Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Senate Labor and Human Resources Meeting (2 pages)	5/3/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA] Senate and Labor and Human Resources Committtee

gf138

RESTRICTION CODES

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

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

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
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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]
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Senate Labor & Human Resources Com.

TO: Chris Jennings

FROM: David Nexon

DATE: 9/27/93

SUBJECT: SENATE LABOR AND HUMAN RESOURCES COMMITTEE HEARING WITH THE FIRST LADY

Format

As you know, the hearing will be held in the historic Senate Caucus Room, Russell 325, starting at 10:00A.M., and finishing at approximately 12:30 on Wednesday, September 29, 1993.

Senator Kennedy and Senator Kassebaum will both make short opening statements--no more than two to three minutes apiece. Mrs. Clinton will then make her statement.

Beginning with Senator Kennedy and Senator Kassebaum, and alternating between the Democrats and Republicans in order of seniority, each member will have five minutes to ask questions or make a statement. The order is as follows:

Kennedy
Kassebaum (R)
Pell
Jeffords (R)
Metzenbaum
Coats (R)
Dodd
Gregg (R)
Simon
Thurmond (R)
Harkin
Hatch (R)
Bingaman
Durenberger (R)
Wellstone
Wofford

Depending on how the time goes, there may be a second, shorter round of questioning.

SPECIAL REPUBLICAN CONCERNS

Two issues are of particular concern to Republicans on the Committee, and it might make sense for Mrs. Clinton to address them in her opening statement. Senator Kassebaum is very concerned that the alliances will be too big, regulatory, and bureaucratic--more like government agencies than purchasing cooperatives.

In response, the First Lady might focus on a couple of points:

--The alliances will represent the purchasers of health care in an area; **it is the purchasers who will control the alliance, not the Federal government.**

--The alliances resemble the benefits departments of large corporations much more than they do governmental entities. Their job is to negotiate the best deal possible with health plans on behalf of the members of the alliance, to provide information to consumers, to handle enrollment, and to adjudicate complaints.

--Alliances do not regulate health plans. That responsibility is left to state governments, where it is today.

--In fact, alliances are **required** to offer any health plan that is certified by the State government, is willing to fulfill the same contractual obligations as any other insurer offered by the alliance, and will offer a premium consistent with the budget.

--The whole point of the managed competition system is to **put the individual consumer in the driver's seat, not the government and not the health plans.**

The Republicans have a general concern about the impact of the program on small business, as do many of the Democratic members. The general approach of shared responsibility that the President and First Lady have been advocating is a persuasive one. A strong pitch, with

specific examples, of the assistance this plan will provide to small businesses would be very effective.

An additional issue that is of concern to Senator Durenberger--and to some of the Democratic members--is the question of whether a uniform national rate of increase will penalize areas that already have competitive, efficient health systems--like Minnesota. (Other members, like Senator Kennedy, would object to a program not based on historical spending).

Senator Durenberger feels the Medicare program already penalizes such areas in two ways. First, the Medicare payment to HMOs that enroll seniors is unfairly low in such areas. As you know, Medicare pays 95 per cent of the average community rate; since the community rate in Minnesota already factors in savings from managed care, Durenberger feels HMOs are victimized by below-cost reimbursement. Second, Durenberger feels that the national financing of Medicare shifts money from low-cost states to high cost states. Like others, Durenberger has not fully grasped the distinction between a program financed nationally by taxes and a program financed locally by premium-payers.

This issue is sufficiently complicated that I would not address it in an opening statement. If Durenberger raises it, the response might emphasize the following points:

--I want to work with you on the issue of Medicare reimbursement to HMOs;

--the budget is a ceiling, not a floor, and businesses and individuals in the high cost areas will have a strong incentive to hold cost increases below the cap.

--this is an issue the national board will be looking at. We do not have enough data today to separate out higher costs that are due to population characteristics from those that are due to wasteful practice patterns.

LIKELY QUESTION TOPICS AND ISSUES

We will hopefully have a list of the topics that will be covered by at

least the Democratic Senators by tomorrow. At this point, topics that seem likely to come up include:

1. Budget targets/financing. We thought that Senator Kennedy's first question might focus on the Medicare/Medicaid cuts and the realism of the financing, so that Mrs. Clinton has the opportunity to respond right up front.

2. Abortion--likely from Coats or Mikulski.

3. Tax cap--a Durenberger favorite. The response that the equal employer contribution serves the same purpose would be effective.

4. Long term care--Mikulski

5. Primary care emphasis--Wofford

6. Senator Pell--longevity, prevention.

7. Biomedical research--Harkin

8. Jeffords--State flexibility

9. Wellstone--Co-payments, deductibles, lack of subsidy beyond the average premium; also mental health.

10. Bingaman--rural health, small business, health education, enforceable budget cap.

11. Dodd--insurance and pharmaceutical industry concerns

12. Metzenbaum--Consumer protection

13. Coats--Medical savings accounts

14. Hatch--dietary supplements, enterprise liability, budgets are tantamount to price controls and rationing

Senate Labor + Human Resources

Sen. Labor/HR

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510–6300

October 19, 1993

Mrs. Hillary Rodham Clinton
The White House
Washington, DC 20500

Dear Hillary:

Many thanks for your call last night. I'm looking forward to the introduction of the bill, and with a little Irish luck, we'll have Jim Jeffords and a strong representation of Democrats on the Labor Committee as sponsors--even the single-payers!

I wanted to follow up with you on two issues I raised during our conversation--funding for academic health centers and funding for public health. In both cases there are some issues on which I would appreciate your assistance as the Adminstration bill becomes final.

Academic Health Centers

In general, the Administration has done a good job of designing a structure that will enable academic health centers to compete effectively without jeopardizing the research, training, and tertiary care that have made them such a national resource. The problem is the proposed sixty percent reduction in their indirect medical education (IME) payments under Medicare.

A cut this deep is unjustified on policy grounds, according to the Prospective Payment Review Commission, and could be a very serious problem for the centers--particularly since this cut would be on top of the Medicare reductions they'll absorb along with other hospitals. The cut also jeopardizes the support of institutions that can credibly and

effectively make the case that the President's plan will maintain and improve quality of care.

I hope this reduction can be set at the level the Prospective Payment Assessment Commission has said is reasonable. The current 7.7 percent factor would be reduced to 5.6 percent instead of 3.0 percent. A cut at this level would be acceptable to the institutions and would still save $1.2 billion annually.

Public Health

All of us agree that expanded public health services are essential to realize the full potential of health reform and to assure that vulnerable populations actually have access to the services to which the health security card entitles them. For the new funding in the President's plan to be meaningful, it should be mandatory, and not subject to the budget cap on discretionary spending or available for deficit reduction.

I am not suggesting an entitlement in the form of an open-ended commitment. What is needed is a limited, controlled form of directed spending that would not be subject to the discretionary caps. Short of such a requirement, the likelihood of actually funding the new public health initiatives is small. As in the case of other mandatory spending programs, no dedicated tax or premium is necessary, as long as the total spending in the Administration bill is deficit neutral.

In addition to these two concerns, I hope that the proposal is carefully drafted to maintain traditional Labor and Human Resources Committee authority over public health programs and to provide an appropriate role for the Committee in non-Medicare funding of academic health centers. To avoid distorting established authority, funding for these two functions must come from general revenues and not from dedicated taxes, premiums or a government trust fund, pool, or special account. In addition, in the case of academic health centers, Medicare funding must be included in the Medicare title and be separate from private sector funds.

I have attached a short drafting guide on these topics which may be helpful as the bill-writing team puts the final touches on the legislation

With respect and warm regards, and I'm most grateful for your consideration of these requests.

All the best—

Ted—

Concerns About Premium Surcharges (for Funding Academic Health Centers, New Public Health Programs, and Other Purposes)

In general:

(1) Spending should be mandatory, not subject to discretionary caps

(2) Language imposing premium surcharges that will be used to finance federal spending must be written in a separate title by itself or in a tax title

(3) Funds collected from premium surcharges must go into general revenues, not into a segregated account, pool, or trust fund

(4) Payments for these purposes must come from general revenues

A. Academic health centers

(1) Medicare's contribution to funding academic health centers should be written in separate Medicare title

(2) Premium surcharge contribution:

a. For corporate alliances:

(i) surcharge should be written in separate title or tax title

(ii) surcharge should go to general revenues, not trust fund, pool, or special account

b. For regional alliances:

(i) surcharge should be written in separate title or tax title, as for corporate alliances

(ii) alternatively,

(a) surcharge can be included with other surcharges paid to regional alliances, e.g., bad debt.

(b) in this case, surcharge should not be sent to Washington but should be retained at alliance and offset against subsidies or other Federal payments

(3) Private payments to academic health centers must come from general revenues, not from trust fund, pool, or account

B. New Public health spending

(1) Spending should be mandatory (not subject to discretionary cap)

(2) Any surcharge to finance public health spending must go to general revenues under separate title or tax title

(3) Spending must be from general revenues, not pool, trust fund, or separate account

Senate Labor & Human Resources

Office of Legislation and Policy

ADMINISTRATOR'S DAILY UPDATE

Wednesday, October 20, 1993

ACSHA

Nothing to report.

EPA

- On Tuesday, October 19, the Senate Labor and Human Resources Committee held a hearing to discuss issues and options available for a single-payer health care system. Victor Sidel, Physicians for National Health Program; Patti Tripoli, New York State Nurses Association; and two doctors spoke on behalf of American health providers that desire a single-payer system. Hugh Scully, Toronto General Hospital; Michael Rachlis, Hassle Free Clinic; Ted Marmor, Yale University; and Michael Walker, The Fraser Institute; testified about the success of the Canadian health care system. All witnesses agreed that the single-payer system must be seriously considered by the committee and not overlooked because of "political infeasibility". Dr. Rachlis presented committee members with miniature Toronto Blue Jay baseball bats to beat off special interest groups. (Contact: Roberta Levy, 690-8070)

- The Senate Labor and Human Resources Committee held a hearing today to discuss health alliances. Judy Feder testified on the role of alliances. Several Senators expressed concern that large regional alliances would be monopolistic, overly bureaucratic and unresponsive to consumer needs. Other witnesses included Judy Waxman of Families USA, Leslie Cummings of the California Managed Risk Medical Insurance Board, Sean Sullivan of the Jackson Hole Group, Jeff Smedsrud of the Coalition for Voluntary Health Alliances, Elliot Wicks of the Institute for Health Policy Solutions, and Robert Laszewski of Health Policy and Strategy Associates. Waxman, Cummings and Wicks testified in favor of large regional alliances, while Sullivan, Smedsrud, and Laszewski testified in favor of smaller, competing alliances. (Contact: Suzanne Calzoncit, 690-5525)

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SENATE LABOR AND HUMAN RESOURCES COMMITTEE

DEMOCRATS:

SENATOR EDWARD KENNEDY (D-MA) (Chairman, Labor and Human Resources Committee) - Senator Kennedy, Chairman of the Labor and Human Resources Committee, is the Senator most closely associated with health care issues. He has been working on comprehensive health care reform issues for well over two decades. Although previously a strong single payer advocate, in recent years, Kennedy has moved to employer-based approaches. He believes that using business to significantly underwrite the cost of health care reform will substantially reduce the need for federal tax increases, and therefore make the package more sellable to both the Congress and the American public.

He joined with Majority Leader Mitchell, Senator Rockefeller and Senator Riegle in introducing a play or pay employer-based health care model. Despite the backing of these Democratic leaders, it received surprisingly little rank-and-file support. Perhaps as a result of this, Senator Kennedy has come to believe that only a plan backed by the President can be enacted. For this reason, Kennedy will likely be open to any comprehensive reform approach that meets the criteria of universal coverage, cost containment, and quality assurance.

He is also concerned about coverage for long term care. He introduced a substantial and expensive ($45 billion a year when fully phased-in) long term care plan with Senator Mitchell. This also garnered little support. Alternatively, he worked with Senators Pryor, Hatch, Packwood and Bentsen to pass a long term care insurance standards bill. That attempt was blocked because it did not include the tax clarifications that the insurance industry sought.

In addition to all these reform efforts, Senator Kennedy has been extremely active in the public health service areas. His interests are broad ranging, including concerns about tobacco advertising, adequate funding of AIDS research and services, Head Start, extensive oversight of FDA, effective illicit drug strategy, and minority health.

Recent Developments: Recently, Kennedy has been pressing for primary or sole jurisdiction over Health Care Reform. Howard, Steve and Chris met with Labor Committee Staff Director Nick Littlefield. At that meeting he was informed that we appreciated their suggestions but would defer to the Majority Leader on this highly controversial issue. The Committee has also agreed to hold hearings that are consistent with our message in early to mid-May. Specifically, they will focus on the cost of not doing health care reform and the cost effectiveness of mental health coverage in the benefit package (Mrs. Gore is scheduled to testify.). Lastly, Senator Kennedy will want to be significantly consulted in the upcoming weeks.

SENATOR CLAIBORNE PELL (D-RI) (Chairman, Labor Subcommittee of Education) Senator Pell is the most senior member of the Senate Labor and Human Resources Committee and a long-time advocate of "cradle to grave" health coverage. On health care reform, he is not an ideologue and is not committed to any method of reform. In 1972, he joined in introducing legislation which would have mandated employer-based health care reform. As a member who has been working on the issue for sometime, he would enjoy seeing actual progress.

Because of his well-to-do elderly constituency, Senator Pell voted to repeal the Catastrophic Health Care Reform legislation. This is significant because it may indicate that a prescription drug benefit that most well-to-do elderly already have will not be adequately responsive to an influential constituency of his. This helps explain why Senator Pell's top health care concerns include coverage for long term care - Rhode Island has one of the highest percentages of elderly of any state in the country - preventive services and expanding the use of non-physician health provider. He is opposed to smoking and has sponsored legislation to provide grants to states for health promotion programs. He is also interested in studying other countries' health care systems and taking lessons from their experiences. At Friday's bipartisan Senate meeting (April 30), Senator Pell asked if the Task Force was looking at other countries as models for reform.

SENATOR HOWARD METZENBAUM (D-OH) (Chairman, Labor Subcommittee on Labor) - Senator Metzenbaum strongly believes in the need for health care reform and has cosponsored Senator Wellstone's single payer bill. He is concerned about the managed competition approach because he fears that it is too easy on the special interests, especially the insurance companies. He believes to truly reform the health care system, the Administration must be willing to take on and defeat the special interests and take the program to the American people. He views health care as a social good that should be provided to all people and believes the system should be based on providing services to people at the lowest possible cost. Metzenbaum strongly favors rate setting and a national budget.

Senator Metzenbaum also favors eliminating fraud and abuse in the system. He has major criticisms of HCFA for not ferreting out fraud and abuse. Other concerns are anti-trust (he chairs the Judiciary subcommittee), malpractice reform and long term care.

<u>Recent Developments</u>: Senator Metzenbaum's staff has indicated a great concern about the apparent Administration infatuation with caps for medical malpractice. He is strongly opposed to caps and might even oppose the legislation if they are included at the time of introduction. He has also expressed concern that quality standards may be vulnerable to the Administration's decision to cut back on what we view as unnecessary regulation and he would like us to proceed cautiously in this area.

SENATOR CHRISTOPHER DODD (D-CT) (Chairman, Labor Subcommittee on Children) - Senator Dodd chairs the Labor and Human Resources Subcommittee on Children, Families, Alcohol and Drugs. He has been one of the chief architects of the Act for Better Child Care and the Family and Medical Leave Act. He has also championed full funding for Head Start and expansion of childhood immunization programs. On health care reform, Dodd is keeping an open mind and is inclined to wait for President Clinton to take the lead.

In the last Congress he cosponsored Senator Bentsen's health care reform legislation. However, despite his close friendship with Senator Kennedy, he did not cosponsor the "pay or play" plan put forth as a Democratic leadership proposal. This may be attributable to the fact that Connecticut is the insurance capital of America with many large and midsize insurers based there. Connecticut also is home to many drug manufacturers and he is concerned that they will be hit too hard under cost control proposals. He notes that this is the only industry in his state to have an increase in jobs over the last five years. He is supportive of the Pharmaceutical Manufacturers Association's proposal to negotiate price reductions with the Administration.

SENATOR PAUL SIMON (D-IL) (Chairman, Labor Subcommittee on Employment) - Senator Simon is very interested in health care reform, and leans toward a single payer approach but also cosponsored the Leadership's HealthAmerica bill. He is close to organized labor and sponsored amendments to strengthen the cost containment provisions of HealthAmerica proposed by the AFL-CIO. He has also been one of the Senate's strongest advocates for long term care and has cosponsored many bills in this area. He is very interested in children's and minority issues. He has a long standing interest in education, particularly higher education. He is a strong supporter of increasing enrollment of minorities in health professional schools.

Recent Developments: Senator Simon recently met with Robyn Stone and reiterated his avid support of a significant long term care plan. He cites his Senate campaign in which he advocated comprehensive long term care legislation which outlined specific tax mechanisms. This plan received a great deal of support in the state, so much so that his opponent, then-Secretary Lynn Martin, pulled ads attacking the tax because they were so negatively received by the electorate.

SENATOR TOM HARKIN (D-IA) (Chairman, Labor Subcommittee on Disability Policy) - Senator Harkin has not sponsored any reform legislation or backed any particular reform approach. He has focused instead on specific issues that will need to be components of an overall plan. He has a strong interest in all rural issues. He was recently named Co-Chair of the Senate Rural Health Care Coalition. Harkin is a leading advocate in the Senate for anything related to people with disabilities. (He has a brother who is deaf.) His sponsorship of the Americans with Disabilities Act is perhaps the major achievement of his

political career. Ensuring that the plan provides access to health care, including long term care for people with disabilities, is a major concern.

Senator Harkin is especially interested in prevention; he sponsored a bill giving money to states for preventive health programs. As a member of the Labor Committee and Chairman of its Appropriations Subcommittee on Human Resources, he is a key player on public health legislation and funding. Inclusion of preventive services in the benefit package will be key as Senator Harkin opposes co-pays for these services.

SENATOR BARBARA MIKULSKI (D-MD) (Chair, Labor Subcommittee on Aging) - Senator Mikulski is known as an outspoken liberal. She supports the Clinton health care reform plan in principle but is concerned about the influence of the Jackson Hole group who she calls "a bunch of geriatric Republicans that represent everything that's wrong with health care." As a former social worker she would like to see greater use of non-physician health professionals to deliver care.

She is a champion of women's health and an strong pro-choice advocate. The plan's position on women's reproductive health services will be critical. She is concerned about improving research into women's health and eliminating the gender bias of NIH research. She is also a strong advocate for seniors. She introduced and passed the Spousal Impoverishment provisions in 1988 so that seniors did not have to spend down all of their assets to qualify for benefits. As the new Chair of the Labor Subcommittee on Aging, she is promoting the expansion of home and community-based long term care services.

On the Appropriations Committee, she heads the HUD/VA and Independent Agencies Subcommittee. VA, the largest managed health care system, is a big concern for Mikulski. She cites the Canadian experience where under the massive change to a single payer system, vets lost out. She feels strongly that vets need a seat at the reform table.

Recent Developments: At the Senate retreat, Senator Mikulski stressed talking the people's language on health care reform and asked for a mechanism to assure this happens. She also said that the Democratic women Senators would lead the floor fight for reproductive health benefits in the package.

SENATOR JEFF BINGAMAN (D-NM) - Senator Bingaman joined the Labor and Human Resources Committee in May of 1990. While he does not have a long record on the issue of health care reform, he has been exhibiting increasing interest in the subject. He supports the managed competition model's focus on market adjustment of health care costs but has also supported an eventual cap on health care spending. He has cosponsored legislation with Senator Durenberger to implement the Jackson Hole group recommendations - a managed competition model which rejects global budgets. However, in hearings last December of the Labor Committee, Bingaman expressed strong support for the idea of a global budget to

"limit the amount of revenue going into the system, limit the amount of premiums that people can pay into the HPICs." He is a strong advocate of rural health and prevention. He has expressed concern about the effects that employer-based health care reform could have on small businesses.

Recent Developments: Reportedly, Senator Bingaman was unhappy over our language change from "HIPC" to "Alliance." He feels "cooperatives" are rural friendly. At Jamestown, Bingaman raised concerns about small business. He felt that a payroll contribution of 7 to 8 % was too high. In his view, we should lead with cost containment and make sure small businesses are protected.

SENATOR PAUL WELLSTONE (D-MN) - Senator Wellstone is very interested in health care reform. In March, he reintroduced his single payer bill, the Senate counterpart of the McDermott bill. Despite his strong bias toward single payer and his suspicions of managed competition, he has expressed a willingness to work with you. His strong desire for reform and his belief that we must act now make him likely to support the Administration plan. He has a strong interest in mental health and substance abuse benefits. He modified his previous bill to strengthen its mental health provisions. Other concerns include rural health, consumer choice and state flexibility (so that Minnesota might pursue a single payer option).

Recent Developments: Senator Wellstone indicated concern regarding talking points distributed by the Task Force to the members of Congress, particularly how single payer was characterized. At the retreat, he stated that he doesn't want anyone to be able to opt out of the Purchasing Cooperative because he fears that healthy people will opt out. He asked for a meeting with Ira. At the Senate meeting on Friday, Senator Wellstone mentioned that he had spoken to the First Lady by phone.. Follow-up action by Ira is being arranged.

SENATOR HARRIS WOFFORD (D-PA) - Since his Senate race victory, which was widely attributed to his support of health care reform, Senator Wofford has actively pursued this issue in the Senate. He is part of the group of five (with Senators Daschle, Baucus, Kerrey and Bingaman) on a single financing state-implemented health system with a national health board approving state plans. Employers and individuals would pay a progressive premium to a fund which would be returned to the states on a percentage basis. The original Daschle-Wofford bill was called the American Health Security Act, partially because Wofford believes so strongly in the importance of the success of the Social Security system. He believes that his proposal took into account a middle road between the single payer and managed competition crowds. He believes everyone should be required to participate in the Health Alliances (no opt-outs), that the program must be state or regionally administered, and that long term care coverage is essential. He has previously expressed concern over what he felt was the lack of discussion by the Administration of long term care in connection with reform.

He is working with the Democratic Policy Committee health working group and is looking at the health insurance purchasing cooperatives and how they could work. He is very intellectual and savvy about how difficult some of the concepts are for the public to comprehend. For example, he dislikes intensely the term "global budget," believing that it is too large to understand and turns people off. He believes that President Clinton and Congress must do a lot of educating on health care reform.

Recent Developments: It has been more and more clear to the Senator that his election is tied to Health Care Reform. He will be very helpful. Language used to describe and sell the plan is very important to him. He is very appreciative that the First Lady attended his forum in Harrisburg earlier this year. At the Senate retreat, Senator Wofford stated his support for short term cost controls. He believes that abortion should be out of health reform and does not want the federal government overriding state abortion restrictions.

REPUBLICANS:

SENATOR NANCY KASSEBAUM (R-KS) (Ranking Republican Member, Labor and Human Resources Committee) - Senator Kassebaum is the new ranking-minority member of the Labor and Human Resources Committee. As such, she'll be working closely with Chairman Kennedy on many provisions the committee has jurisdiction over.

Kassebaum has taken a strong interest in health care reform and has introduced her own reform bill, the BasiCare Health Access and Cost Control Act (S. 325). This legislation provides tough cost controls, focussing on controlling what insurance companies can charge for premiums. She would finance this bill through raiding the Social Security Trust Fund. When the First Lady met with the Senate Women's Caucus, Kassebaum pushed for a national commission on abortion, like the base closure commission, so that the members would have one up or down vote on the issue.

She is very concerned about over-regulation by HHS and the federal government generally. Along with Senator Metzenbaum, Kassebaum authored legislation on orphan drugs; their bill would have eliminated the current regime in which drugs for rare diseases enjoy special market exclusivity for the pharmaceutical manufacturer.

While considered a moderate, Sen. Kassebaum will toe the party line if she perceives an issue is being politicized. If she senses this is happening with health reform, we will have little chance of winning her support.

Recent Developments: Senator Kassebaum has expressed concerns about the Health Alliance. Specifically, whether they will remain a non-profit entity or whether they will become government or quasi-governmental agencies. She interested to know if large groups with healthy populations are penalized for opting out, whether sick groups that opt out will get a subsidy. Kassebaum is also interested in how the global budgets will be allocated to the states and how these state budgets will be enforced. Her elderly mother lives at home, so Kassebaum also has a personal concern about long term care. We believe she is one of our top Republican chances. She is also scheduled to meet with you and Ira on Thursday along with Sens. Danforth, Burns and Reps. Glickman and McCurdy sometime next week.

SENATOR JIM JEFFORDS (R-VT) - Senator James Jeffords is a progressive Republican who has shown a fair amount of interest in health-related matters. He has sponsored his own bill (The Medicare Health Act), a single-payer approach with 70% federal financing. He believes his is a unique approach and really hopes that the Administration considers his proposal seriously.

According to his staff, the main agenda item for Senator Jeffords this year will be the ERISA preemption. This is an especially important issue for Vermont, which currently has a waiver

application in order to pursue comprehensive reform in the state. As a result, he would also like to see state flexibility built into a comprehensive reform initiative.

Senator Jeffords is an advocate of improving access to health in rural areas. As part of health reform, Jeffords believes there needs to be an emphasis on primary care and efforts that encourage providers to enter primary care. He also favors loan deferment programs and expansion of the National Health Service Corps (NHSC) which aim to address the provider shortage issue in rural communities. Jeffords has raised questions regarding how managed competition will effect the need for primary practitioners.

Jeffords has also taken an active stance on lifting the ban on fetal tissue research, increasing AIDS education, and eliminating the special market exclusivity for producers of orphan drugs (drugs for rare diseases.)

Recent Developments: Jeffords has been taking a lot of credit lately for the fact that the President advises the plan will be providing lots of state flexibility. This public credit-taking has alienated Senator Leahy in particular because Senator Leahy believes he is the leader in this area.

SENATOR DAN COATS (R-IN) - Senator Dan Coats is more conservative across a wide spectrum of social issues than almost any other member of the committee. He is strongly opposed to abortion. He is the author of several amendments to require parental consent in the case of abortion for minors (one of which passed the Senate).

On the other hand, Coats, the ranking member on the Children and Families subcommittee, has been a fairly strong advocate for child welfare and has broken with the Republican party to these ends. He is viewed to have something of a pragmatic streak on certain issues and is not afraid to differ with his party on these issues. He supported the Family and Medical Leave Act and extending tax credits for families with children. He has been supportive of Senator Dodd in his efforts and is more of an enabling ranking member rather than an obstructing one.

SENATOR JUDD GREGG (R-NH) - Senator Judd Gregg, the newest member of the Senate Labor and Human Resources, was elected governor of New Hampshire in 1988 and re-elected in 1990. He is the son of Hugh Gregg, a former Republican governor of New Hampshire. During his two terms in office, he showed a strong interest in and commitment to environmental protection and economic development. He took a conservative position on spending and taxes.

Senator Gregg was a member of the House of Representatives from 1980 until he assumed the governorship of New Hampshire. He served on the Ways and Means Health Subcommittee and voted along conservative lines. He was involved in the movement to

repeal Medicare Catastrophic. New Hampshire recently took flack in an article in the Washington Post where the state shifted Medicaid funds to balance their state budgets. Senator Gregg was Governor and said to approve of the plan.

SENATOR STROM THURMOND (R-SC) – Senator Thurmond has not played a strong role in health-related matters. The one area of health where Thurmond has shown a strong interest is in research. He backed the NIH reauthorization and supports fetal tissue research. He is also concerned about AIDS funding, which he thinks should be increased; he feels there is an improper perception about funding imbalances between AIDS and other disease research activities. Thurmond has a daughter who is diabetic and testifies before the Appropriations Committee on behalf of diabetes funding yearly. He also supports more funding for cancer research.

Senator Thurmond also has a longstanding interest in alcohol education issues. He was the primary sponsor of the legislation which requires a Surgeon General's warning label on alcohol beverage containers. He currently is advocating legislation requiring similar warnings for alcohol advertising.

Thurmond has real concerns about the budget deficit and will interested in the impact of reform on the deficit.

SENATOR ORRIN HATCH (R-UT) – Senator Hatch is relatively new to the Committee having joined during the last Congress. He is one of the brightest Senators, but has yet to really get a comfortable grasp of the Finance Committee. Although well known for his very conservative philosophy, in recent years he has appeared to become more open to more traditionally moderate approaches. For example, although close to the drug industry, he has been willing to push them to be more responsive on pricing issues.

Up until 1993, he served as either the Chairman or the Ranking Republican of the much more conflict-oriented Labor and Human Resources Committee. In this capacity, he became extremely well informed about PHS, NIH, and FDA issues. On health reform issues, he can be expected to be very supportive of market-oriented reforms to the health care system. In that vein, he will be extremely uncomfortable with employer mandates and discussions of global budgeting and enforcement. He has introduced legislation to reform the medical malpractice system and sees it as an important means for reducing health care costs.

Recent Developments: Senator Hatch has just hired a health care staff person straight from Reagan/Bush DHHS. It is unclear what impact this will have on his willingness to be constructive on health care debates--more likely to be negative. Sen. Kennedy, who is close to Hatch, believes we should not write him off. He views Hatch as a potential coalition builder between moderate Republicans and Democrats.

SENATOR DAVE DURENBERGER (R-MN) – Senator Durenberger, the ranking Republican on the Finance Committee on Medicare, is one of the Committee's most well versed Members on health care reform. He also is one of the few Members who has served concurrently on the Labor and Human Resources Committee (the other major health care committee) and the Finance Committee. He is a moderate who is viewed by the Republican leadership as somewhat of a loose cannon. Because of this and his long-standing interest in health care reform, Durenberger, too, is a candidate to be a possible and important ally.

In the last Congress, he joined Senator Bentsen as the lead Republican on the Texas Senator's incremental (insurance market reform, etc.) health reform initiative. He has been a key health care player for years, however. He now is the ranking Republican on Jay Rockefeller's Subcommittee on Medicare and Long Term Care, and he has served as either a Chairman or ranking Member of this Committee for years. In addition, he served (as a Vice-Chair) on the Pepper Commission. While he joined all the other Republicans in voting against the access recommendations of this Commission, (he did vote for the long-term care recommendations) it is important to note that it was unclear that Durenberger was going to vote against the Pepper Commission recommendations until very late in the process. An important offshoot of this experience, though, was the close working relationship he forged with Rockefeller.

Most recently, Durenberger has focused on state-based health reform initiatives. He does not believe that a consensus yet exists for national reform and his own state is tired of waiting. Minnesota has a long tradition of moving ahead on health care reforms. It is one of the 5 or 6 states that has gone ahead and passed legislation to implement its own reform proposal.

Minnesota is also THE nation's capital of managed care/HMO delivery systems. As a result, Minnesota has historically been more efficient than other states in terms of the delivery of health care. Senator Durenberger will be very concerned about the allocation of the global budget, particularly that it does not reward the inefficient at the expense of the efficient.

Senator Durenberger called Chris Jennings on April 17th and indicated his nervousness with any price controls. He said he thought we could get some savings from speeding up implementation of the new physician payment system. He also urged us to find a way to fold in Medicare into whatever we do. At a meeting with Ira Magaziner on April 21, Durenberger stressed that he, unlike some Republicans, thinks we can and should do health care this year, although he expressed reluctance about universal coverage (and its associated costs) in the near term. Feedback from Gov. Carlson's office was very positive, but Durenberger is still telling the press that he's against new taxes and isn't sure the bill can be moved this year.

<u>Recent Developments:</u> At the Bipartisan meeting in the Senate last Friday, April 30th, Senator Durenberger outlined the issues which are most problematic for Republicans: employer mandates, global budgets and standby authority for cost controls, the degree of federal control over states and in turn state authority over the Health Alliances, and the $100 billion price tag.

To: Chris Jennings

Fax #: 202-456-7739

From: Marjorie Ross, Office of the Assistant Secretary for Health

Date: December 23, 1993

Pages: 4, including this cover sheet

fax

Chris -

FYI...

Hope you have a great holiday and New Year! Sorry I missed you.

Margi

From the desk of...

Marjorie Ross
Policy Advisor
Office of the Assistant Secretary for Health

tel:
fax: 401-7736

Sen. Labor & Human Resources

TO: Bill Corr
Chris Jennings

CC: Risa Lavizzo-Maurey, MD
Arnie Epstein, MD
Simone Reuchmeier

FROM: Margie Ross

DATE: December 22, 1993

RE: Quality Briefing- Labor/Human Resources

Risa Lavizzo-Maurey, Arnie Epstein, Simone Reuchmeier and I met with three committee staff members from Labor/Human Resources this morning to address their concerns regarding quality management in the Health Security Act.

Staff:
Hal Hassin, MD, MPH
Van Dunn, MD
Julie Ann DeStephano

Overall, they were very knowledgeable about the problem with current quality measures, but had difficulty at the beginning conceptualizing the principles in the Health Security Act. They still had relatively primitive knowledge of the structure of the system (ie. Board function vs. alliance function). Future briefings should begin with placing the issue at hand (ie. quality or rural issues) in the "big picture" to give them a feel for where the topic fits in, and how it is essential for reform in general. The materials Arnie and Risa used were well received.

The following are their concerns:

1. Will there be incentives for doctors to not provide care under cost-containment pressures?

2. What assurances will there be that HMOs will use the proscribed measures of quality, when they are using others to exclude certain providers already?

3. Will measures be so standardized that alliances cannot use others not listed? (ie. ability to speak Spanish, etc)? Can these measures be adjusted?
   - emphasis on keeping the yearly updates
   - emphasis on diversity of council in devising types of measures that are appropriate/useful
   - priorities given 5 years ahead of time. No surprises.
   - continual research on outcomes measures and quality correlation

4. What measures of quality exist now?

5. Won't there be alliance opposition to setting these measures?
   - measures must be universal to avoid excess burden
   - alliances may negotiate higher standards of quality

6. How do providers protect themselves from patients who unnecessarily overutilize?
   - measure of appropriateness
   - may modify national guidelines to match regional variation
   - like AHCPR method of having a consumer version and a provider version of practice guidelines. Takes pressure off provider.
   - liked interactive video (Wennberg)

7. What about provider satisfaction of plans? Why is this not used?
   - protocols will be published for providers to judge.
     providers not obliged to join plans that have inappropriate methods
   - advisory board for every regional alliance

8. How will providers be protected from not following the practice guidelines?
   - demonstration project for guidelines to see if malpractice will decrease
     Will use better models than VT, ME, FL.
   - almost all managed care organizations use them now. The guidelines will assure that the measures being used are appropriate clinical guidelines and based on science.

   Will behavioral modification be employed to encourage changing poor habits (1920s medicine)?

9. Why continue to use a physician data bank?
   - need to protect innocent providers
   - need to prosecute offenders, modify ADR
   - need more valid measures to judge
   - define repeat offenders

   Discussed working on clarifying this concept and clarifying during mark-up.

10. ADR- Why isn't emergent care addressed? What ensures that an urgent issue will be resolved quicker than 24 hours?

    Discussed creating better language

11. Can the reviews be done like JACHO guidelines (spontaneous review)?
    - incentives for plans to demonstrate good performance and not to game the reviews

12. Why revise the personnel standards downwards? What happens to our PhDs in

clinical fields?

- the language reduces the restrictions from using personnel that have the skills proficiency, but leave it up to the employer to demand higher degrees of credentialling. It was designed to help underserved areas use the resources they have. It leaves more options open.

13. Why aren't there National Standards of quality? Does this mean there will be 50 different standards for plans?
    - Federal-state issue revisited

14. Council- will it act full-time?
    - just like PPRC

15. Why can't the alliance do credentialling instead of separate ones for hospitals and plans?
    - issue of using the alliance as a bureaucracy

16. Who is likely to serve on the National Health Board?

17. What is the relationship of the Consortium to the RPFs? Do they report to someone above them?

Other committee staff interested in quality management:

Michelle Varnhagen- Moynihan

Karen Hine- Finance
Benefits, quality financing
William - Data systems, information sharing

Sally Citelle- Kassebaum

Sen. L & H Rep.

Statutory

COMMITTEE ON LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON DISABILITY POLICY

TO: Chris Jennings, Peter Edelman, Judy Feder, Stan Hern, Mike Lux, Bob Sevigny, Judy Heumann, John Monahan

FROM: Bobby Silverstein

Number of Pages To Follow: 2

COMMENTS:

If you have any transmittal errors,
please call the subcommittee's staff assistant

TEL: (202) 224-6265
FAX: (202) 228-2923
TTY: (202) 224-3357

Thank You

Chris -

11/24

I spoke to Bobby Silverstein today at 11:45 AM. He says they got a response to their letter to HRC from Jody Feder last night at 6pm. According to him,

(1) The response implies no available actuarial #'s for outpatient rehab - when Shalala + T-Ra have implied otherwise.

(2) They want a meeting in a few weeks with Jody to walk through some of this

(3) They are considering the response from Jody

as the official response to attached letter -

Have a good Thanksgiving

Debbie

United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

- file

November 2, 1993

Hillary Rodham Clinton
Office of the First Lady
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Hillary:

Again, congratulations on your continuing efforts to focus our nation's attention on the need for health care reform. I look forward to working with you to improve the quality of health care provided to all Americans.

In reviewing the Administration's bill, I was gratified to see that EPSDT services have been maintained for poverty-level children with special needs on Medicaid, and that standards will be developed to ensure coordination with services under parts B and H of the Individuals with Disabilities Education Act. However, I remain concerned about coverage for outpatient rehabilitation services for children and adults who are not eligible for EPSDT services.

Under the bill, outpatient rehabilitation services, including outpatient occupational therapy, outpatient physical therapy, and outpatient speech therapy services for the purpose of attaining or restoring speech, are covered to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury. Further, at the end of each 60-day period, the need for outpatient rehabilitation services must be reevaluated and additional periods of services are covered only if it is determined that functioning is improving.

By using the phrase "illness or injury" the bill does not appear to cover functional limitations due to birth disorders or congenital conditions. Am I correct in my reading of this limitation?

Also, by using the phrase "functioning is improving" the bill appears not to cover therapies designed to "maintain functioning" or "prevent further deterioration." Am I correct in my reading of this limitation?

If I am correct in my reading of these two limitations, I would appreciate receiving information on the following additional questions as soon as practicable. As you may know, the

Labor and Human Resources Committee is planning a hearing on November 19 regarding the Administration's proposal and the needs of Americans with disabilities. The information I am requesting will be invaluable to me as I prepare for this hearing.

ADDITIONAL QUESTIONS:

1. Why did the Administration limit outpatient rehabilitation therapies to functional limitations due to illness or injury and not cover therapies relating to birth disorders or congenital conditions? Why did the Administration limit continued treatment after reevaluations to "improving functioning" and not include "maintaining functioning" and "preventing further deterioration"?

2. If therapies for those with birth disorders and congenital conditions were not included because of anticipated costs to provide such therapies, what were the cost estimates? How were the costs arrived at? By whom? What assumptions were made in calculating the number, in terms of the size of the prospective population? Do you have a breakdown by age group? Did the actuaries assume any cost savings from preventing secondary disabilities? If not, why not in light of the fact that studies clearly show that preventing secondary conditions associated with disabilities saves money.

3. What are your thoughts about how people in need of outpatient rehabilitation services not covered in the comprehensive benefits package will obtain necessary therapies? Many people with disabilities will not be able to afford supplemental insurance (assuming that companies will make such insurance available) and may not be eligible for the new home and community-based long-term care program. Also, the long-term care program does not have limits on the amount of copayments.

4. It appears that under the Administration's proposal, children currently receiving Medicaid and poverty-level children with special needs (under the new program established in the bill) will have access to outpatient rehabilitation services to treat congenital conditions and birth disorders. How much would it cost to expand the new program to include all children, not just poverty-level children or expand the comprehensive benefits package to provide these therapies for all children?

Again, thanks for your attention to these issues. If you have any questions, please contact Bob Silverstein of my staff (224-6265).

Sincerely,

Tom

Tom Harkin
Chair, Subcommittee on
Disability Policy

Senate Labor + Human Resources

TO: Chris Jennings

FROM: David Nexon

DATE: 9/27/93

SUBJECT: SENATE LABOR AND HUMAN RESOURCES COMMITTEE HEARING WITH THE FIRST LADY

Format

As you know, the hearing will be held in the historic Senate Caucus Room, Russell 325, starting at 10:00A.M., and finishing at approximately 12:30 on Wednesday, September 29, 1993.

Senator Kennedy and Senator Kassebaum will both make short opening statements--no more than two to three minutes apiece. Mrs. Clinton will then make her statement.

Beginning with Senator Kennedy and Senator Kassebaum, and alternating between the Democrats and Republicans in order of seniority, each member will have five minutes to ask questions or make a statement. The order is as follows:

Kennedy
Kassebaum (R)
Pell
Jeffords (R)
Metzenbaum
Coats (R)
Dodd
Gregg (R)
Simon
Thurmond (R)
Harkin
Hatch (R)
Bingaman
Durenberger (R)
Wellstone
Wofford

Two issues are of particular concern to Republicans on the Committee, and it might make sense for Mrs. Clinton to address them in her opening statement. Senator Kassebaum is very concerned that the alliances will be too big, regulatory, and bureaucratic--more like government agencies than purchasing cooperatives.

--The alliances will represent the purchasers of health care in an area; **it is the purchasers who will control the alliance, not the Federal government.**

--The alliances resemble the benefits departments of large corporations much more than they do governmental entities. Their job is to negotiate the best deal possible with health plans on behalf of the members of the alliance, to provide information to consumers, to handle enrollment, and to adjudicate complaints.

--Alliances do not regulate health plans. That responsibility is left to state governments, where it is today.

--In fact, alliances are **required** to offer any health plan that is certified by the State government, is willing to fulfill the same contractual obligations as any other insurer offered by the alliance, and will offer a premium consistent with the budget.

--The whole point of the managed competition system is to **put the individual consumer in the driver's seat, not the government and not the health plans.**

The Republicans have a general concern about the impact of the program on small business, as do many of the Democratic members. The general approach of shared responsibility that the President and First Lady have been advocating is a persuasive one. A strong pitch, with

specific examples, of the assistance this plan will provide to small businesses would be very effective.

An additional issue that is of concern to Senator Durenberger--and to some of the Democratic members--is the question of whether a uniform national rate of increase will penalize areas that already have competitive, efficient health systems--like Minnesota. (Other members, like Senator Kennedy, would object to a program not based on historical spending).

Senator Durenberger feels the Medicare program already penalizes such areas in two ways. First, the Medicare payment to HMOs that enroll seniors is unfairly low in such areas. As you know, Medicare pays 95 per cent of the average community rate; since the community rate in Minnesota already factors in savings from managed care, Durenberger feels HMOs are victimized by below-cost reimbursement. Second, Durenberger feels that the national financing of Medicare shifts money from low-cost states to high cost states. Like others, Durenberger has not fully grasped the distinction between a program financed nationally by taxes and a program financed locally by premium-payers.

This issue is sufficiently complicated that I would not address it in an opening statement. If Durenberger raises it, the response might emphasize the following points:

--I want to work with you on the issue of Medicare reimbursement to HMOs;

--the budget is a ceiling, not a floor, and businesses and individuals in the high cost areas will have a strong incentive to hold cost increases below the cap.

--this is an issue the national board will be looking at. We do not have enough data today to separate out higher costs that are due to population characteristics from those that are due to wasteful practice patterns.

LIKELY QUESTION TOPICS AND ISSUES

We will hopefully have a list of the topics that will be covered by at

least the Democratic Senators by tomorrow. At this point, topics that seem likely to come up include:

1. Budget targets/financing. We thought that Senator Kennedy's first question might focus on the Medicare/Medicaid cuts and the realism of the financing, so that Mrs. Clinton has the opportunity to respond right up front.

2. Abortion--likely from Coats or Mikulski.

3. Tax cap--a Durenberger favorite. The response that the equal employer contribution serves the same purpose would be effective.

4. Long term care--Mikulski

5. Primary care emphasis--Wofford

6. Senator Pell--longevity, prevention.

7. Biomedical research--Harkin

8. Jeffords--State flexibility

9. Wellstone--Co-payments, deductibles, lack of subsidy beyond the average premium; also mental health.

10. Bingaman--rural health, small business, health education, enforceable budget cap.

11. Dodd--insurance and pharmaceutical industry concerns

12. Metzenbaum--Consumer protection

13. Coats--Medical savings accounts

14. Hatch--dietary supplements, enterprise liability, budgets are tantamount to price controls and rationing