position. On access HIAA would require employers to offer, but not pay for, a plan, and offer payroll deduction so that employees can purchase the coverage. A gradual phase in of a mandate might be acceptable. On cost containment, HIAA's position is that providers must use uniform rate setting methods with all payors. On HIPCs, HIAA likes existing association type schemes. Believes HIPCs should be tried but should compete against other pooling arrangements. Want federal preemption of state anti-managed care laws. Support a tax cap. Opposed to budgeting.

Large Insurers:

Aetna
Prudential
Cigna
Travelers
Metropolitan Life Insurance Company

Policy positions: These very large companies generally support managed competition strategies, favor expanded managed care (all are deeply into managed care), favor HIPCs (but should be exclusive), favor a tax cap, oppose global budgeting, and support insurance reform (ban on preexisting condition exclusions, community rating but with geographic and age bands, single claims forms). They favor tort reform. They are concerned about the impact of a mandate on small employers and that subsidies could lead to rate suppression. All these companies are members of the Health Leadership Council and HEAL, coalitions which support "pure" managed competition. Travelers preferred to keep controls on the public sector and let managed competition be tested in the private sector. Travelers is also a leader in electronic data and will soon have terminals at every provider in CT. Health Policy Alternatives have been retained by these companies to see if a budgeting mechanism can be found to work with managed competition.

Mid Range Insurers:

Massachusetts Mutual
New York Life
Mutual of Omaha
General American Life
Phoenix Home Life

Policy Position: These companies are all members of HIAA and generally support its position. Many are in the small group and individual market and are concerned about loosing that business. New York Life made a very effective presentation that managed competition is essentially a change in the market with a focus on employees/consumers. Their entire marketing is targeted to employers/purchasers. NYLife argues that the Clinton plan should not take employers out of this picture in making coverage purchase decisions. It argues that insurers be allowed to operate outside HIPCs but be subject to all the same rate and access regulations. NY Life argues (like some of the larger insurers) that association coverage should be permitted under a new plan. Mutual of Omaha supports an employer mandate. MoO prefers an all-payor system to budgeting given the complexity of budgeting. MoO has a position similar to NY Life, supporting allowing insurers to play outside a HIPC but with the same regulations so that it can sell to individuals. MoO raised concerns about the solvency of insurers is small insurers drop out and the number of covered lives is expanded.

BlueCross BlueShield Association

Policy Position: BC/BS has a more progressive position than their commercial counterparts. They support 1) insurance reform (rating/preexisting condition bans), increased managed care, administrative simplification, 2) moving the market to community care networks with obligations that the percentage of people in AHPs increase each year. Also would require employers to continual increase %age employees in AHP each year in order to keep their deduction. 3) cost containment -- may support targets with triggered caps: see IOWA plan

Dental Insurers

Delta Dental Plans

Policy Position: Two concerns: 1) tax cap may have unintended consequences. In CA only 21% of teachers elected to take dental coverage with after tax dollars;2) if dental is part of core benefit package it should be priced realistically ($9-10/ month/person)

Supplemental Insurers

American Family Life Assurance Company (AFLAC)

Policy Position: AFLAC expects to do well in a reformed system since it focuses coverage on benefits not normally covered by a primary insurance plan. Would be well positioned to be a supplemental insurer for benefits not covered by the core benefit package.

Miscellaneous

Independent Insurance Agents of America

Policy Position: Concerned about their future in HIPCs. Point to federal flood and crop insurance programs as ones where independent agents play a role. No position on tax caps. Asked for input on forms and administrative simplification.

Self Insurance Institute

Policy Position: This group is focused on retaining the ability of employers to self-insure. Size of HIPCs are a big concern. This group prefers smaller. Also not opposed to mandatory coverage. They were asked to provide recommendations on how self-funding could be meshed with managed competition. Nothing has been received as of this date.

PHYSICIANS

American Medical Association
Policy Position: The AMA's position is set out in Health Access America. It calls for an essential benefits package for all, universal pay-or-play coverage, competitive market based strategies to control costs while protecting the right to choose providers, ban on preexisting condition exclusions, and tort reform. Also favor community rating, taxation of benefits above a "benchmark", small group reforms, and administrative simplification. AMA opposes global budgeting.

American College of Physicians
Policy Position: ACP's positions are very close to the President's. ACP supports a global budget, pay-or-play universal coverage, ban on preexisting condition exclusions, community rating, outcomes research and practice guidelines, control of technology.

American Academy of Family Physicians
Policy Position: Very similar to ACP.

American Academy of Pediatrics
Policy Position: Urge that coverage be phased in by covering children and pregnant women first. Also, benefits package should be child sensitive, recognizing that children are not "little adults." AAP supports a one tier system. Also recommends that HCFA develop an RBRVS for children (was in tax bill, needs no legislative authorization.)

American Society for Internal Medicine
Policy Position: ASIM supports a tax cap. Also believes access should not take a back seat to cost containment, and supports an employer mandate. Opposes global budgets, but prefers flexible goals if necessary. Strongly supports increased focus on primary care.

National Medical Association
Policy Position: Supports a single-payor system

Society on General Internal Medicine
Policy Position: A single-payor group, mostly academic, very progressive. Support mandates and budgeting.

Physicians Who Care
Policy Position: Supports maintenace of fee-for-service medicine. Opposes managed care reimbursed on capitated basis.

American Academy of Opthomology
American College of Obstetricians and Gynecologists
American College of Preventive Medicine
American College of Surgeons
American Psychiatric Association
College of American Pathologists
Society of Thoracic Surgeons

NON-PHYSICIAN PROFESSIONALS
American Nurses Association
American Chiropractic Association
American Dental Association
American Psychological Association
American Optometric Association
American Podiatric Medical Association
American Association of Nurse Anesthetists
American Physical Therapy Association
American Academy of Physician Assistants
American Association for Marriage and Family Therapy
American Occupational Therapy Association
American Speech-Language-Hearing Association
American College of Nurse Midwives
Association of Minority Health Professions
Employee Assistance Professionals Association

Policy Positions: These groups have a variety of positions on different issues. They share a concern that non-physician health care professionals be assure of appropriate roles in a new health care system. Concerns run not only to issues of licensure and reimbursement but also to coverage of their services (i.e., chiropractic care, mental health services) in the core benefit package. Some groups such as the ANA have detailed positions or principles on various system design issues. Most are concerned about their members ability to provide care in the new system.

HOSPITALS

American Hospital Association
Policy Position: AHA has a well developed reform proposal entitled: A Healthier America through Community Care Networks. This plan is similar in many ways to the President's position on managed competition. It calls for coverage of a core benefit package in a pay-or-play system. Its networks are similar to the delivery reform/managed care approach. AHA is concerned that managed competition will drive hospitals to be lowest-priced vendor and threaten the mission orientation. Might support budgeting if "bottom up", based on capitated payment system. Strongly urge anti-trust reforms to permit easier collaboration/coordination by hospitals.

Catholic Health Association
Policy Position: Has a very progressive plan, very similar to the President's except has favored a single-payor approach. Now moving to more of a managed competition strategy but with a mandate for employer coverage, budget caps, delivery reform though capitated payments. Interesting in that plan starts with an articulation of values and builds delivery and financing from their.

Federation of American Health Systems (for-profit hospitals)
Policy Position: Very supportive of Conservative Democratic Forum plan. Supports a tax cap. Absolutely opposed to rigid budgeting. Opposed to mandate due to alliance with small employers through HEAL. Major player in HEAL and Health Leadership Council.

American Healthcare Systems Institute
Policy Position: Supports elimination of medical underwriting. Wants a tax cap. Wants medicaid expansion to cover the uninsured. Wants tort reform. Wants equivalent funding for training of primary care and specialty doctors. Wants practice guidelines. Oppose global budgets. Supports CDF managed competition plan.

St. Joseph's Hospital (on Ethics)
Policy Position: These religious based hospitals and systems are mission oriented, and generally are supportive of the President's direction on health care reform.

Columbia Hospital Corporation
Policy Position: This for-profit system has a position similar to FAHS's.

American Association of Osteopathic Hospitals
Policy Position: Concerned about survival of these often small hospitals in a managed competition setting where AHPs are likely to contract with traditional MD oriented institutions.

Methodist Health Systems
American Protestant Health Association
Riverside Methodist Hospitals
Lutheran General Health Systems
Miami Baptist Hospital
InterHealth
National Association of Children's Hospitals and Related Institutions
Voluntary Hospitals of America

MANAGED CARE PROVIDERS

Group Health Association of American
American Managed Care and Review Association
American Association of Preferred Provider Organizations
Kaiser Permanente
FHP, Inc.
United Healthcare
US Health Care
Healthcare Compare
Foundation Health

Policy Position: GHAA supports managed competition. It is concerned that typing tax deductibility to the lowest AHP premium may encourage "low-balling." HIPCs should be exclusive for small employers, should be non-profit and not allowed to self-insure. The term "manged care" should be defined by statute, with an HMO component (they prefer the Medicare definition per Title 18, section 1876.) They recommned the basic benefit package under the federal HMO act for the President's benefit package.

AMCRA generally supports the CDF approach to managed competition.

Kaiser supports managed competiton and made several points on HIPCs: They would have HIPCs cover small and mid-sized employers, individuals and part-time employees, Medicaid beneficiaries. HIPCs should be exclusive. There should be one per market. HIPC should cover 200,000 to 500,000 lives.

REHABILITATION

National Association of Rehabilitation Facilities
National Rehabilitation Coalition

Policy Position: These groups are focused almost exclusively on having rehabilitation services included in the core benefit package.

LONG TERM CARE

Home Care Coalition

- Health Industry Distributors Association
- American Federation of Home Health Agencies
- American Association for Respiratory Care
- The Oley Foundation

Policy Position: This coalition of providers and consumers supports increased delivery of health care in the home. Wants benefits and delivery system to permit and encourage greater use of home care in the health care system.

LABORATORIES

MetPath

Policy Position: Concerned that doctors are padding laboratory charges. Would like for laboratories to be able to direct bill patients.

OTHERS PROVIDERS

Ad Hoc Hispanic Health Care Providers and Policy Experts
COSSMHO-- Coalition of Hispanic Health and Human Services Provider
Wellness Councils of America

MISCELLANEOUS

American Heart Association

Policy Position: No position on health care reform beyond general principles which would permit support for the President's plan. Major focus on the need for increased medical research.

SUPPLIERS

Health Industry Manufacturers Association

Policy Position: Most concerned with FDA and its failure to make decisions regarding new technologies. Also concerned with global budgets.

National Association of Medical Equipment Suppliers
National Association for Infusion Therapy

Policy Position: Both these groups are concerned that the core benefits package include coverage for their services.

ADMINISTRATION/ELECTRONIC DATA PROCESSING/FINANCING

American Health Information Management Association
Health Care Financial Management Association
Joint Commission for the Accreditation of Healthcare Organizations
GMIS , Inc.

Policy Position: Each of these groups has specialized expertise in various aspects of health care financing, financial and health data processing, quality assurance, and overall administration. Each can offer valuable information in their areas of focus.

RESEARCH/ACADEMIA

Association of Independent Research Institutes
Association of American Medical Colleges
American Federation for Clinical Research
Association of Minority Health Professions Schools
Association of Academic Health Centers
Association of Schools of Allied Health Professions
Federation of American Societies for Experimental Biology
Howard University
National Coalition for Cancer Research
Cystic Fibrosis
Arthritis Foundation
American Society of Tropical Medicine and Hygiene
AIDS Action Council
Merck
Alliance for Aging
Johns Hopkins University
American Society of Microbiology
Hereditary Disease Foundation

Policy Position: General concern about research funding, role and leadership of NIH, and similar research oriented issues.

RURAL INTERESTS

National Rural Health Association
National Association of Rural Electric Cooperatives
Communicating for Agriculture

Policy Position: These groups are especially concerned about reform of the delivery system. Their concerns focus on the lack of managed care in rural communities and the resulting inability for managed competition to function successfully; the urgent need for health care professionals and institutions in many small communities; the need for increased funding for

the National Health Service Corps and community health centers. Additionally, CoA is supportive of risk pools as a means of assuring affordable care for agricultural families, given the high cost of coverage for these high-risk workers.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Dole, Chafee Visit Following Senate Democrats Meeting (1 page)	2/4/93	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:
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Chris Jennings (Health Security Act)
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FOLDER TITLE:
January 1993 HSA

gf73

RESTRICTION CODES

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

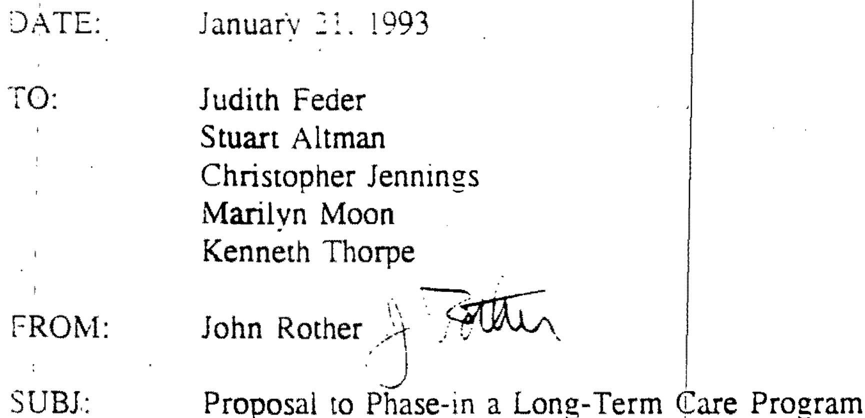
P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the 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]

MEMORANDUM



DATE: January 21, 1993

TO: Judith Feder
Stuart Altman
Christopher Jennings
Marilyn Moon
Kenneth Thorpe

FROM: John Rother

SUBJ: Proposal to Phase-in a Long-Term Care Program

Over the past several weeks, AARP staff, with comments from members of the long-term care policy and advocacy community, have continued to refine our proposal for phasing-in a comprehensive, social insurance LTC program. The proposal has been revised to reflect the comments we received. It represents our most recent thinking as to how this important endeavor might be accomplished.

The basic structure of the proposal has not changed significantly. Notable differences between the attached draft and the earlier version include changes in:

- **the definition of eligibility** (the proposal now begins by providing services to people who require assistance with 3+ ADLs, as opposed to people who are limited in 3+ ADLs);

- **protection for nursing facility residents with low incomes** (financial protection will extend to people with incomes below 300 percent of poverty, not 425 percent); and

- **the phase-in of benefits and the cost-sharing amounts that beneficiaries would have to pay** (fuller benefits are extended much earlier to people with low incomes).

The attached draft has also been revised to reflect concerns of the disability community.

Program cost-estimates are presented in constant 1994 dollars. In addition, these estimates now present federal and state costs separately. To facilitate comparison with the tables accompanying the memo of Dec. 10, tables reflecting nominal costs are available upon request. You will note that this version does not include detailed options for financing the program. Additional details on financing may be found in the documents that you received from AARP on December 3.

We appreciate your interest in this critical issue and would be happy to discuss the proposal with you in greater detail.

DRAFT (Jan. 21 -- 8:00)

PROPOSAL TO PHASE-IN A LONG-TERM CARE PLAN

Overview

The Medicaid program was not originally intended to provide long-term care for all Americans, yet it now constitutes the primary vehicle for the provision of long-term care in the United States. Moreover, in order to have access to long-term care services through Medicaid, many families must face financial ruin.

A long-term care system should be based on a social insurance model, and ultimately become part of Medicare, not Medicaid. The system should be integrated with Medicare to promote better care management. It should be broadly financed and available to all individuals who need it, avoiding the stigma of the current welfare-based Medicaid system. It should provide a uniform federal benefit to people of all ages who meet specified disability criteria. This federal benefit should be administered by the states, under federal guidelines. States should be encouraged, however, to set up innovative demonstration projects.

In fact, **a federal long-term care program provides an ideal opportunity for the development of a care managed** system that ultimately could integrate acute and long-term care on a larger scale for those receiving the most expensive care. Care management already is widely used in state long-term care systems. In order to ensure equity, it is important that people who request long-term care services be assessed for eligibility using nationally uniform criteria. In a care managed system, those people who meet the eligibility criteria would then be authorized to have a plan of care developed.

Such a system can help to control costs in a meaningful way. Care management provides one cost-containment mechanism. In addition, Medicare Parts A and B already are equipped to provide cost-containment models that could be adapted to long-term care. Institutional care should be provided through Part A, and home and community-based care through Part B.

Among the most critical shortcomings of the current Medicaid long-term care system are its requirement for spend-down, institutional and medical bias, and limited eligibility. The first steps of any long-term care plan should be to begin to move long-term care services into the Medicare program, to eliminate the spend-down requirement and to expand the scope of care provided in the home and community. This proposal presents one possible model for phasing-in a reformed long-term care system.

Key Features

This proposal is designed to address nine key features:

1. Gradually move long-term care coverage from Medicaid to Medicare, eliminating the spend-down requirement. (Personal care would be covered under Part B, nursing facility care under Part A.)

2. Make comprehensive coverage, including home and community-based and nursing facility services, available to people of all ages.

3. Assess eligibility based on age-appropriate, nationally uniform criteria.

4. Build cost-containment mechanisms into the program's structure from the beginning, through care management and rate-setting.

5. Build and improve upon the existing structure for long-term care delivery, expanding substantially home and community-based care. More fully integrate the delivery of services along the continuum of acute, transitional, and long-term care.

6. Develop a structure for the delivery of a managed long-term care system, tied initially to a relatively small eligible population. One priority in the development of a managed system would be the expansion of social health maintenance organizations (SHMOs), particularly in metropolitan areas.

7. Maintain benefit flexibility from the program's inception through the provision of a comprehensive array of benefits.

8. Provide a role for the states in managing the provision of long-term care.

9. Target services first to persons most in need. Such targeting can be achieved by: (a) beginning with home and community-based services, (b) directing services to people with severe impairments, (c) providing the greatest benefits first to Medicaid recipients and the poor, and (d) phasing-in nursing facility coverage over a longer period of time.

Step 1 *Establish a care management system.*

Currently, all states provide some form of home and community-based long-term care services under their Medicaid programs -- either through the personal care benefit, waiver programs, or both. **A first step toward implementing a national long-term care program could be to require each state to establish a care management system.** The funding for this care management system would be provided through *Medicare*. Initially, this care management system would aid the delivery of services to Medicaid long-term care beneficiaries. As a comprehensive program for providing long-term care (LTC) to all people with disabilities unfolds, subsequent steps would be to expand LTC care management to all current Medicare beneficiaries, and finally to all other participants, as they become eligible for the program.

Step 2 *Implement a personal care benefit under Medicare Part B.*

The ultimate goal of a personal care benefit would be to maximize the independence and autonomy of people with disabilities and enhance their ability to remain in the home or community. The benefit also should be designed to enable caregivers -- family and friends -- to continue to provide care. In order to meet these goals, a comprehensive array of benefits will be necessary. However, it is possible to phase-in the new personal care program gradually.

What should be included in a personal care benefit?

- The specific services offered through a personal care benefit would be established on an individual basis in consultation between the care manager and the client. **The array of services available through the personal care benefit should include help with activities of daily living, homemaker services, cueing or reminding, rehabilitative and restorative care, nursing, respite care, transportation, minor home adaptations or repairs, and other needed services.**

- Much greater emphasis would be placed on serving people in supportive housing arrangements in an effort to prevent unnecessary institutionalization. In order to ensure an adequate supply of supportive housing settings, such as assisted living, board and care, and congregate housing, it will be necessary to explore financing options that encourage the development of high quality, licensed facilities.

- Many of these community-based services already are provided to dually eligible individuals (i.e., Medicare-Medicaid beneficiaries) and paid for by the Medicaid program.

- Gradually, the funding for these services would be shifted to Medicare Part B.

Who would be eligible for the personal care benefit?

- Tracking the development of the care management system, **eligibility could be phased-in, beginning with two groups: (a) people who are currently eligible for Medicaid, and (b) people with incomes below poverty. Eligibility would subsequently be extended to people who are currently eligible for Medicare, and finally to all other persons not currently covered by either program.**

- As a first step, eligible individuals should include: (a) people who require human assistance with three or more activities of daily living (ADL); or (b) people with cognitive or mental impairments who require substantial supervision; or (c) children who are unable to perform an age-appropriate activity of daily living. Over time, coverage should be extended to people who need human assistance with 2 or more ADLs, people who are limited in multiple instrumental activities of daily living (IADL) and ultimately to all people with significant disabilities. (These additional costs are not reflected in Table 1.)

- Throughout the phase-in period, Medicaid would continue to serve all persons who meet Medicaid eligibility criteria, including special criteria for waiver services, but may not meet the eligibility criteria of the new program. It is anticipated that all such persons would be served under the new Medicare program when it is fully phased-in. For example, many states currently use Medicaid waiver programs to cover special populations such as disabled children and persons with AIDS. It is anticipated that such coverage would continue throughout the phase-in.

- A possible phase-in schedule is illustrated in Figure 1 in the Appendix.

How would people access the system?

- People who request services under this program would first have their eligibility assessed by a care management agency. A uniform assessment tool would be used. If found eligible, the care manager, in cooperation with the individual and/or his representative, would develop a plan of care. The care plan would be developed in consultation with the individual's primary care physician, and would build in regular communication in order to enhance integration of the acute and long-term care systems. The care plan would be comprehensive, and the care manager would authorize the services for which the individual is eligible, including nursing home care, when appropriate. (In early phases, some benefits might not be "covered" for

the purposes of payment, but should, nevertheless, be in the individual's care plan.) Clients would have the right to appeal care plan decisions.

- The personal care benefit should be fully portable. For example, within reasonable financial limits, the beneficiary would choose in which setting to receive care: an individual's home or workplace, an adult day care center, or a board and care home or other assisted living facility.

- A possible area for controlled demonstrations would be in the development of a voucher, coupon book, or service credit-type system. While some individuals would prefer to have a care manager assist them in locating and coordinating their care, other people might prefer to receive a voucher, credit, or coupon-book that they could use to purchase services on their own. Such demonstrations might be particularly appropriate for some adult disabled populations or in rural areas where the availability of home care agencies is limited. Vouchers could only be used by the individuals to whom they were awarded: they could not be sold or transferred. These coupons could specify the type and amount of services for which the individual is qualified, and set cost caps for each service category.

How would cost-containment and quality assurance be addressed?

- **States would have to work within a budgeted system in providing home and community-based LTC.** State budgets for elderly beneficiaries would be pegged to 65 percent of the average cost of nursing facility care in the state. Additional research would be needed to establish appropriate percentages for other populations. States would, in turn, establish aggregate budget targets for care management agencies. A care manager could authorize services above the target for heavy need clients, provided aggregate expenditures did not exceed overall targets.

- Appropriate fee schedules for services would be developed. The use of some form of case-mix or outcomes-based reimbursement for providers should be considered. Demonstrations of prospectively financed packages and capitated systems should also be tried.

- A study should be undertaken to evaluate various methods of reimbursement, including fee schedules, outcomes-based reimbursement, case-mix reimbursement, and capitation.

- Qualified home care agencies would bid competitively to gain approval to participate in the new program. Criteria used to select agencies would include cost and quality indicators.

- The current quality assurance system would be enhanced and expanded in order to provide oversight of service delivery and of the care management process. Strong quality assurance measures can result in cost-savings by preventing the development of conditions such as pressure sores that may require more costly acute medical care. Improvements would include the development of national standards for care managers and expansion of ombudsman programs. Attention should also be paid to enhancing the professional standards and training of providers.

How would the personal care benefit be phased-in?

- **In order to phase-in the benefit gradually, it would be possible for Medicare to begin by covering 40 percent of the cost of care authorized in the care plan during the second year. In subsequent years, this percentage could be increased to 50 percent, then 60 percent, 70 percent and, finally, 80 percent of the cost of the benefit.**

- Beneficiaries of the new program who are not covered by Medicaid would receive a gradually increasing benefit, as Medicare began to pay a larger share of the cost of services received. Because of the relatively small benefit in the initial years, some individuals may be unable to purchase the full array of services for which they are eligible. However, when fully implemented, the 20 percent coinsurance should be affordable for most persons. **Medicaid could continue to subsidize the remaining costs for low-income individuals.**

- **The premium cost for Medicare Part B would be kept at 25 percent of program costs.** While this would result in higher premiums for beneficiaries, the service package would be expanded in a meaningful way.

How would income be protected?

Because the full cost of long-term care in the home and community can be quite high for an individual, a cap on out-of pocket expenditures should be established. People with incomes below poverty should have their costs fully covered by Medicaid. People with incomes between 100 and 300 percent of poverty should have lower out-of-pocket caps, established along a sliding scale. Income protection could be phased-in gradually. (See Figure 1.) As income groups are covered, they would be eligible for the full benefit package. Income protection mechanisms should be crafted to assure equitable treatment of both single and married individuals.

How much would the program cost?

The cost of this proposal is illustrated in Table 1 in the Appendix. It should be noted that these estimates do not account for the fact that 25 percent of program costs would be financed by the Medicare Part B premium. As such, total state and federal costs would be somewhat lower. Costs are presented in constant 1994 dollars. **(Costs presented in nominal dollars, which include the effects of inflation, are available upon request.)**

Step 3 *Provide nursing facility care under Medicare Part A.*

Once the system for providing home and community-based long-term care is well underway, nursing home coverage would be transferred from Medicaid to Medicare Part A. Ultimately, nursing home coverage would be available for those persons who meet the eligibility criteria, regardless of age or type of disability. The Medicare benefit could be phased-in to cover increasingly large percentages of the cost of nursing facility care. (See Figure 2 in the Appendix for an illustration of a possible phase-in schedule.)

- The care management process established for the delivery of home and community-based care would also pertain to the assessment for and delivery of nursing facility care. Preadmission screening by the care managers would prevent unnecessary institutionalization and target nursing facility care to those persons for whom it is required. Ongoing assessment by care managers would monitor nursing facility residents to ensure that the appropriate quality and level of care are being received. Residents who are able to leave nursing facilities for less restrictive environments would be assisted in finding alternatives to nursing homes.

- As with home and community services, currently-eligible Medicaid recipients would continue to receive nursing home coverage through Medicaid while the program is being phased-in; however, a gradually increasing share of the cost of their care would be covered by the Medicare program. Throughout the phase-in period, people who meet Medicaid eligibility criteria, but are not yet phased-in under the new program, would continue to receive coverage under Medicaid. It is anticipated that all such persons would ultimately be covered by the new Medicare benefit.

- In the first year of nursing facility coverage, Medicare might cover 10 percent of the cost of nursing facility care under Medicare Part A. This percentage would be increased annually, until it reached **65** percent of the cost of care. Over time, current nursing facility residents (financed by Medicaid or private payment) would be replaced by persons covered by a federal benefit under Medicare Part A. In this way, the role of Medicaid in the provision of long-term care would be reduced to covering the out-of-pocket costs of low-income individuals and Medicaid-eligible persons with disabilities who do not meet the criteria of the new program, as it is being phased-in.

- Rate setting for Medicare payment to nursing homes, analogous to the prospective payment system (PPS), would be a critical component of cost-containment under this proposal.

Financial protection for nursing home residents.

Because of the high cost of nursing home care, it will be necessary to provide some financial protection for people with low and moderate incomes. Financial protection would be necessary to ensure the ability of nursing home residents to support a spouse or dependents in the community. In addition, comparable mechanisms would be needed to protect a single individual's ability to return home after a limited nursing home stay. These measures would need to be extended beyond the current Medicaid-eligible population. Medicaid should fully cover out-of-pocket costs for people with incomes below poverty. As the benefit is phased-in, Medicaid should also cover a portion of out-of-pocket costs for people with somewhat higher incomes, according to a sliding scale. As with home and community-based care, financial protection mechanisms should ensure equitable treatment of single and married persons.

Program costs.

The cost of this proposal is illustrated in Table 2 in the Appendix. As with the cost figures for home and community-based care, costs are presented in constant 1994 dollars. **(Costs presented in nominal dollars, which include the effects of inflation, are available upon request.)**

Make transitional care part of the acute care system.

The long-term care system should be coordinated with the acute health care system as much as possible. In order to do so, transitional care (such as skilled nursing care that follows a hospital admission) should be part of a mandated benefit package provided by whichever insurance entity provides the individual's medical care. For example, in a system in which all employers provide a standard package of medical care and unemployed individuals receive care through a federal program, provision of transitional care would be the responsibility of either the employer or the federal program, as appropriate.

A necessary step would be to reform the current Medicare coinsurance for skilled nursing facility (SNF) care. The SNF coinsurance should be set at 20 percent and its link to the hospital deductible should be severed. (Note: We are not recommending elimination of the three-day prior hospitalization requirement until the care management system is ready to control admission to nursing homes.)

Step 4 *Integration of care management.*

If the long-term care program is to be part of a system in which medical care is provided through managed care organizations, it would be ideal to ultimately merge the two components. The managed care networks would be responsible for the provision of long-term care as well as acute medical care. State experimentation with innovative models such as On Lok or social health maintenance organizations (SHMOs) should be encouraged, subject to modifications based on lessons learned from first generation evaluations. One goal would be to establish at least one SHMO in each metropolitan area by the time the home care benefit is fully phased-in.

Step 5 *Long-term Care Insurance.*

Because this proposal envisions an incremental phase-in of the Medicare long-term care benefits, there will be a continuing role for private long-term care insurance. Standard LTC insurance packages designed to wrap-around the Medicare personal care and nursing facility benefits should be designed. It also is critical that strong federal standards for long-term care insurance policies be enacted next year in order to afford strong consumer protection.

Step 6 *Financing.*

The phase-in of the long-term care program may be adjusted according to the stream of financing available. The following principles should apply to the financing of a long-term care system.

- Financing of the system should be broadly based and shared across age groups.
- A portion of any savings achieved through cost-containment in the current Medicare system should be immediately channeled into the development of the long-term care program.

It should be noted that the proposal described here assumes that 25 percent of the cost of the personal care benefit will be financed through the Medicare Part B premium.

Conclusion

When fully implemented, it is envisioned that this proposal would result in a universal program of long-term care that is well integrated into a reformed health care system. Long-term care would be available to all who need it, regardless of age, work history, or type of disability. The use of a care managed system would address two important goals: assuring integrated service delivery and containing costs.

Appendix

FIGURE 1

PHASE-IN SCHEDULE FOR HOME AND COMMUNITY-BASED CARE PROPOSAL

Year	Percent of Care Plan Covered	Eligible Population	Income Protection Available
1994	100%	Persons requiring active human assistance with 3+ ADLS with income less than 100% of the poverty level	Persons with income less than 100% of poverty level
1995	40%	Medicare eligible persons requiring active human assistance with 3+ ADLS	Persons with income less than 125% of poverty level
1996	50%	All persons requiring active assistance with 3+ ADLS	Persons with income less than 125% of poverty level
1997	60%	All persons requiring active assistance with 3+ ADLS	Persons with income less than 150% of poverty level
1998	70%	All persons requiring active assistance with 3+ ADLS	Persons with income less than 175% of poverty level
1999	80%	All persons requiring active assistance with 3+ ADLS	Persons with income less than 200% of poverty level
2000	80%	All persons requiring active assistance with 2+ ADLS	Persons with income less than 225% of poverty level
2001	80%	All persons requiring active assistance with 2+ ADLS	Persons with income less than 250% of poverty level
2002	80%	All persons requiring active assistance with 2+ ADLS	Persons with income less than 275% of poverty level
2003	80%	All persons requiring active assistance with 2+ ADLS	Persons with income less than 300% of poverty level
2004	80%	All persons requiring active assistance with 2+ ADLS	All persons
2005	80%	All persons requiring active assistance with 2+ ADLS	All persons

Income Protection Schedule

Income as a Percent of the Poverty Level	Monthly Out-of-Pocket Cap
<100%	$0
100-125%	$50
125.1-150%	$100
150.1-175%	$150
175.1-200%	$200
200.1-225%	$250
225.1-250%	$325
250.1-275%	$400
275.1-300%	$475
300.1% or more	$550

FIGURE 2

PHASE-IN SCHEDULE FOR NURSING FACILITY CARE PROPOSAL

Year	Percent of Care Plan Covered	Income Protection Available
1994	Current Law	Current Law
1995	Current Law	Current Law
1996	Current Law	Current Law
1997	100%	Persons with income less than 100% of poverty level
1998	10%	Persons with income less than 125% of poverty level
1999	20%	Persons with income less than 150% of poverty level
2000	30%	Persons with income less than 175% of poverty level
2001	40%	Persons with income less than 200% of poverty level
2002	50%	Persons with income less than 225% of poverty level
2003	60%	Persons with income less than 250% of poverty level
2004	65%	Persons with income less than 275% of poverty level
2006	65%	Persons with income less than 300% of poverty level

Income Protection Schedule

Income as a Percent of the Poverty Level	Monthly Out-of-Pocket Cap
<100%	
100-125%	[illegible]
125.1-150%	$100
150.1-175%	$150
175.1-200%	$200
200.1-225%	$300
225.1-250%	$425
250.1-275%	$575
275.1-300%	$750
300+%	$862

• Only single persons and married couples where both spouses are in a nursing facility are subject to this schedule. Married residents with a living spouse or dependent in the community are permitted to set aside $1,790 per month as an allowance for the community-based dependent.

TABLE 1

HOME AND COMMUNITY-BASED CARE WITH 20 PERCENT COST-SHARING
FULL PHASE-IN WITH INCOME PROTECTION *
(In billions of 1994 dollars)

Year	Public Program	Net Addtl Public	Net Addtl Federal	Net Addtl State
1994	$13.0	$3.0	$2.6	$0.4
1995	16.7	6.5	6.7	-0.2
1996	19.5	9.0	9.3	-0.3
1997	22.5	11.7	12.0	-0.3
1998	25.8	14.7	14.9	-0.2
1999	28.9	17.4	17.5	-0.1
2000	35.6	23.7	23.1	0.6
2001	36.9	24.7	23.8	0.9
2002	38.1	25.6	24.5	1.1
2003	39.5	26.5	25.3	1.2
2004	41.2	27.9	26.1	1.8
2005	42.4	28.7	26.8	1.9

SOURCE: Lewin-ICF estimates. See Figure 1 for details of proposal.

* These estimates are for the cost of the program. It should be noted that the proposal calls for 25 percent of the costs of the personal care benefit to be financed by the Medicare Part B premium, paid by individuals.

TABLE 2

NURSING FACILITY CARE WITH 35 PERCENT COST-SHARING AND LOW INCOME PROTECTION FOR TWO YEARS FULL PHASE-IN WITH INCOME PROTECTION

(in billions of 1994 dollars)

Year	Public Program	Net Addtl Public	Net Addtl Federal	Net Addtl State
1994	$36.0	$0.0	$0.0	$0.0
1995	37.4	0.0	0.0	0.0
1996	38.8	0.0	0.0	0.0
1997	45.2	4.9	5.2	-0.3
1998	55.2	13.4	13.0	0.4
1999	61.2	17.8	18.5	-0.7
2000	68.3	23.3	24.2	-0.9
2001	74.8	28.1	29.2	-1.1
2002	82.2	33.7	34.4	-0.7
2003	89.0	38.7	38.9	-0.2
2004	94.6	42.5	42.1	0.4
2005	98.7	44.5	43.7	0.8

Current law public spending.

SOURCE: Lewin-ICF estimates. See Figure 2 for details of proposal.

J. ROY ROWLAND
8TH DISTRICT, GEORGIA

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January 27, 1993

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

I am pleased that President Clinton has established a national health care reform task force and that you will chair this panel. I feel that basic changes need to made in our health care delivery system, and the role of this task force will be crucial as health care reform legislation is developed.

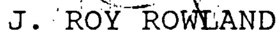
As the plan is developed, many difficult decisions will have to be made in order to solve our health care problems. I am pleased to hear that you plan to meet with many different interest groups and experts to receive their perspective on this issue.

In this regard, I offer my assistance. Having been a family physician for 28 years in rural Middle Georgia, as well as a State Representative for three terms, prior to my service as a Member of Congress, I feel that I hold a dual perspective about health care policy that may be helpful in providing useful information to this process.

For ten years, I have been working on health policy at the Federal level. At the beginning of the 103rd Congress, I was elected Chairman of the House Veterans' Affairs Hospitals and Health Care Subcommittee, which provides care for 2.6 million veterans annually. I also serve as a Member of the House Energy and Commerce Health Subcommittee, which deals with all issues related to health care, except Part A of Medicare.

Mrs. Clinton, I want you to know of my willingness to assist in developing a solution for our nation's health problems that we as a people can afford. I wish you and the Task Force much success.

Sincerely,



J. ROY ROWLAND

PRINTED ON RECYCLED PAPER

THE WHITE HOUSE

February 19, 1993

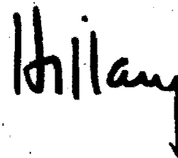
Dear Representative Rowland:

Thank you for your thoughtful letter regarding the health care reform task force.

As both a policymaker and family physician, you are well aware of the enormous challenges we face. I am grateful for your offer of assistance and hope that you will share with us your views on how we may achieve our goal of providing affordable health care to every American.

I look forward to working with you.

Sincerely,



The Honorable J. Roy Rowland
United States House of Representatives
Washington, D.C. 20515

Redesigning Public Policies to Make Private Markets Work Better: The Case of Smaller Firms

by

Lynn Etheredge

National Academy of Social Insurance Conference
Washington, DC
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(Revised)

Revised
12/93

Social welfare strategies that rely on health insurance and pension benefits provided by employers and assisted by federal tax subsidies are failing tens of million of workers in small firms. The intensification of problems with health insurance for small groups has helped propel health insurance reform to the top of the political agenda. Furthermore, the private pension system also faces serious shortcomings in covering these people. Because over one-half of those in the private sector workforce work for firms with less than 100 workers, these shortcomings constitute major failings of social welfare policy.

Other papers in these proceedings address the use of tax subsidies, mandates, means-tested programs, and social insurance taxes to finance more health and pension coverage. But subsidies alone have proved less effective for workers in small firms than for those of larger firms. This paper focuses on the factors that limit market performance and suggests the need for structural reforms if private health insurance and pension plans are to play a large role.

In the health insurance arena, the reform debates have produced proposals for a nationwide system of "Health Plan Purchasing Cooperatives" (HPPCs)that would radically change the health insurance market for a majority of the population. These new HPPCs (now often referred to as "health alliances") are a central feature of the "managed competition" approach that President Clinton endorsed during his campaign. This paper discusses the HPPC concept and, in the spirit of this conference of examining together the problems and solutions of health and pension systems, it suggests similar market reforms -- Pension Plan Purchasing Cooperatives (PPPCs) -- to improve the private pension system. Both approaches could be combined with a variety of financing strategies to offer broader consumer choice among health insurance and pension options.

Coverage of Small Firm Workers

Over the past decade or more, some of the early successes of employer-based, tax-subsidized coverage have reversed. The percentage of employers offering pension insurance coverage declined from 61% in 1979 to 55% in 1990, while the proportion of workers included in such employer plans fell from 49.5% to 42.9%. In 1990, over 68 million workers had no pension coverage. [1] In health insurance, the proportion of the nonelderly population who were uninsured rose from 12.3% in 1978 to 16.6% in 1992. In 1992, 37 million persons had no health insurance coverage. [2]

Market-based strategies have been least successful in assuring coverage for workers in the millions of small firms -- donut shops, gas stations, beauty parlors, restaurants, and the like. Although estimates from different sources vary, there is no disagreement about the relation of benefits to firm size.

Proportion of Private-Sector Workers Whose Employers Offer Health Insurance and Retirement Benefits, By Firm Size, 1988 [3]

Firm Size	Workers	Health insurance	Retirement benefits
250+	38.4 million	90%	83%
<100-249	6.3	88%	62%
25-99	11.1	78%	47%
<25	21.1	46%	18%

In effect, the nation now has a two class system of health and pension benefits for workers, and employees of small firms are most often in the second class system. [4] Nearly three-quarters of private workers without pension coverage work in firms with fewer than 100 employees, and nearly two-thirds of those without health insurance are in such firms or are self-

employed. [5] Dealing with the special barriers to coverage of these workers will be central in improving private pension and health insurance coverage.

Beyond the direct consequences of inadequate health and pension coverage for economic security, access to health services, and retirement incomes, these patterns have broad implications for social equity and economic policy:

• Equity In general, workers for smaller firms do not benefit from federal tax subsidies to the same extent as workers for larger firms. This difference has large economic consequences for these groups. In 1993, the net exclusion of pension contributions and earnings is estimated to account for general revenue losses at the federal level of $56.5 billion, and the exclusion of health insurance contributions by employers to $46.4 billion -- a total of $102.9 billion. [6] Not only are tens of millions of workers for small firms (and their families) excluded from this assistance because their employers do not offer such coverage, but also they help finance the benefits of these other workers.

• Economic consequences Flaws in the private health insurance and pension systems also impair labor mobility and savings. Polls now report that one in five workers say they or members of their families are subject to "job lock" because they fear losing affordable health insurance coverage.[7] Workers are also reluctant to shift jobs because of the inadequate portability of pensions and the potential loss of contributions under vesting rules. These issues seem likely to impinge most on the ability of small firms to attract workers since they are least likely to offer these benefits. Moreover, because these small firms account for a growing part of the economy - and thus opportunities for benefits are relatively scarcer - workers are likely to become even less mobile. Indeed, one could make a case that fully portable health and pension

coverage is essential to a smoothly functioning labor market, and, on these grounds alone, should be a top objective of reform.

Poorly-functioning markets for retirement savings may also be implicated in the inadequate U.S. personal savings rate. A rise of even 1 or 2 points in the annual savings rate, which is now about 5 percent, would make significantly more funds available for investment and economic growth. Availability of better savings arrangements, along with portability of pensions, will likely be increasingly important as the "baby boom" generation enters its high earning (and retirement savings) years.

Health Insurance Reforms

What special problems does private health insurance coverage pose for employees of small firms? A long list of factors helps to explain why "laissez faire" markets have not produced satisfactory results.[8] Four major shortcomings could be rectified by public policies.

• Medical underwriting and exclusions for pre-existing conditions Traditional community-rating for small employers has virtually collapsed, and insurers now routinely use medical screening and underwriting practices. Insurers refuse to cover pre-existing conditions, screen out high-risk employees, and limit benefits to compete against each other on the basis of risk selection rather than on the basis of cost control, quality and consumer satisfaction. With such market practices and the resulting variations in premiums, health insurance coverage may not be affordable, or even available. The individual small employer and consumer simply lack the market presence to fight these practices.

• <u>Administrative expenses</u> High marketing costs, broker commissions, and other expenses, together with firms' switching of insurance coverage and workers' switching of jobs, drive up administrative expenses for small firms. These expenses average 35-40% of health benefit costs for firms with fewer than 10 employees, compared with 5-6% for employers of over 10,000 workers. The administrative hassles employers and employees face in changing coverage impose additional costs. Both groups have a legitimate grievance if they must purchase coverage from a market so poorly designed that it consumes this much of their premiums in administrative expenses. Taxpayers also have a legitimate grievance if they must subsidize such expenses.

• <u>Ineffective regulation</u> As the health insurance market for small groups disintegrated, neither the federal government nor most state governments took adequate preventive or remedial action. Lack of knowledge and ideas about solutions has not been the problem. But devising effective regulatory interventions to police hundreds of insurance companies in their relationships to millions of very small firms has posed insurmountable political and practical problems.

• <u>Limited consumer choice</u> Consumers in small firms lack broad, well-informed choices in the health insurance market. Typically, a small firm will offer only one or two options, plans are not standardized so comparisons are impossible to make, and, as yet, data on quality are not routinely available to permit consumers to compare health insurance plans.

Can we design a better health insurance system for individuals working for small firms?

The HPPC Model - A Brief Summary [9]

The Health Plan Purchasing Cooperative (HPPC) model, designed to achieve a "radical reform of the health insurance industry" (President Clinton's phrase), uses public policy to address these problems on behalf of the majority of Americans who work for small firms. HPPCs will consolidate employer, worker, and government health insurance contributions, offer consumers choices among standardized health plans that are accountable for competing on the basis of cost, quality, and patient satisfaction, and manage competition among these plans on behalf of its members.

Name:	Health Plan Purchasing Cooperatives
Sponsors:	Quasi-government, non-profit, governing board representing membership
Number:	One per geographic area, e.g. MSA, major market area, or state Exclusive offerer of basic insurance for small business in area
Coverage:	Small employers <100 (perhaps to <1,000, <10,000, or universal) Individuals outside the workforce, part-time workers Medicaid recipients, perhaps Medicare
Financing:	Covered employers and employees required to purchase nationally standard health insurance plan through HPPC Administrative expenses paid from premiums
Functions:	Issues RFPs for standardized plans that include: Standard benefits Standard premium structure (modified community-rating) Standard data reporting, e.g. outcomes/quality data Guaranteed issue/open enrollment/portability No pre-existing condition exclusions for continuously insured persons Other "qualified carrier" criteria established by HPPC Selects plans to be offered, contracts with insurers Sets standard employer contribution rate, based on cost of economical plans Distributes marketing material to small business employees, operates annual "open season" Handles Medicaid "buy-ins", COBRA continuity, coordination among HPPCs Manages competition among carriers, e.g. through risk adjusters, negotiation

Today's system, which relies on willingness and ability of each small firm to arrange, offer, and manage coverage, would be replaced by a system that largely eliminates the role of the employer. A smaller firm would simply contribute a dollar amount for its covered workers to the HPPC. Individuals would sign up for health insurance through the HPPC and choose among the competing plans it offers. Coverage would be fully portable when an employee shifted jobs among participating employers, or moved on and off Medicaid. HPPC proposals aim to structure a market system that works at least as well for workers in small firms and self-employed individuals as it does for the largest, most sophisticated purchasers. A notable prototype is the Federal Employees Health Benefits Program.[10] A HPPC could combine the purchasing power of upwards of 1 million or more people in negotiating on behalf of its enrollees.

This arrangement redesigns competitive markets to work better for the public than the current system does. It is intended to assure affordable, high quality, and seamlessly portable coverage, eliminate medical underwriting, screening and experience rating, reduce administrative expenses, obviate the need to police many bad actors, and offer a range of quality choices to informed consumers.

The HPPC model is compatible with, and can enhance, consumer choice regardless of which financing sources are involved. The Medicaid program, for example, could purchase coverage through HPPCs to assure quality care and portable coverage for its beneficiaries, and eliminate the economic "notch" as individuals move between welfare and private employment. The HPPC structure can also be used to provide Medicare enrollees with expanded choice to purchase other coverage, as well as qualified Medigap plans. The California Garamandi bill,

ColoradoCare, and a proposed West Virginia plan all combine tax-based health care financing for the entire population with a HPPC structure to focus competition and allow consumer choice.

Extending a HPPC Model to Pensions

In many ways, the nation's system of retirement income is better developed than its health insurance system. Most of the population has been covered by the Social Security system since 1935, with mandated employer and employee contributions; since 1974 pension plans have had to meet standards including fiduciary responsibility, management and reporting, government oversight, and public back-up insurance, and they have also faced limits on tax-favored employer contributions. For health insurance, in contrast, the degree of coverage, employer and employee financial shares, basic standards for health insurers, and limits on tax-favored employer contributions are still very much at issue.

Yet it is already clear that the coverage of workers in small firms for pensions is so much worse than for health insurance that rethinking these market arrangements is also imperative. Smaller firms fail to offer pensions for much the same reasons that they fail to offer health insurance. In both instances, the experience of the past decade has been dismal, and the list of contributing factors is very long. In this light, any argument that tax subsidies for voluntary employer contributions, offered alone, will work better in the future than they have in the past calls for heroic assumptions.

Five elements of the problem suggest that restructuring markets would improve the situation:

• Nature of the product Retirement funds work best as long term arrangements, with reserve build-ups from contributions over many years, plus substantial interest earnings on these balances, to produce income decades into the future. Particularly for workers in firms and in occupations with high turnover rates, it seems irrational to have to rely on a succession of pension plans, with differing provisions and limited portability, to patch together an adequate retirement income. An on-going pension plan, which can receive payments from successive employers, seems better-designed for the high job mobility that characterizes the typical American worker and for substantial retirement-age balances.

• Firm turnover The problem of short-term employment arises, in part, from the volatility of business formation and failure. Smaller firms have accounted for about 80% of new jobs since the 1970s, but they have also accounted for about 80% of job losses. [11] About 50% fail within their first five years, and the uncertainty that many of them will be around for very along makes it less likely that they will trouble to set up a company-based pension system. Such benefits usually imply some confidence that the firm will be around and that employees can plan a longer-term career. About 1/2 of the small firms that do offer pension plans were in operation at least five years before adoption of such a plan.

• Employee turnover Smaller firms also tend to have a higher rate of employee turnover. For example, waiters and waitresses, kitchen workers and short order cooks, cashiers, hotel clerks, child care center workers, garage and gas station -- occupations typical of small businesses -- have median tenures of less than three years. [12]

• <u>Choice</u> Pension plans offered by small firms do not usually involve individually directed investment. Moreover, when benefits are provided through a company's own stock (an employee stock ownership plan), employees may be exposed to high risk.

• <u>Administrative hassle:</u> Finally, small firms are less equipped to confront the complexities of learning about, setting up and administering pension plans. To experts, setting up a simplified employee pension (SEP) may seem quite manageable, but smaller firms do not have benefit managers, and the time and energy of the owner may be better invested in running the company. Anything more customized than such a plan requires much more sophistication and paperwork. Furthermore, pension laws, regulations, and reporting requirements change frequently, thus adding to a firm's compliance costs.

Isn't it possible to design a better pension system for workers in smaller firms? Wouldn't it be simpler to have market arrangements in which one has a permanent pension account, to which each employer, as well as the employee, contributes? Couldn't this account also be fully vested and completely portable, with minimal hassles and with broad consumer choice among a number of quality products?

<u>A Pension Plan Purchasing Cooperative (PPPC) Model</u>

Extending the proposed HPPC model to pensions -- a Pension Plan Purchasing Cooperative (PPPC) model -- would achieve these reforms. Indeed, an HPPC and a PPPC might be the same institution. A viable PPPC might be conceived in several ways. One such model is outlined below.

Name: Pension Plan Purchasing Cooperatives
Sponsors: Quasi-government, non-profit, governing board representing membership
Number: One serving each geographic area
Non-exclusive offerer of retirement benefits
Coverage: All workers not now offered employer-sponsored retirement benefits
Financing: All employers required to offer automatic payroll deduction option to a PPPC account for workers not covered by an employer-sponsored pension plan. Worker deducts this PPPC contribution on his/her own tax return, receives same tax advantage as enrollees in employer-sponsored plans.
Administrative fees paid from revenues.
Functions: Issues RFPs for retirement plans, including annuities, mutual fund families allowing self-directed investments
Selects plans to be offered, using criteria such as fiscal soundness, investment performance, customer service; contracts with offerers
Distributes comparative marketing material to eligible employees, covering future benefits & rates of return, financial risk, customer service
Collects contributions
Distributes contributions to the individually-selected retirement funds
Coordinates among other PPPCs to assure national portability and continuity as individuals move to other geographic areas
Assures overall management responsibility

There are three key differences between the HPPC and PPPC models described here.

• Number and exclusivity HPPCs should be exclusive offerers in an area to prevent health insurers from competing by "skimming" risks rather than through cost, quality and consumer satisfaction. PPPCs do not face the same constraint and need not supplant arrangements employers already offer. Although HPPCs usually should be organized on a state or sub-state basis because health plans compete by health market area, a PPPC might be state-based, or even multi-state in scope.

• <u>Coverage</u> HPPC buy-ins for medium-to-large firms must be either mandatory or subject to a carefully-constructed set of rules to prevent the HPPC being selected mostly by high-cost firms. This selection issue does not seem to apply to PPPCs, and they can be open to any worker not covered by an employer pension plan. In this way, every worker could be assured of equal access to a payroll-withholding financed, tax-favored retirement plan.

• <u>Financing</u> Workers with a PPPC account should be accorded the same tax advantages as workers with an employer-sponsored pension plan. This tax equity can be achieved by allowing workers to deduct PPPC contributions on their tax returns, like Keogh and IRA contributions. The combination of payroll deductions, tax advantages, immediate vesting, universal portability, and choice of first-rate plans should encourage many uncovered workers to take advantage of PPPC plans - particularly as uncovered members of the baby boom generation confront the inadequacies of their future social security benefits.

Just as there are functioning prototypes for a HPPC (the federal employees health insurance program and CalPERS), there is a national prototype to show now a PPPC would work in practice. The Teachers Insurance and Annuity Association (TIAA), which covers primarily college and university employees and non-profit institutions, provides each enrollee with a personal retirement account. The employing institution simply makes a payment to this account for its employees, in lieu of setting up a separate pension system. Employees may supplement these amounts through additional payroll withholding. All contributions are vested immediately and are fully portable among the participating institutions. With TIAA, institutions do not incur the expense of managing their own pension funds. TIAA is supplemented by options for purchase of shares in a stock mutual fund (College Retirement Equities Fund) and for life insurance. Why shouldn't smaller firm workers also have a system that is this good?

As with HPPCs, a PPPC concept could be financed in various ways. A model embodying voluntary contributions is described above, but the concept would also be compatible with a mandatory employer contribution. Such a system, the Mandatory Universal Pension System (MUPS), was recommended by the President's Commission on Pension Policy (1981). The PPPC approach has advantages over Social Security. It offers a flow of savings to private investment rather than to federal debt finance, and thus also offers a higher rate of return.

Assessing the HPPC and PPPC Models

Today's private market arrangements for pensions and health insurance -- even aided by $103 billion of general revenue subsidies from the federal treasury -- have clearly hit their limit, leaving uncovered tens of millions of persons, to whom more are added every year. The proposed HPPC and PPPC models are intended to bring far-reaching improvements to these markets and offer a way to cover many of the 37 million persons without health insurance and the 68 million workers without pension coverage.

The HPPC managed competition model has become a major reform proposal only over the past year, aided particularly by President Clinton's endorsement. Many complexities and issues remain to be resolved. The related PPPC model, advanced in this paper, also calls for discussion by experts in pension and small business issues. Some early reactors have suggested that this approach might also be used for life insurance, for long term care insurance...even as a vehicle for offering "cafeteria plan" benefits for workers in smaller firms.

This managed competition strategy for reform in health insurance and pension plans, using HPPCs and PPPCs, offers a middle ground for debates often polarized by advocacy for

employer-linked coverage and unfettered markets, at one end of a continuum, and elimination of a private market and consumer role by social insurance, at the other end. Using public policy to design rational new markets and market-facilitating institutions may make it possible to expand both the coverage of health insurance and pension plans and consumer choice among those plans. For millions of workers in small firms who do not benefit from current employer-oriented strategies, such improvements are long overdue.

1.Employer Benefits Research Institute EBRI Databook on Employee Benefits, (1992), pg. 69

2. CBO Selected Options for Expanding Health Insurance, July 1991, cited in EBRI pg. 226, and EBRI Sources of Health Insurance and Characteristics of the Uninsured, SR-16, Jan. 1993

3. Source: EBRI (1992), p 44. Data are for non-farm wage and salary workers.

4. President's Commission on Pension Policy Coming of Age: Toward A National Retirement Income Policy, February 1981. pg. 21

5. Employee Benefit Research Institute EBRI Databook on Employee Benefits, (1992) pg. 44 (based on May 1988 CPS; calculations exclude "don't know" category) and Sources of Health Insurance and Characteristics of the Uninsured (Issue Brief #133), January 1993, (Based on March 1992 CPS, estimates include self-employed) pg. 50.

6. These estimates exclude foregone social security taxes, as well as state and local taxes. From 1992 Green Book, Ways and Means Committee, pg. 984. Estimates by Joint Committee on Taxation.

7. *Medical Benefits* November 15,1992, pg 1. Data from Henry J. Kaiser Foundation/Louis Harris poll.

8. An overview of pension problems, which also applies to health insurance coverage, is Larry Atkins, "Proposals to Expand Pension Coverage Among Small Firms" testimony to the Department of Labor ERISA Advisory Council Work Group on Small Business Retirement Income Plans, September 11, 1991. Firm characteristics cited: low profitability, uncertain finances, limited tax liabilities, owner motivation, industry wage and benefit structure. Labor characteristics cited: high labor turnover, young and old workers, low-wage and part-time workers. External factors cited: pension benefit costs, administrative costs, regulatory complexity, regulatory uncertainty, lack of awareness.

9. P. Ellwood, A. Enthoven, L. Etheredge "The Jackson Hole Initiatives for a 21st Century American Health System" Health Economics, vol. 1 149-68 (1992). Reprinted in US. Senate Labor & Human Resources Committee Achieving Effective Cost Control In Comprehensive Health Care Reform S. Hrg. 102-955, December 16 & 17, 1992 pp. 45-64. The HPPC concept evolves Enthoven's earlier proposals for a public "sponsor" for small employers and individuals. HPPCs have also been called "health insurance purchasing cooperatives" (HIPCs).

10. T he FEHBP would need to standardize plans, institute quality reporting, limit its employer contributions to a moderately-priced "benchmark", and become a more effective manager of competition among plans in order to be fully consistent with the HPPC model.

11. Congressional Research Service Retirement Income for an Aging Population, WMCP 100-22, (1987) pg. 348

12. Bureau of the Census Statistical Abstract of the United States, 1990 pg. 393 These statistics refer to tenure in an occupation; an individual may have more than one employer during this period.