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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Distribution Re: Upcoming CBO Reports (2 pages)	4/15/93	P5
002. memo	Chris Jennings to Hillary Clinton Re: Meeting with Senator Durenberger (2 pages)	3/8/94	P5
003. memo	Chris Jennings to Hillary Clinton Re: Thursday Meeting with Ron Wyden (1 page)	3/10/93	P5
004. memo	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senator Biden (2 pages)	3/8/94	P5
005. memo w/attach	Linda Bergthold, Robert Valdez to Hillary Clinton Re: President Clinton's Meeting with Congressional Caucus for Women's Issues on Thursday, March 11, 1993 (9 pages)	3/10/93	P5
006. memo	Chris Jennings to Hillary Clinton Re: Meeting with Conservative/Moderate Democrats (1 page)	3/16/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
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FOLDER TITLE:
HRC Memos-HSA [4]

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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]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

M E M O R A N D U M

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

April 13, 1993

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

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

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

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

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

April 13, 1993

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

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

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

Accompanied by a longer paper related to global health budgeting

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

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

APRIL 13, 1993

SUMMARY OF ISSUES UNDER NATIONAL HEALTH REFORM:

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

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

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

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

FEDERAL GOVERNMENT ROLES AND RESPONSIBILITIES:

Under national health reform, the federal government will:

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

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

- Update and refine the comprehensive benefit package

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

- Establish and implement national quality and access standards

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

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

- Oversee federal funding for training of health professionals

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

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

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

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

STATE GOVERNMENT: ROLES AND RESPONSIBILITIES:

Under national health reform, the states will:

- Establish at least one consumer health alliance

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

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

- Set boundaries for consumer health alliances to ensure:

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

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

  - Contiguous boundaries

- Administer and assure compliance with national health budget

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

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

  - Inclusion of a range of health plans within budget targets

  - Solvency requirements

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

  - Administrative expenses

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

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

MEDICAID:

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

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

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

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

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

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

LONG-TERM COST CONTAINMENT: A NATIONAL HEALTH BUDGET

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

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

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

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

- If budget exceeded in successive years:
  - Impose a penalty tax on providers, with revenues to pay for federal subsidies
  - Implement rate setting
  - Operate consumer health alliance
- Consistent with the national health budget, the federal government will constrain payments to providers to limit spending for its programs

LONG-TERM COST CONTAINMENT: ADMINISTRATIVE SIMPLIFICATION

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

- Simplify information collection requirements for billing and enrollment purposes
- Require use of national, standard forms
- Require use of national, standard data sets for financial, clinical, quality and other information
- Develop national procedures for coordination of benefits until new health system fully implemented
- Develop and adopt unique provider, patient, plan and employer-identification numbers
- Set national communication standards for electronic data interchange
- Set uniform national rules regarding privacy and security
- Simplify utilization review

GROUP 4: GLOBAL BUDGETS

Note: The budget structure presented here presumes the following:

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

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

1. HOW IS THE BUDGET DEFINED?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Short-term cost control options

Option 1: Insurance premium regulation

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

Option 2: All-payer rate setting

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

Option 3: Provider price controls

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

Option 4: Marginal revenue ~~taxes~~

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

Option 5: Voluntary controls

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

Short-term cost control options

Option 1: Insurance premium regulation

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

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

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

Option 2: All-payer rate setting

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

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

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

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

Option 3: Provider price controls

This option would control prices based on historical

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

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

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

Option 4: Marginal revenue taxes

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

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

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

Option 5: Voluntary controls

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

This option does not ensure cost savings.

AN OPTION TO FREEZE AND CONTROL PROVIDER PRICES

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

TIMING:

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

GENERAL DESIGN:

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

DESIGN BY SECTOR:

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

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

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

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

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

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

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

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

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

ENFORCEMENT:

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

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

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

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

MARGINAL REVENUE TAXES

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

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

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

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

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

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

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

ALL PAYER RATE SETTING OPTION

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

I. Implementation Schedule

For 1994:

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

For 1995:

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

II. Administration and Monitoring

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

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

III. Implications of All Payer Rate Setting

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

TIMELINE FOR IMPLEMENTING ALL PAYER RATESETTING APPROACH

For July 1994 Implementation

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

For 1995

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

Health Insurance Premium Regulation as an Interim Measure

I. Why

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

II. What

Set allowable rate of increase for:

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

III. How

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

  -- People or technical assistance in most states

  -- Complete office in nine relatively small states.

Primary State functions:

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

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

Primary Federal functions:

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

IV. Problems and Solutions

Without consumer protections, this could INCREASE uninsured.

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

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

Mechanisms for insuring continuity of coverage for the currently insured:

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

V. Implementation Requirements

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

Increase Use of Managed Care as an Interim Cost Control Measure

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

A. Private Sector Options

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

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

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

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

- Reduce the tax code bias towards excessive health spending

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

- Remove barriers to managed care

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

  - willing provider requirements

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

- Implement standardized performance/quality measures

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

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

B. Public Sector Options

- Increase the use of managed care in Medicare

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

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

- Require increased coinsurance for Medigap policy-holders

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

- Remove barriers to use of managed care in Medicaid

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

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

April 13, 1993

TO: Chris Jennings

FROM: David Abernethy

SUBJ.: Questions for tomorrow's meeting

****

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

Questions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMORANDUM

TO: Tricia Neuman

FROM: Sean

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

In order of importance and likelihood of actually being asked:

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

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

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

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

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

SANDER M. LEVIN
12TH DISTRICT, MICHIGAN

COMMITTEES:
WAYS AND MEANS
VICE CHAIR, HEALTH SUBCOMMITTEE
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Congress of the United States
House of Representatives
Washington, DC 20515

Questions for Health Reform Meeting -- April 14, 1993

Congressman Sander Levin

COST CONTAINMENT:

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

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

FEDERAL - STATE ROLES:

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

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

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

COMMITTEE ON WAYS AND MEANS
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ELECTED REGIONAL WHIP, ZONE 2

Congress of the United States
House of Representatives
Washington, DC 20515

QUESTIONS FOR MEETING
WITH MRS. CLINTON
APRIL 14, 1993

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

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

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

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

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LEGISLATIVE UPDATE

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

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

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

****

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

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

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

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

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

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FOLDER TITLE:
HRC Memos-HSA [4]

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HRC Memo File

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings, Steve Edelstein
RE: Meeting with Senator Dorgan
cc: Distribution

March 9, 1994

Tomorrow you are scheduled to meet with Senator Byron Dorgan (D-ND). He has not cosponsored any of the major health bills but has signed Sen. Wofford's letter on universal coverage.

BACKGROUND:

As a freshman, Dorgan might not be influential in the Senate, but he still has wide respect in the House where he was a member of the Ways and Means Committee. Dorgan now serves on the Commerce and Governmental Affairs Committees. He voted for Budget Reconciliation and National Service. His 23-year-old daughter died in November after undergoing surgery for a congenital heart ailment.

Dorgan's staff has said that while he feels universal coverage is imperative, he has a strong business and insurance constituency. Dorgan himself has said that it may not be possible to have universal coverage at a comprehensive level. He has been working with the North Dakota Health Care Task Force which is outlining a single payer system, funded from a 10% payroll tax, and a federal compatible plan.

In general, Senator Dorgan can be expected to back the package as long as careful attention is given to the problems of rural areas and the financing is sound. His other area of concern is cost containment. He will also be sensitive to coverage for Native Americans.

According to his staff, the Senator has concerns regarding the following specific issues:

- Employer Mandates - putting the burden entirely on small businesses is not workable. They cited North Dakota's Health Mandate as an example of an individual mandate. In it, employers must pay for employee's insurance but not that of their families.

- Health Alliances - feels they are too bureaucratic. Five thousand employees may not be the right size factor in determining which companies can opt out.

- Cost - proposed costs are too high. Wants to consider a more modest benefit package.

- Rural Access - because Medicare reimburses at 70 to 80% of the private rate, North Dakota hospitals cannot withstand a cut.

RECENT DEVELOPMENTS:

Senator Daschle's staff tells us that Dorgan did not attend the Rural Health Summit officially because of a previous commitment - to speak to the Potato Chip Association seminar - unofficially because of a family conflict.

TALKING POINTS:

Rural Hospitals: Rural hospitals stand to benefit greatly from the President's plan. First, with universal coverage, they are guaranteed payment for everyone that walks through their doors. Second, by integrating Medicaid, they will be paid the same private pay rate for Medicaid beneficiaries as they are for patients with private insurance. For these reasons, Medicare disproportionate share payments to pay for uncompensated care should not be necessary.

General: You may want to express your understanding that he could not attend the Rural Summit but your pleasure at being in the midwest and having an opportunity to hear first-hand some of the health related problems of those constituents.

Universal Coverage: You may want to thank him for signing the Wofford letter and the importance of universal coverage for addressing other concerns such as controlling costs and improving access in rural areas. You may wish to explore his views on the best way to achieve universal coverage in a way that will be attractive to moderates of both parties.

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002. memo	Chris Jennings to Hillary Clinton Re: Meeting with Senator Durenberger (2 pages)	3/8/94	P5

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PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings, Steve Edelstein
RE: Meeting with Senator Moseley-Braun
cc: Distribution

March 8, 1994

Tomorrow you are scheduled to meet with freshman Senator Moseley-Braun (D-IL).

BACKGROUND:

A Health Security Act and Wellstone cosponsor, Senator Moseley-Braun fully supports the concept of universal coverage. However, given Administration statements on the negotiability of other elements to reach this goal will want reassurance on issues on concern to her. She supports a one-tier system with high quality care for everyone. Toward that end, she supports the integration of Medicaid. She will want assurances that there are adequate protections for minority populations from discriminatory practices in marketing or participation by health plans.

In October, Senator Moseley-Braun sent two letters to the First Lady expressing specific concerns. The first, she sought protection for children's hospitals as "essential community providers." The second, expressed concern over the phase-out of Medicaid disproportionate share and the impact on hospitals which serve a high percentage of Medicaid patients.

The Senator is hosting a meeting on Wednesday prior to your meeting with her with Senators Daschle, Moynihan, Kennedy, and Rockefeller and the leadership of the National Medical Association to discuss minority health provider concerns. The Administration will be represented by Risa Lavizzo-Mourey and the Senator's office is appreciative. NMA's concerns will be uppermost in her mind, particularly how to ensure that minority providers have the opportunity to participate fully under the plan.

A related issue, is protection for essential community providers. In the Senator's view, these providers, particularly community health centers and public hospitals, have shown cultural sensitivity and a willingness to take all comers. Her concern is that after reform, once everyone is a well paying customer and competition sets in, that these providers can continue to treat the populations they have historically served. She would also like to see that ties to the community, such as through the community boards of Community Health Centers, are not lost once we move to the bigger system of alliances.

She has raised the issue of violence and its impact on our health care system. She has also been adamant that abortion services be available to all women. After the State of the Union, she praised the President for linking the need for both health care and welfare reform and for seeking health care security for every American.

She voted for NAFTA, Budget Reconciliation and National Service.

TALKING POINTS:

Universal Coverage: You may wish to express your appreciation for her support for universal coverage and our commitment to a system in which everyone participates equally.

Children's Hospitals: This concern was addressed through the drafting process and under the bill all children's hospitals which receive maternal and child health funding under Title V are automatically considered essential community providers.

Disproportionate Share: The bill phases out DSH payments for each state as it joins the new system. With universal coverage there will no longer be any need for DSH payments since the problem of the uninsured will be addressed. However, for those hospitals which continue to serve a disproportionate number of poor or undocumented persons a residual $800 million vulnerable populations fund will be established.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. memo	Chris Jennings to Hillary Clinton Re: Thursday Meeting with Ron Wyden (1 page)	3/10/93	P5

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004. memo	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senator Biden (2 pages)	3/8/94	P5

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. memo w/attach	Linda Bergthold, Robert Valdez to Hillary Clinton Re: President Clinton's Meeting with Congressional Caucus for Women's Issues on Thursday, March 11, 1993 (9 pages)	3/10/93	P5

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
006. memo	Chris Jennings to Hillary Clinton Re: Meeting with Conservative/Moderate Democrats (1 page)	3/16/93	P5

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

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23758

FOLDER TITLE:
HRC Memos-HSA [4]

gf127

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]