THE WHITE HOUSE

WASHINGTON

September 2, 1993

The Honorable Robert Dole
Senate Republican Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Leader:

As you know, I share your belief that health reform is and must be a non-partisan issue. It is clear that our constituents want us to work together to pass a long overdue health reform initiative.

For months now, Hillary and representatives from the Administration have held numerous meetings with Senators and Representatives from both parties on the health reform issue. I have been pleased with reports from her and others about how constructive the discussions have been. It has become clear that the vast majority of the Congress wants to contribute to and support a package that stems the tide of skyrocketing health care expenditures while assuring that all Americans have health insurance protection.

While there have been many extremely encouraging signs that we are working with similar health policy goals and approaches to reach those goals, we can do better in developing a closer and more constructive working relationship. I would, therefore, like to take this opportunity to invite you and the Republican Senate Members of your choosing to meet with the First Lady and me as soon as our schedules permit early this month.

I believe these meetings will give us the opportunity to review the options that we have before us to meet our mutual goals of containing costs, providing universal coverage, improving quality, and assuring choice of health care providers. These are daunting but achievable goals that must be met in order to provide health and economic security for all Americans.

In addition, I have directed Administration representatives to prepare a health care briefing workshop to be offered to Republican and Democratic Members BEFORE the Health Security plan is publicly released later in September. These bipartisan meetings will provide detailed briefings on the health reform policy and the rationale behind it.

The workshop will provide a general outline and philosophy of the proposal by the First Lady, followed by much more specific discussions of the provisions of the plan as they relate to issues of most concern to Members. For example, issues such as (1) cost containment; (2) financing; (3) the role, benefits and responsibilities of businesses; (4) rural health care; (5) how the Medicare and Medicaid populations will be affected; and many others will be discussed in great detail during these workshops.

Members of the Cabinet, White House officials and other key staff within the Administration will conduct these briefings and question and answer sessions. As currently envisioned, the briefings will be offered on a repeated basis starting late in the afternoon on Sunday, September 19, and ending early in the afternoon on Tuesday, September 21. If this concept and timeframe meets with your and Republican Leader Michel's approval, I would like to have my staff meet with your staff to discuss the logistics of these sessions.

There are few issues which offer the opportunity to forge new, bipartisan working alliances as much as health care. It is my hope and expectation that we will develop a plan that both Republicans and Democrats can proudly support. I look forward to hearing from you and House Republican Leader Michel, who has received a similar letter.

Sincerely,

Bill Clinton

M E M O R A N D U M

TO: First Lady Hillary Rodham Clinton February 4, 1993
FR: Chris Jennings
RE: Dole, Chafee Visit Following Senate Democrats Meeting
cc: Melanne, Steve R.

Following your Senate Democrats Meeting, you and your staff are scheduled to meeting with Senator Dole and Senator Chafee (R-RI), Chairman of the Republican Health Task Force. Steve Richetti has indicated that there may be others, in particular Senator Durenberger (R-MN).

ISSUES TO RAISE

* Consistent with the President's appointment of Senator Dole as one of the four lead Congressional health care representatives, will look forward to building on what you feel will be a close and productive working relationship.

* If there are problems, I want to know about it. I will be as responsive as possible. Based on our previous conversation, I know that this will be a two-way commitment.

* Will consult Senator Dole as frequently as possible. Interested in having a good relationship with not only Senator Dole, but with all Republicans committed to effective cost containment and universal coverage.

* Outline the structure and roles of Task Force and Working Groups. Omit ANY discussion of incorporation of staff into the work groups, however. (They should not know anything about the Democratic staff role at this time and we believe it is unwise to address unless raised by them).

ISSUES THEY MAY RAISE AND TO DANCE AROUND (as you have)

* They will suggest that the Administration needs Republicans to pass a bill and it would be best not to draw significant lines of destinction between the way Democrats and Republicans are treated.

* Raise questions about financing and how cost containment savings are allocated.

* Raise questions about legislative strategy, i.e. what will be timing and the likely legislative vehicle.

Dole/Packwood File

DRAFT

August 9, 1994

SUMMARY OF DOLE/PACKWOOD HEALTH REFORM PROPOSAL

I. GUARANTEED ACCESS TO COVERAGE

A. Insurance Reforms

1. There are two health insurance market sectors:
   a. Individuals and small employers size 1 to 50.
   b. Large groups (employers with more than 50 employees or members, and associations and MEWAs with at least 500 participants).

2. The insurance market reforms apply to all health plans, including self-insured plans, with the following exceptions:
   a. Accident, dental, vision, disability income, or long-term care insurance;
   b. Medicare supplemental policies;
   c. Supplements to liability insurance;
   d. Workers compensation insurance;
   e. Automobile medical-payment insurance;
   f. Specific disease or illness policies; or
   g. Hospital or fixed indemnity policies.

3. Guaranteed issue and guaranteed renewal.
   a. A health plan may not deny, limit, condition, or refuse to renew a health benefit plan except as indicated in (c) below.
   b. A self-funded health plan sponsored by an employer cannot deny, limit, condition, or refuse to renew coverage for any employee (and family) except as indicated in (c) below.
   c. Exceptions:
      i. Pre-existing condition limitations can be imposed on individuals who do not maintain continuous coverage as described in (4) below.
      ii. Failure to pay premiums;
      iii. Misrepresentation of information to the insurer, or fraud;
      iv. The health plan doesn't serve the area;
      v. The health plan withdraws the health benefit plan from the market entirely.
      vi. The health plan does not serve the market sector to which the person or group belongs.
      vii. The health plan has insufficient capacity to enroll new members.

d. A health plan that has approached its capacity limitations can refuse to accept new enrollment, or limit enrollment based on a first-come, first-served basis.

e. Individuals will have an annual open enrollment period of at least 30 days prior to the expiration of their health plan policy, during which individuals can change health plans without being subject to pre-existing condition exclusions. Individuals can make changes between open enrollment periods for certain qualifying events like changes in family status, employment, residence, etc.

f. Newborns are covered automatically on the parent's policy at birth.

g. Insurers or employers cannot impose waiting periods for coverage beyond a reasonable time necessary to process enrollment, except in accordance with the standards for pre-existing condition exclusions described in section 4 below.

4. Portability and Pre-existing Conditions

a. Health plans may not impose pre-existing condition limitations on individuals enrolling as a member of a group, except in cases where the individual has not been insured during the previous 6 month period.

i. The maximum allowed pre-existing condition exclusion for a condition diagnosed or treated during the 3 months prior to coverage is 6 months.

ii. The maximum is reduced by one month for every month the individual had coverage during the preceding 6 month period.

b. Health plans may not impose pre-existing condition limitations on individuals who are not enrolling as a member of a group, except in cases where the individual has not been insured during the previous 12 month period.

i. The maximum allowed pre-existing condition exclusion for a condition diagnosed or treated during the 6 months prior to coverage is 12 months.

ii. The maximum is reduced by one month for every month the individual had coverage during the preceding 12 month period.

c. Amnesty period.

i. Each state will set an initial 90 day open enrollment period during which individuals who have not previously had health benefit coverage can enroll without being subject to pre-existing condition limitations.

ii. A state may establish a limit on the number of new enrollees a health plan must accept during the amnesty open enrollment period. The limit should correspond proportionately to the total number of enrollees the plan has in that market sector.

5. Modified community rating (applies to all products in the individual and small group market only).
   a. Uniform age and family classes will be defined by the National Association of Insurance Commissioners (NAIC).
   b. NAIC will recommend allowed discounts for health promoting activities.
   c. The ratio of rates between the highest and lowest age factor (ages 18-64) may not exceed 4:1 for the first 3 years after implementation, and 3:1 for years thereafter.
   d. NAIC to recommend allowed variations in administrative costs (not to exceed 15 percent of premium) based on size of group.
   e. States will define community rating areas subject to the following:
      i. Minimum area population of 250,000.
      ii. May not divide metropolitan statistical areas within a state.
      iii. May cross state boundaries if states agree.

6. Every health plan selling in the individual and small group market sector must offer the FedMed package.
   a. An insurer must at least offer one of the following versions of the FedMed package:
      i. Fee-for-service,
      ii. Preferred Provider Organization (PPO), or
      iii. Health maintenance organization (HMO).
   b. Health plans may offer any other health benefits packages in addition to the FedMed package.
   c. Health plans may offer supplemental packages to the FedMed package, but may not require an individual or a group to purchase supplemental coverage or link the pricing of a supplemental benefit package to that of the standard package.

7. There is no restriction on the number of different benefit packages that can be offered by a health plan. However, the rates for all of the health benefit packages offered by the health plan must be based on the health plan's total enrollment in the individual and small group sector. Rating variations are allowed only to the extent of the difference in actuarial value of the specific benefit variations for that same population.

8. Health plans and purchasing cooperatives may require payment of premiums through payroll deductions. Employers must comply with employee request for payroll deduction and remittance of premium.

9. Risk adjustment (applies to the individual and small employer market only.) States are to risk adjust community-rated health plans and reinsurers of health plans for small employers who self-insure. All self-insured small employers are required to carry "stop-loss" insurance.

10. Standards developed by the NAIC for the individual and small group market shall be uniform for all carriers.

11. Each state will publish annually and disseminate a list of all of the health plans in the state offering the FedMed package and their modified community rate for the package. This effort will be coordinated with the information on health plan quality.

12. Neither the states nor purchasing groups would be permitted to interfere with the ability of health insurers to establish and pay adequate compensation to licensed agents and brokers.

13. Taft-Hartley health plans, rural electric and telephone cooperative health plans and church association health plans shall be subject to the insurance reforms applicable to large employer plans.

B. Purchasing Cooperatives, FEHBP, HMOs and Association Plans

1. Nothing in this bill requires the establishment of a purchasing group -- nor prohibits the establishment of more than one --in an area.

2. Purchasing groups established to serve the individual and small employer market must be open to all individuals and small employers who wish to join.

3. Any health plan offering a benefit package through a purchasing cooperative must offer at least the FedMed benefit package through the cooperative.

4. Insurers are prohibited from establishing a purchasing cooperative but may administer one under contract with the purchasing cooperative.

5. Federal Employees Health Benefit Plan
   a. Self-employed individuals and small employers (size 2 to 50) may purchase health benefit plans offered through FEHB program.
   b. Insurers shall offer self-employed individuals and small employers the same benefit plan(s) that are available to federal employees at the same premium price (government and employee share) plus an administrative fee.
   c. Health plans may impose group participation requirements as long as they are standard for all groups.

6. MEWA and Association Health Plans
Limited rules are applied to existing MEWAs and Association health plan offering health plans on 1-1-94 (i.e. " Grandfathered plans") and a more comprehensive regulatory scheme is applied to all new MEWAs and association plans. Grandfathered plans and all new plans that meet the following rules shall be treated as a large employer for insurance reform purposes.
   a. Grandfathered plans (both insured and self-insured) must have at least 500 participants. In addition, grandfathered plans cannot:
      i. Condition its membership on health status or health claims experience of a potential member.
      ii. Exclude an employee or dependent of a member based on their health status.
   b. Grandfathered plans that self-insure must:
      i. File written notification with the Secretary of Labor that:
         (1) includes a description of the plan; and,
         (2) names a plan sponsor.
      ii. Meet minimum financial solvency and cash reserve requirements for claims established by the Secretary of Labor.
      iii. File annual funding reports (certified by an independent actuary) and financial statements with the Secretary of Labor and all participating employers in the plan.
      iv. Appoint a plan sponsor that would be responsible for operating the plan and seeing that it complies with all federal and state laws.
   c. All new MEWAs and association health plans must:
      i. Cover at least 500 participants.
      ii. Complete a certification procedure established by the Secretary of Labor.
      iii. Meet all the requirements in 6.a. and if self-insured, meet the additional requirements in 6.b.ii. through iv. above.

iv. Be formed and maintained for substantial purposes other than obtaining or providing health insurance to members.
v. Be offered or sponsored by a permanent entity which receives a substantial majority of its financial support from its active members.
vi. Not be owned or controlled by an insurance carrier.
vii. Has a constitution, bylaws, mission statement or other similar governing documents.
viii. All persons involved in operating, administering and/or handling money with respect to plan would have to be bonded for theft and other intentional acts.
ix. Pay a $5,000 certification fee to the Secretary of Labor. The Secretary may also charge a reasonable annual fee to cover the cost of processing and reviewing annual filings.

d. The Secretary of Labor shall develop regulations implementing the requirements of this section including expedited registration, certification, review and comment procedures.
e. The Secretary may enter into agreements with states to enforce the provisions of the section to the extent that the delegation does not result in a lower level or quality of enforcement. Such delegation may include certification and registration of MEWAs and association plans.
f. Associations and MEWAs must provide written notice to each contributing employer as to whether it has met the applicable requirements of this section 6.
g. All individuals operating or administering or involved in the financial affairs of association health plans or MEWAs must be bonded.
h. Taft-Hartley health plans, rural electric and telephone cooperative health plans with 500 or more participants and church association health plans with 100 or more participants are exempt from all requirements described in section 6 and are subject to the insurance rules applicable to large employer plans.

C. Affordable Coverage

1. Tax Deduction for Self-Employed

Self-employed individuals and other individuals who do not get health insurance from their employers would get a deduction equal to 100 percent of the cost of insurance phased in as follows:

1994 and 1995 -- 25% 1998 and 1999 — 75%
1996 and 1997 -- 50% 2000 and after -- 100%

2. Medical Savings Accounts
   a. Medical savings accounts (MSAs) are linked with the purchase of catastrophic health insurance coverage (health insurance policy with a minimum $1,000 annual deductible for single, and $2,000 for family coverage).
   b. Employer contributions to MSAs are excludable from an employee's income and not subject to payroll taxes. Employer can deduct its contributions.
   c. Contributions by self-employed and individuals (whose employers do not provide employer-subsidized insurance) are deductible from income and excludable from payroll taxes.
   d. Annual limit on contributions--$2000 single person and $4000 for families (one account per family).
   e. No lifetime limit on amounts contributed.
   f. Distributions from the account would be tax-free and penalty-free if used for medical expenses not reimbursed under the catastrophic policy, premiums for catastrophic coverage during "COBRA" continuation coverage, and for premiums and medical expenses for long-term care. Premiums for catastrophic coverage cannot be paid out of MSA unless the individual qualifies for COBRA continuation coverage.
   g. MSAs subject to prohibited transaction, reporting and certain other rules applicable to IRAs.
   h. Tax-free rollovers between MSAs but not between MSAs and IRAs.
   i. Non-qualified withdrawals are taxable and subject to a 10 percent penalty.
   j. Not transferable at death and taxable to decedent.
   k. No tax-free build-up.
   l. Distributions on account of divorce to follow rules applicable to IRA's.

3. Low-income Subsidies
   a. Creates a new safety net subsidy program for low-income individuals and families not covered by employer-provided insurance or public programs. Subsidies would be financed by the Federal government consistent with the Budget Fail-Safe mechanism (described later).
   b. Subsidies would not be provided to:
      i. Individuals/families who are not U.S. citizens or permanent resident aliens;
      ii. Medicaid eligibles;
      iii. Medicare beneficiaries; or

iv. Individuals who receive employer-financed coverage.

c. An employer that finances health care coverage for any employee would not be allowed to discriminate against any employee based on his/her eligibility for a low-income subsidy. Employers who violate this rule would be assessed a penalty equal to the maximum subsidy amount for the geographic area multiplied by the number of affected individuals.

d. In the case of an employee working for an employer providing employee-only coverage (not including the employee's dependents) and whose family is otherwise eligible for a subsidy, the employee would have the option to take the employer's coverage or subsidized family coverage.

e. Subsidies will be applied only to the purchase of the FedMed package defined by the Secretary of HHS. By regulations, the Secretary shall establish a FedMed benefits package that includes, at a minimum, the categories of benefits described in Title 5 of the United States Code for the Federal Employees Health Benefit program and in the HMO Act of 1973 (Section 1302(1) of the Public Health Service Act). In so doing, the Secretary shall take into account, the following priorities:
   i. Parity (with respect to cost-sharing and duration of treatment) for mental health and substance abuse services, managed to ensure access to medically appropriate treatment and to encourage use of outpatient treatments to the greatest extent feasible;
   ii. Consideration for needs of children and vulnerable populations, including those in rural, frontier, and underserved areas; and
   iii. Improving the health of Americans through prevention.

f. In general, health plans will determine the medical appropriateness of specific treatments. Coverage decisions about new procedures and technologies will be made by health plans, which may refer to criteria for medical appropriateness developed by the Secretary.

g. The Secretary shall vary cost sharing arrangements to accommodate different delivery system models through which subsidized individuals may receive health care services. All versions of the FedMed package shall have reasonable cost-sharing (including an out-of-pocket limit) appropriate to the delivery system.
   i. For a moderate cost sharing version, cost sharing shall be similar to the health plan in the Federal Employees Health Benefit

program with the highest enrollment that uses a fee-for-service delivery system.

ii. For a low cost sharing version, cost sharing shall be similar to the HMO plan in the FEHB program with the highest enrollment.

iii. For plans with provider networks, higher cost-sharing sufficient to encourage use of the network shall be allowed for out-of-network, nonemergency services.

h. In defining the initial benefits package, the Secretary shall ensure that the actuarial value of the package in its fee-for-service version be equal to the actuarial value of the highest-enrollment plan offered under the Federal Employees Health Benefit program in 1994, assuming a national population under age 65. Managed care health plans shall offer the same set of services defined by the Secretary for fee-for-service health plans.

i. Subsidies would be provided for premiums only, up to a maximum amount. The maximum subsidy amount would be the amount the Federal government uses to calculate its maximum (75%) contribution for Federal employees' insurance under FEHBP, calculated without the population 65 and older. The maximum amount would be determined annually. Nothing shall be construed as preventing an individual or family from buying a health plan covering the FedMed package that is more expensive than the maximum subsidy amount. The individual would have to pay the difference between the health plan's premium and the maximum subsidy amount.

j. The Secretary of HHS will specify maximum subsidy amounts for each geographic market area for the same age groups and family composition classes in the small group market. The Secretary would use appropriate factors to adjust the maximum amount for:

i. Geographic differences in health care costs;

ii. Age; and,

iii. Family composition (there would be no poverty adjustment for family size greater than 4).

k. Individuals and families with income below 100% of the Federal poverty level (if funding is available) would receive a full premium subsidy.

l. If additional funding is available, individuals with income above the poverty level would receive a partial premium subsidy. Individuals above 150% of poverty would not be eligible for a subsidy.

m. For individuals with income above the poverty level but below 150%, the subsidy percentage would

decline on a stepped basis as income increased. The amount of the subsidy would be a percentage of the maximum subsidy amount for individuals below poverty.

n. Eligibility for subsidies will be calculated on an annual basis. Tax return information will be used in determining eligibility to the extent possible.

o. An individual or family that has an approved application for a subsidy must file an end-of-year income reconciliation statement. Failure to do so will result in ineligibility for subsidies until the statement is filed, unless there is good cause.

p. States would determine eligibility for subsidies. States will be liable to the Federal government for subsidy payments made in error. The Federal government would share the administrative expense of determining eligibility for subsidies at a rate of 50% Federal/50% state.

q. States would designate appropriate agencies/organizations that would determine eligibility and enroll individuals in health plans on-site. States would be required to provide information on all health plans offering the FedMed benefit package in the geographic area.

r. The Secretary of HHS will develop standards to assure consistency among states with respect to data processing systems, application forms, health plan information, and other necessary activities to promote the efficient administration of subsidies.

s. The Secretary will study and make recommendations to the Congress regarding use of state-adjusted poverty level guidelines instead of the Federal poverty level guidelines when determining eligibility for subsidies.

D. Report on Health Care System

By January 15, 1998, the President must submit to the Congress findings and recommendations on each of the following:

1. Characteristics of the insured and uninsured, including demographic characteristics, working status, health status, and geographic distribution.
2. Steps to improve access to health care and increase health insurance coverage of the chronically uninsured.
3. Effectiveness of insurance reforms on access and costs.
4. Effectiveness of federal assessments of new technology on the cost and availability of new products.

5. Effectiveness of cost containment strategies at the federal and state level and in the private sector.
6. Effectiveness of efforts to measure and improve health care outcomes in the public and private sector.
7. Effectiveness of new federal subsidy programs, including recommendations to restrain future growth.
8. Effectiveness of initiatives targeted to underserved urban and rural populations.

II. IMPROVED HEALTH CARE DELIVERY SYSTEM

A. Consumer Value In Health Plans

1. A "Consumer Value" program will be developed by the states for the purposes of:
   a. Assuring minimum quality standards for health plans;
   b. Making available comparative information about health plan offerings; and
   c. Establishing certain consumer protections.

2. The Secretary of Health and Human Services will assist the states in carrying out these activities by:
   a. Consolidating research activities for quality and consumer information areas;
   b. Developing minimum guidelines for use in certifying health plans in the areas of quality assurance, consumer information, consumer protections, and financial practices and performance; and
   c. Requiring states to establish a consumer value program that results in comparative information on health plan offerings and quality distributed to all consumers.
   d. Offering grants to states to set up the consumer value program.

3. Consolidating Research Functions for Quality and Consumer Information
   a. Current federal research activities supporting quality and consumer information will be consolidated within HHS and called the Agency for Quality Assurance and Consumer Information. The agency will carry out its activities in close consultation with expert private and public entities in quality and consumer information. Research priorities will be set in consultation with expert groups.
   b. The focus of the new consolidated research area will be to support activities in the areas of:

i. Effectiveness and appropriateness of health care services and procedures;
ii. Quality management and improvement;
iii. Consumer information and surveys concerning access to care, use of health services, health outcomes, and patient satisfaction;
iv. Development, dissemination, applications, and evaluation of practice guidelines;
v. Conduct effectiveness trials in the private sector in partnership with expert groups;
vi. Assure the systematic evaluation of existing as well as new treatments and diagnostic technologies in a continuous effort to upgrade the knowledge base for clinical decision-making and policy choices;
vii. Recommend minimum guidelines for quality measures, consumer information categories, and access (to health services and practitioners) for use in health plan certification;
viii. Recommend standards and procedures for data and transactions related to quality, consumer information, access, effectiveness, and other areas as appropriate to assure a smooth coordination with the administrative simplification framework; and
ix. Oversee basic and applied research, with equal attention to each.

c. Funding will be $250 million a year by the year 2000 (phased in). Spending will be split to support research and the application of research in the private health care delivery system.

4. <u>Process for Certification</u>

a. Secretary of HHS Responsibilities

i. The Secretary, in consultation with NAIC and expert groups in the areas of quality assurance (such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, and the Peer Review Organizations) will set minimum guidelines for the certification of health plans. The Secretary is to complete the guidelines within 6 months of enactment of the bill.
ii. Special Federal rules would apply to self-insured multi-state employer plans and MEWAs.
iii. The Secretary will approve certifying organizations that are qualified to complete health plan certifications in any state.

b. States' Responsibilities
   i. States will be responsible for implementing the guidelines;
   ii. States are expected to coordinate public health department and insurance commissioner offices' (and other relevant agencies) responsibilities in designing the certification process (and enforcement procedures);
   iii. States shall consult with expert private entities in designing their certification and enforcement processes;
   iv. States may contract with private entities (giving them deemed status) for carrying out the certification activities; and,
   v. Health plans must absorb the costs of certification, however, the State and/or the Secretary may provide monies for technical assistance for health plans serving vulnerable populations to pay for certification or to assist these plans in preparing to be successfully certified.

5. Minimum Guidelines for Health Plan Certification
The Secretary of HHS will develop minimum guidelines for certification of health plans in these areas:
a. Quality Assurance Guidelines
   i. Quality management
   ii. Credentialling
   iii. Utilization management
   iv. Governance
   v. Policy and quality processes
   vi. Provider selection and due process
   vii. Guidelines and protocols
b. Consumer Protections
   i. Comparative consumer information
   ii. Marketing-agents and materials
   iii. Non-discrimination
   iv. Continuation of treatment (in the event of insolvency)
   v. Grievance procedures
   vi. Advanced directives
   vii. Financial practices that interfere with quality of care
c. Reasonable Access
   i. Assuring access to services for vulnerable populations-ProPAC will complete recommendations within one year, including:
      (1) Anticipated impact of health reform on access to services for vulnerable populations; and

(2) Safeguards required to assure continued access to services and reasonable payment for services for vulnerable populations.

ii. Anti-redlining rules

iii. Provider non-discrimination (e.g., discrimination solely based on the provider's academic degree)

d. Financial standards (using NAIC model standards)

i. Solvency

ii. Other financial standards including liquidity, accounting, and reporting

iii. Guaranty fund participation

In establishing minimum guidelines, the Secretary (in consultation with the NAIC) will address the issues (and recommend customized guidelines for each) of certification for various models of health plans, taking into consideration:

a. Multi-state insured plans,

b. Frontier, rural and inner city considerations (and other start-up issues for small delivery systems in underserved areas), and

c. Commercial insurance, managed care plans, and delivery-system (provider-based) plans.

6. <u>Consumer Value Program</u>

a. States shall begin immediately, upon enactment, to establish a consumer value program that results in the distribution of comparative information on health plan offerings and quality outcomes to consumers;

b. States may designate an independent organization to carry out the consumer value program (giving it deemed status);

c. The Secretary of HHS will provide to states the minimum guidelines for the consumer value program (see minimum guidelines for comparative consumer information (5.b.i.), including a model "report card" to assure a level of standardization to allow state to state comparisons;

d. States may exceed the minimum guidelines- federal grants will be available to states for demonstrations experimenting with guidelines beyond the federal minimums;

e. If the Secretary determines that states have not established a consumer value program within six years, the Secretary may implement such in the state.

7. Pre-emption of State Anti-Managed Care Laws
State anti-managed care laws are preempted, such as:
   a. 'Any willing provider' laws;
   b. Corporate practice of medicine;
   c. Health benefits mandates;
   d. Cost-sharing mandates;
   e. Utilization review mandates; and,
   f. Involuntary denial of life-saving medical treatment.

8. Administrative Simplification
   a. Secretary of HHS will adopt standards for health data and transactions (from common practices in the private sector). Categories of standards may include:
      i. Financial, administrative transactions;
      ii. Enrollment information;
      iii. Financial and administrative data;
      iv. Unique identifiers (subject to strict patient confidentiality requirements).
   b. Use of and access to standard transactions and standard data through the National Health Care Data Network.
      i. Health plans, providers must keep data available for authorized access and comply with transmission standards set by the Secretary. Clearinghouses may be used to comply.
      ii. Penalties apply for noncompliance to standards.
   c. State 'Quill Pen' laws are preempted.
   d. Entities operating in the national health care data network. Secretary develops standards for the Health Care Data Clearinghouses. Private entities may be designated to certify such systems and clearinghouses.
   e. The Secretary of HHS will set standards for providers and health plans to access information from the network, including standards for privacy. Only minimum data necessary will be disclosed and only when authorized by privacy laws.
   f. A Health Care Data Advisory Panel will be established to assist the secretary in all standards and processes, including standards for privacy.
   g. Secretary may authorize grants for demonstration projects.
   h. Administrative simplification standards and processes will coordinate with the quality and consumer information processes and certification areas.

i. The Medicare/Medicaid data bank (from OBRA93) will be repealed once the administrative simplification system is operational.

9. Authorization of Appropriations
This bill would authorize appropriations for the activities described above.

10. Fraud
a. The Secretary of HHS and the Attorney General shall jointly establish and coordinate a national health care fraud program to combat fraud and abuse in government and certified health plans.
b. Monies raised from anti-fraud and abuse penalties, fines, and damages will be dedicated to an account to pay the costs for anti-fraud and abuse efforts.
c. To give greater guidance to health care providers (so they can comply with fraud and abuse laws), there will be established:
i. New safe harbors;
ii. Interpretive rulings; and,
iii. Special fraud alerts.
d. The current Medicare and Medicaid penalties for health care fraud and abuse will apply to all health care fraud affecting Federal subsidies or other Federal outlays. These include exclusion from participation in Federal health programs and the imposition of civil money and criminal penalties.
e. The Secretary will comply with certain requirements to communicate violations anti-fraud and abuse laws.
f. A new health care fraud statute will be developed modelled after the mail and wire fraud statutes.

B. Building Primary Care Capacity in Underserved Areas

1. Purpose
a. Safeguards to assist vulnerable populations to access local health services and practitioners;
b. Funding in certain areas to assist providers and health plans to reconfigure services and establish networks to compete in the changing market;
c. Funding to increase primary care capacity in underserved areas; and
d. More flexible Medicare rules for providers in underserved areas.

2. Redefining Underserved Areas in the Changed Market
States to designate frontier, rural and urban areas as underserved taking into account:

a. Lack of access to health plans; and
b. Lack of access to quality providers and health care facilities in such areas.

The designations must be approved by the Secretary of HHS. Underserved areas do not need to meet MUA or HPSA definitions. The designation is for no longer than three years. Underserved areas receive priority for special funding included in this section.

3. Network Development Funds
   a. Planning funds
      i. Medicare and Medicaid waiver demonstrations to form health care networks; and,
      ii. Grants to private entities and states for use in planning and development of networks of providers and plans.
   b. Technical assistance funds -- to comply with health plan certification guidelines, administrative simplification data and transaction standards, quality assurance activities, consumer information programs, insurance reforms, and other reform requirements; and
   c. Capital (low interest loans) assistance for the reconfiguration of facilities, start-up capital, establishing reserves, and setting up information systems for entities in networks.

4. Increasing the Numbers of Services, Practitioners, and Plans
   a. Loan repayments for primary care practitioners in geographic areas recognized by the Federal Office of Shortage Designation.
   b. Tax incentives:
      i. A physician who provides primary health services in underserved areas would be eligible for a nonrefundable credit against Federal income taxes of up to 60 months.
      ii. A physician who provides primary health services in underserved areas would be eligible to take an additional $10,000 per year as section 179 deduction for health care property placed in service during the tax year.
   c. Increase Federal support for primary and preventive health care services aimed at segments of the population most likely to be uninsured and at high risk:
      i. Comprehensive Maternal and Child Health coordination aimed at improving health;
      ii. School-based Health Education -- Increase assistance for pre-school and elementary programs that provide comprehensive health

education to children; and,
iii. Special grants to frontier areas for preventive health services.

d. Increase Public Health Act funding for:
i. Grants to Community Health Centers, Migrant Health Centers, FQHCs and look-alikes;
ii. Increase funding for AHECs through 2000; and
iii. Fully fund the National Health Service Corps;

e. Funding for telemedicine and related telecommunications technology support for frontier and rural areas; and

f. Funding for medical transportation in frontier and rural areas.

5. Payment Flexibility
a. Extending RACH/RPCH to all states and making technical corrections;
b. Creating the REACH program;
c. Extending Medicare Dependent Hospital classification through 1998;
d. Extend the MAP demonstration to all states; and,
e. Increase Medicare reimbursement to physician assistants and nurse practitioners in rural and urban areas.

6. Studies, Responsibilities
a. ProPac will make recommendations within six months on the need for any transitional provisions to assure access for vulnerable populations;
b. The Secretary will study the need for and design of a 'supplemental rural benefits package' within six months of enactment; and
c. An Office of the Assistant Secretary for Rural Health will be established (elevates an existing position) to advise the Secretary on all rural provisions in reform.

7. Anti-Trust Clarifications
a. Mechanisms for clarification of anti-trust treatment for providers:
i. Certificates of Review- providers may apply to the Attorney General for certificates of review to be granted case-by-case.
ii. Notification- providers may file a notification of their joint venture activities with the Attorney General. Certain rule of reason analysis and damage rules shall apply in any subsequent suits.
iii. Guidelines- the Department of Justice shall issue guidelines clarifying legitimate collaborative activities of health care providers responding to community needs.

iv. Safe Harbors- The Department of Justice shall develop "safe harbors" in certain health care delivery areas by soliciting input through notice and comment procedures. The safe harbors shall help to reduce both the costs and administrative burdens of antitrust regulation reviews. Certain rules of enforcement and defense shall apply for organizations and ventures falling within the safe harbors. Certain areas must have safe harbor clarifications by the Justice Dept.

C. Health Professionals

1. Education

a. Oversight:

i. Establish Independent, Advisory Commission on Workforce --

(1) Federal oversight will be limited to an independent, non-governmental advisory council to the Congress, modeled on ProPAC and PPRC. COGME will be discontinued, with its funds used to partially finance the new Commission.

(2) The composition of the board will include experts in medical education, teaching hospitals, health plans, and other relevant parties.

(3) Sets in law the role of the Commission and a timetable for reports on specific questions of workforce policy and payment, including but not limited to:

(a) Profile the composition of the physician and non-physician workforce and address how the composition (numbers and mix) fits market needs;

(b) Amounts and process for funding;

(c) Future payment policy for Medicare for graduate medical education;

(d) Incentives for primary care and underserved areas;

(e) Foreign medical graduates' policy;

(f) Future direction and coordination of grants, demonstrations, and other funding affecting the workforce.

b. Increasing Primary Care Practitioners and Ambulatory Training.

i. Consortia demonstrations to increase primary care. The Secretary will conduct 10 Medicare

demonstrations for the purposes of increasing the numbers of primary care practitioners trained (graduate education). The demonstrations may be multi-state. All Medicare DME funds historically used in the geographic area may be distributed to consortia. Criteria for consortia will be established by the Secretary. Additional incentives dollars may be paid to consortia from any savings from IME reductions.

ii. Non-hospital-owned ambulatory sites will be eligible to receive DME payments.

c. Biomedical and Behavioral Research.
A voluntary check-off on individual income tax returns will be established to contribute dollars to a national research fund.

2. Malpractice

a. Cap on Non-Economic Damages at $250,000, with entity established to study a schedule of caps for congressional consideration.

b. Several Liability for non-economic and punitive damages.

c. Periodic Payments for damages of over $100,000, with judge given discretion to waive in interests of justice.

d. Collateral Source Rule - collateral sources are deducted from award to plaintiff.

e. Limits on Attorney Fees - Limited to 33 1/3% percent of the first $150,000 and 25% of amount over $150,000, after taxes.

f. Statute of Limitations - two years from date of discovery and no later than 5 years after occurrence. Claim may be initiated for minors under age six if two years from date of discovery and no later than six years after occurrence or before minor turns 11, whichever is later.

g. Clear and Convincing Standard for first seen obstetric cases.

h. Punitive Damages Reform. Includes Clear and Convincing Standard of proof; elements of proof; pleading and process requirements; cap on punitive damages (lesser of 2x compensatory damages or $500,000); dedication of 50% of award to health care quality assurance program.

i. Right of Subrogation or Automatic Subrogation under Collateral Source Rule.

j. Prohibition on Vicarious Liability.

k. All provisions cover all defendants in any Health Care Liability Action.

l. Consumer Protections - Require Risk Management by health care professionals, providers and insurers;

permits licensure boards to enter agreements with professional societies to license and review health care professionals; liability protection for state licensure boards.

D. Long-Term Care

1. Tax clarification

a. All long-term care services are treated as medical expenses under the tax law, meaning that --
   i. Long-term care expenses and insurance premiums above 7.5% of AGI would be deductible from income; and,
   ii. Payments under long-term care insurance policies would not be taxable when received.

b. Insurance companies can deduct their reserves set aside to pay benefits under long-term care insurance policies.

c. Permit long-term care riders on life insurance policies and treat like long-term care, not like life insurance.

d. Do not permit tax-free exchange of life insurance contract to long-term care.

e. Exclude certain accelerated death benefits from taxable income.

2. Minimum Standards for Long-Term Care Insurance

In order to receive favorable tax treatment, long-term care insurance policies would have to meet certain consumer protection standards. These standards include provisions based on the NAIC Model Act and Regulation (as of January, 1993) and supported by the insurance industry.

3. A nonrefundable tax credit of up to 50 percent of an employed individual's personal assistance expenses of up to $15,000 per year will be provided.

4. Modifications to Medicaid long-term care (see below).

5. Acute/LTC integration demonstration project.

III. IMPROVED FEDERAL HEALTH PROGRAMS

A. Medicaid

1. Acute Care

a. Beginning 1/1/00, all AFDC and non-cash Medicaid recipients will be integrated into the low-income subsidy program. These individuals will no longer

be entitled to acute care benefits under Medicaid, but would receive private health insurance through the low-income subsidy program. Supplemental benefits will be provided under a capped entitlement to the states. Nothing in this section should be construed as affecting an individual's eligibility for long-term care services under Medicaid.

b. Individuals eligible for AFDC and non-cash Medicaid recipients whose income exceeds the income thresholds of the low-income subsidy program would be grandfathered, i.e., deemed to have income below 100% percent of the Federal poverty level, and therefore eligible for a full premium subsidy.

c. Like all other individuals eligible for the low-income subsidy program, AFDC and non-cash Medicaid recipients would receive premium subsidies, up to a maximum amount, for the purchase of a certified health plan covering the FedMed benefit package.

d. Medicaid acute care (non-long-term care) services not covered by the FedMed benefit package would be provided as supplemental benefits under a capped entitlement program to the states, based on historical Medicaid spending for these services, plus a growth factor.
   i. States could provide these supplemental benefits to any individual qualifying for the low-income subsidy program.
   ii. States may give priority for the supplemental benefits to children, pregnant women, and individuals in medically underserved areas.
   iii. At the end of each Federal fiscal year, states may apply for any Federal funds for supplemental benefits not allocated to other states.

e. SSI and SSI-related (e.g., state SSP) recipients would generally remain eligible for services under the traditional Medicaid program. However, states would be given additional flexibility to enroll SSI and SSI-related recipients in Medicaid managed care programs, or in certified health plans covering the FedMed benefit package at a negotiated premium rate. The number of individuals electing to enroll in a certified health plan will be limited to 15% of the eligible SSI and SSI-related Medicaid population in the state in each of the first 3 years (beginning 1/1/97), increasing by 10 percentage points (e.g., 25, 35, 45, etc.) in each year thereafter.

f. State maintenance of effort.

i. States will make "maintenance of effort" (MOE) payments to the Federal government in an amount equal to each state's spending on acute care services covered by the FedMed benefit package for AFDC and non-cash recipients under Medicaid in the year prior to integration.

ii. Each state's MOE payment will be increased annually from the previous year by the weighted average increase in the maximum premium subsidy amounts in the state under the low-income subsidy program, plus the change in the state's population.

iii. Federal spending for the supplemental benefits will be based on Federal spending for AFDC and non-cash recipients for non-long-term care, non-FedMed-related Medicaid acute care services in the year prior to which the state's AFDC and non-cash recipients become eligible for the low-income subsidy program. Federal expenditures will increase annually from the previous year by the weighted average increase in the maximum subsidy amounts in the state under the low-income subsidy program, plus the change in population.

iv. At least 3 months prior to the date AFDC and non-cash recipients are integrated into the low-income subsidy program, the state must have an integration plan approved by the Secretary of HHS. The final plan will specify the state's MOE obligation.

g. Transition.

i. The bill establishes a Medicaid risk contract program which would allow states (at their option) to enter into risk contracts with organizations that meet Federal standards for access, enrollment, and quality assurance.

ii. Upon enactment, states would be permitted to:
(1) Enroll any groups of Medicaid recipients in Medicaid risk contract programs or private health plans (states would be required to offer recipients a choice of at least 2 plans); or,
(2) Apply for 1115 demonstration waivers.

iii. States with existing 1115 demonstration waivers would be allowed to continue until the state or the Secretary terminates the waiver, or until 1/1/00, whichever is earlier.

iv. At any point after enactment, states may apply for a waiver from the Secretary of HHS to integrate its AFDC and non-cash recipients into the low-income subsidy program when the low-income subsidy program begins (1/1/97). All states must integrate their AFDC and non-cash recipients into the low-income subsidy program by 1/1/00.

v. Beginning 1/1/97, Federal and state expenditures for FedMed-related acute care services would be capped on a per capita basis at the Federal and state matching rates multiplied by the weighted average maximum premium subsidy amount in the state. Federal expenditures for non-long-term care, non-FedMed-related acute care services would become a capped entitlement to states, based on Federal expenditures for such services in the state in the base year, increased annually by the increase in the weighted average maximum premium subsidy amount in the state.

vi. For states that integrate AFDC and non-cash recipients into the low-income subsidy program before 1/1/00, states will make "maintenance of effort" (MOE) payments to the Federal government in an amount based on each state's spending for acute services covered under the FedMed benefit package for AFDC and non-cash recipients in the year prior to which the state's AFDC and non-cash recipients become eligible for the low-income subsidy program.

vii. Each state's MOE payment for the FedMed-related services will be increased annually from the previous year by the weighted average increase in the maximum premium subsidy amounts in the state under the low-income subsidy program, plus the change in the state's population.

h. Federal Medicaid DSH expenditures will be reduced by 25 percent. The Secretary shall make recommendations regarding phasing out the DSH program or integrating the DSH expenditures into the per-capita amount as coverage increases.

i. Federal match rates would not be changed except to fix inequities for Alaska.

2. <u>Long-Term Care</u>

a. Eliminates the need for waivers to provide home- and community-based long-term care services under Medicaid (i.e., make them a state plan option).

b. Codifies that the "cold bed rule" does not apply (i.e., states can provide services to more individuals than there are nursing home beds in the state).
c. Allows On-Lok/PACE to expand sites and to be afforded provider status under Medicare/Medicaid.
d. Allows states to pursue public-private partnership programs that link Medicaid eligibility to the purchase of a qualified private long-term care insurance policy. Policies would have to meet Federal standards described in the tax code (see also "Long-Term Care").

B. Medicare

1. Medicare remains a separate program.

2. The Secretary of Health and Human Services will make recommendations to Congress, within one year of enactment, on the following:
   a. Allowing Medicare beneficiaries the option of:
      i. Enrolling in private health plans; and,
      ii. Establishing Medical Savings Accounts.
   b. Allowing Medicare-eligible military retirees to enroll in health plans sponsored by the Department of Defense or other appropriate federal health programs.

3. Improve risk contracts
   a. The Secretary shall provide Medicare beneficiaries information on Medicare options available in a beneficiary's area.
   b. Improvements in Medicare risk contract payment methodology:
      i. The Secretary shall establish Medicare rating areas to replace the current county based system. Metropolitan Statistical Areas may not be divided into different rating areas.
      ii. In determining the amount of payment for Medicare risk contracts, the Secretary shall use a direct calculation methodology applied to each rating area, adjusted to reflect the use of military, veterans, and other federal health program services.
   c. HMOs will have the option of requiring Medicare beneficiaries that enroll in risk contract plans to disenroll only during an annual enrollment period. HMOs choosing this option must inform Medicare beneficiaries of the disenrollment limitation prior to enrollment.

d. The Secretary of HHS may waive 50/50 rule (at least 50 percent of enrollment be non-Medicare) for Medicare risk contractors that meet certain quality standards.

4. Medicare Select will be a permanent Medigap option in all states.

5. The Social Health Maintenance Organization demonstration project is extended for two years.

C. **Veterans Affairs**

1. Grants VA sufficient flexibility to enable the VA to respond rapidly and effectively to Federal and state market reforms.

2. Grants the Department of Veterans Affairs the necessary legal authority and resources to respond effectively.

IV. FINANCING

A. Spending Savings

1. **Medicare Savings**

a. **Reduce Hospital Market basket Index Update.** This proposal reduces the Hospital Market Basket Index Update by 1%. Currently Medicare changes the inpatient per-discharge standardized amount be a certain amount every year to reflect input costs changes in Congressional direction. OBRA 1993 reduced the Index in Fiscal Years 1994 through 1997. This proposal would reduce the updates by 1% for Fiscal Years 1997 through 2000.

b. **Adjust Inpatient Capital Payments.** This proposal combines three inpatient payment adjustments to reflect more accurate base year data and cost projections. The first would reduce inpatient capital payments to hospitals excluded from Medicare's prospective payment system by 15%. The second would reduce PPS Federal capital payments by 7.31% and hospital-specific amount by 10.41% to reflect new data on the FY 89 capital cost per discharge and the increase in Medicare inpatient capital with a 22.1% reduction to the updates of the capital rates.

c. **Revise Disproportionate Share Hospital Adjustment.** This proposal phases down, but does not eliminate, the current disproportionate share hospital adjustment over five years.

d. **Indirect Medical Education (IME).** This proposal lowers the IME adjustment for teaching hospitals from 7.7 percent to 6.7 percent. (The IME adjustment recognizes teaching hospitals' higher costs for offering a wider range of services and technologies, caring for more severely ill patients, and providing more diagnostic and therapeutic services to certain types of patients than other hospitals.)

e. **Partially Extend OBRA 93 Provision to Catch-up after the SNF Freeze Expires Included in OBRA 93.** Sets SNF cost limits at 106% of the mean. OBRA 93 established a two-year freeze on update to the cost limits for skilled nursing facilities. A catch-up is allowed after the freeze expires on October 1, 1995. This bill allows a partial catch up for nursing homes while still realizing savings.

f. **Partially Extend OBRA 93 Provision to Catch-up After the Home Health Freeze Expires.** Sets cost limits for home health at 106% of the mean. OBRA 93 eliminated the inflation adjustment to the home health limits for two years. This bill allows a partial catch-up for home health after the freeze expires on July 1, 1996.

g. **Moratorium on New Long-term Care Hospitals.** This proposal eliminates new designations of PPS-exempt long-term care hospitals.

h. **Change the Medicare Volume Performance Standard to Real Growth GDP.** This changes the formula that is used to calculate the target rate of growth for Medicare physician services. This change directly connects the growth in physician services to the growth of the nation's economy.

i. **Establish Cumulative Growth Targets for Physician Services.** This changes the formula used to calculate the target rate of growth for Medicare physician services. Under this provision, the Medical Volume Performance Standard for each category of physician services would be built on a designated base-year and updated annually for changes in beneficiary enrollment and inflation, but not for actual outlay growth above and below the target.

j. **Reduce the update in the Medicare Fee Schedule Conversion Factor by 3% in 1995, except Primary Care Services.** The conversion factor is a dollar amount that converts the physician fee schedule's relative value units into a payment amount for each physician service. This provision reduces the 1995 annual update by 3%.

k. **Establish outpatient prospective payment system for hospital outpatient departments.** The Secretary of HHS is directed to establish a prospective payment system for hospital outpatient department services by January, 1995. If such a system is not established by that time, the Secretary would reduce hospital outpatient department payments sufficiently to achieve the anticipated savings.

l. **Extend the requirement that the Part B premium cover 25% of Part B costs.**

m. **Extend OBRA 93 Medicare Secondary Payor Data Match with SSA and IRS.** OBRA 93 included an extension of the data match between HCFA, IRS and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare.

n. **Extend OBRA '93 disabled provisions.** Extends the OBRA '93 provision making Medicare the secondary payer for disabled Medicare beneficiaries who have employer sponsored coverage.

o. **Extend the End-stage renal disease secondary payor provision.** Makes Medicare the secondary payer for ESRD patients with employer sponsored health insurance for 24 months, instead of the current 18 months.

2. Medicaid Savings

a. Federal Medicaid expenditures will reduced by integrating AFDC and non-cash recipients into private health insurance plans, with a capped entitlement for supplemental benefits.

b. Medicaid payments for disproportionate share hospitals (DSH) would be reduced by 25 percent (starting in 1997) to help pay for subsidies for low-income individuals and families without health insurance.

B. Budget "Fail-Safe" Mechanism

1. To ensure that new spending for health insurance subsidies for low-income persons and the health insurance tax deductions (including MSAs) do not exceed projections and increase the federal budget deficit, a fail-safe mechanism is included.

2. A baseline consisting of current projected spending for Medicare and Medicaid expenditures is established in the bill.

3. In any year that the Director of the Office of Management and Budget (OMB) notifies Congress that

total federal spending for:
a. Medicare,
b. Medicaid,
c. Low-income health insurance subsidies, and
d. New tax spending for health insurance deductions (including MSAs)

will exceed the statutory baseline, the following will occur:
a. The phase-in of the tax deductions will be frozen at whatever percentage it is;
b. The deduction for contributions to MSAs will be reduced; and,
c. The low-income subsidy phase-in will be slowed or rolled back to the extent necessary to assure no deficit spending.

4. Congress may enact alternative savings measures to avoid the automatic reduction in subsidies.

Some Talking Points on the Mitchell Bill and its Benefits for the Private Sector

- The two most important consequences of the Mitchell bill are:

  (1) it extends coverage to 27 million Americans, allowing us to reach 95% coverage through voluntary measures alone.

  (2) it reduces the deficit over 1995-2004.

- On average, a person purchasing private health insurance under reform in 1997 would pay about 9% less than they would have paid for the same package under the current system; in 2004 the average savings would be about 6%. The two most important reasons for these gains are:

  (1) reductions in uncompensated care from expanding coverage. Today, providers shift the unreimbursed cost of services delivered to the uninsured into higher charges for private payors, which pushes up premiums for the insured. Expanding coverage will permit these extra private charges to decline.

  (2) administrative savings from pooling individuals and small groups into purchasing cooperatives. Some pay administrative costs or "loads" of up to 40% today. CBO assumes and recent California experience suggests that loads closer to 13.5% are achievable under Mitchell-like conditions.

- The community-rated sector (individuals and firms with fewer than 500 employees) gains the most from the Mitchell bill, but the large firm sector gains as well, primarily from uncompensated care.

- While the community-rated sector does very well under the Mitchell bill, bringing the uninsured, nonworkers, and most under-65 Medicaid recipients into the community rated pool does increase costs slightly. The Mitchell bill has a mechanism to share the costs of demographic differences across the community-rated and experience-rated pools, which serves to equalize the average premiums in each pool by increasing experience rated premiums and decreasing community rated premiums. CBO estimates the required adjustment to be about 1.25%.

- If the mandate is not triggered, aggregate private health spending will be virtually equal to what it would have been in the absence of reform as 27 million more people would be insured with coverage that costs less than today.

- If the mandate is triggered, aggregate private health spending would be about 2% higher than baseline in 2004 as we add the remaining 14 million Americans to private health insurance coverage.

Dole Bill Fly 8/4/94

The Bob Dole "You're Out Of Luck" Plan

If you're looking for health insurance you can count on....you're out of luck.
Unlike Senator Mitchell's plan, which guarantees secure, affordable insurance, the Dole plan provides no guarantee of decent coverage. Millions would still have phony, fly-by-night insurance, and an estimated 30 million Americans would have no coverage at all.[Lewin-VHI, July 1994]

If you're looking for health insurance you can afford....you're out of luck.
The Dole plan allows insurance companies to continue to raise rates higher and higher each year, and to charge older people three to four times more than younger people. Some small businesses will continue to pay more than others, and some families more than other families. You could still work hard, pay your premiums, and have medical bills sent back "not covered".

As his Republican Colleague John Danforth said of the Dole plan, *"It creates a new entitlement and it doesn't have any cost control....I don't think we can do that."*[AP, 8/10/94]

Newsweek predicts the Dole plan *"will increase premiums for middle class people and could increase [the] number of uninsured."* [Newsweek, July 25, p. 19]

If you're a senior.....you're out of luck.
The Dole bill takes significant money out of Medicare and does little or nothing for seniors - no prescription drug coverage, and pitiful help with long-term care.

If you're a child with no insurance....you're out of luck
The Dole plan will continue to leave an estimated 30 million people with no coverage, including 6.2 million children. What does that mean? In means millions of kids will go without seeing the doctor, millions will not get needed health care in time to prevent disabling illnesses. And under Dole's plan, even workers who get coverage can find that their insurance policy covers them, but not their kids. Employers will continue to drop back family coverage and offer bare-bones, worker-only policies -- leaving millions more children at risk of losing the coverage they have now.

If you're a small business....you're out of luck
The Dole bill continues to permit insurers to charge higher rates to small employers just because they're small.[Dole Bill Sec.9002(d)(1) p. 117] Small companies pay 35% more on average as it is, and this insurance company abuse against smaller employers will mean the little guy still gets overcharged. And unlike the Mitchell proposal, there are no subsidies to help small businesses who can't afford coverage today afford it tomorrow.

If you lose your job....you're out of luck
The Dole plan theoretically allows people to take their same insurance with them when they leave their job and go to a new one (portability), this only helps those who can pay the full premium themselves. That is not realistic for most people, since they can't afford the full cost of coverage, especially if they are without a job. In fact, most workers have that protection now, either through state insurance laws or through COBRA coverage. But as a recent study by the Department of Labor shows, only one in five can take advantage of it -- the rest can't afford it. Even Senator Chafee admits:*"I have great trouble seeing how you get portability without universal coverage."*

The Bob Dole "The Insurance Company Protection" Plan

Insurance Companies Can Still Deny Coverage Through Loopholes and Fine Print

While the Dole plan describes a standard benefits package (called the FedMed package) and says that every health plan has to offer that option, it also allows insurance companies to offer any benefits package they want. [Dole Bill Sec. 21115 (a) p.85] This allows insurance companies to effectively deny coverage of certain illnesses by structuring benefits packages to not cover certain treatments. Millions of Americans will continue to face the nightmare of insurance claims coming back: "Sorry, not covered."

Few People Will Benefit From the Community Rating Reforms

Many of the insurance reforms in the Dole bill, modified community rating for example, apply only to the "community rated market" -- but there is no "community" in the bill's reform. Any employer can self-insure, so employers with young, healthy employees will likely stay out of the community-rated pool and provide insurance on their own. In addition, associations can opt out of the community-rated pool and buy as a group, leaving even fewer people in the pool. This "vicious spiral" will lead to very high premiums in the community-rated market and will encourage healthier people to drop coverage.

Mid-Size Businesses Could Face Large Premium Increases

Under the Dole Bill, many small to medium-sized companies would be left between a rock and a hard place -- too small to self-insure, but too large to get the benefits of insurance reform in the community-rated pool. An employer with 55 employees could have extremely high costs because of just one employee with a history of illness. They could see their rates jacked up based on one worker with a serious medical condition. For most firms in this category, insurance costs will continue to be high and unpredictable.

Insurance Companies Can Decide They Don't Want to Sell to Small Businesses

Insurance companies can decide that they want to avoid the small business sector altogether and refuse to sell insurance to any small businesses. Under the Dole plan, they could continue to deny coverage to small businesses.

Insurance Company Profits Protected, Middle Class Families Left Waiting

The Dole plan limits, but does not eliminate, the ability of insurance companies to deny or forestall coverage for "pre-existing conditions" [for six months to a year]. While all agree that pre-existing condition limitations are a necessary transition tool to universal coverage, the Dole bill will **never** get there, so exclusions will never go away.

Insurance Companies Could Charge You Three to Four Times More Because You're Older

The Dole plan allows insurance companies to charge older workers three to four times more for insurance than younger workers, and twice as much as under Senator Mitchell's bill.

Americans with Insurance Would Still Be At Risk of Losing It

The real bottomline is that under the Dole plan, everyone remains at risk of losing the insurance they have now -- because under a non-universal system, no one is guaranteed protection. As Newsweek magazine reported last week, the Dole plan "will increase premiums for middle class people and could increase [the] number of uninsured." [Newsweek, July 25, p. 19]

The Bob Dole "Cheating Seniors" Plan

Raids Medicare and Gives Seniors Nothing Back

While other bills reduce the rate of growth in Medicare, the Dole Bill relies heavily on savings from the Medicare program to finance reform. The Dole bill gives nothing back to the older Americans that Medicare was set up to serve. No help with prescription drugs. Nothing but lip service on long-term care.

Forces Millions of Seniors to Choose Between Food and Medicine

The Dole plan does not add prescription drug coverage to Medicare -- giving millions of older Americans no help paying for costly prescriptions. Prescription drug costs are the highest out-of-pocket expense for three out of four seniors, and the Dole plan would provide no help, forcing millions of older Americans to continue to choose between food and medicine. More than 31 million Americans under age 65, and 18.5 million Americans over age 65 would be denied prescription drug coverage under the Dole bill. [NCSC, "Six Reasons the Dole Bill is Bad for Seniors," 7/94] That's just one reason the AARP calls the Dole bill *"a harmful prescription for older Americans"*

Leaves Older Americans in Need of Long-Term Care at Grave Risk

Unlike Senator Mitchell's proposal, which invests $50 billion in a new home and community-based long-term care program, the Dole bill does next to nothing for long-term care. Older Americans in need of assistance will continue to face no choice but to enter nursing homes.

Discriminates Against Small Companies With Older Workers

Small firms with more than 50 employees will remain at the mercy of insurance companies who charge higher rates for older workers, higher rates for sicker workers, and raise rates when even one employee gets sick. This means older workers will have their jobs at risk when their employers look at their insurance premiums.

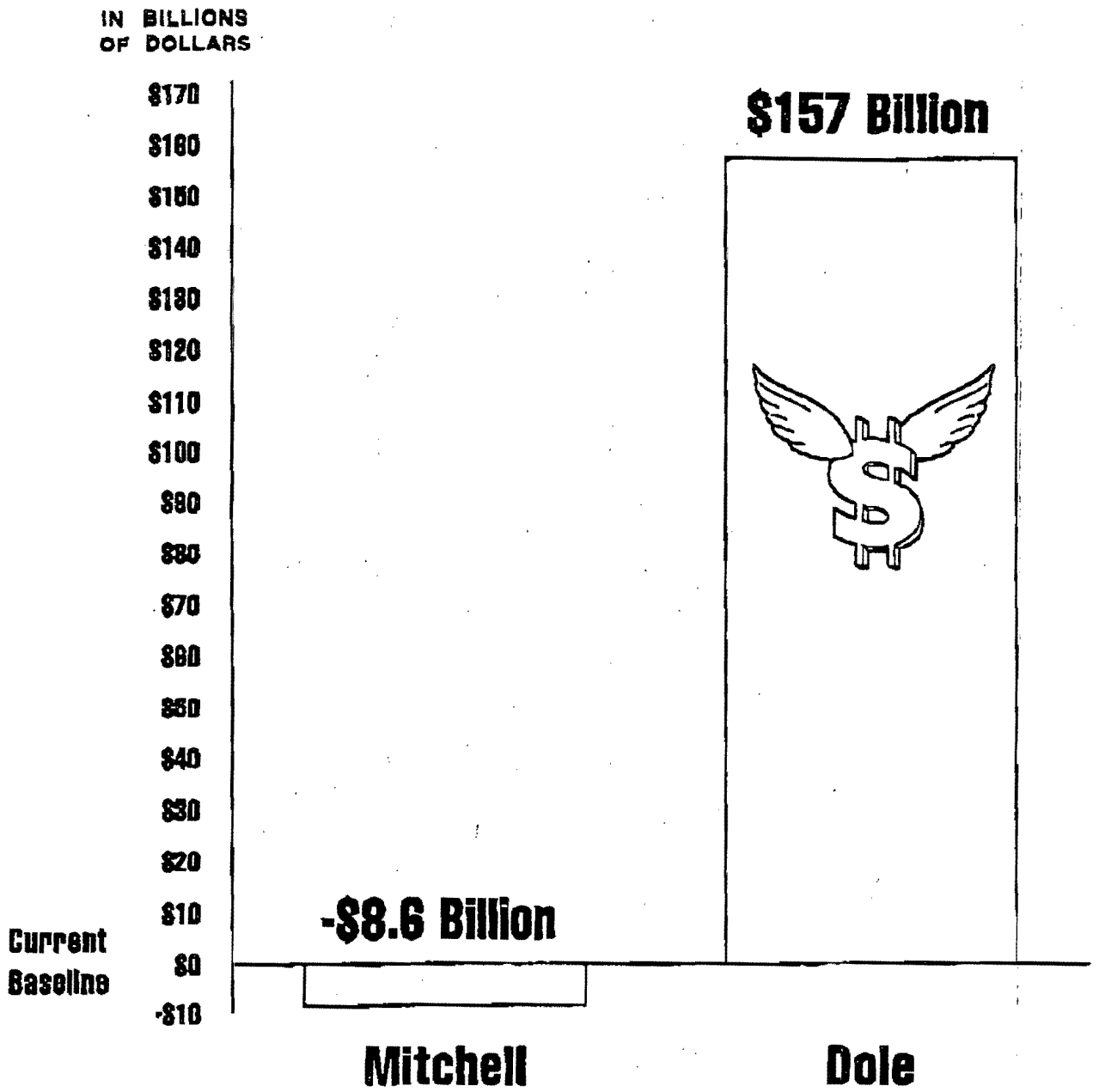
Insurance Companies Could Charge Older Americans Three to Four Times More Than Those Younger, and Double What They'd Be Charged Under the Mitchell Plan

The Dole plan allows insurance companies to charge older workers three to four times more for insurance than younger workers, and twice as much as under Senator Mitchell's bill.

Dole Fly

THE DOLE PLAN DRIVES UP THE DEFICIT BY MORE THAN $150 BILLION

Net Impact on the Federal Deficit, 1995-2004



Source: Mitchell—CBO Memorandum, 8/12/94; Dole—OMB Fiscal Analysis of the Dole Plan, 8/19/94

Dole File

CBO-Consistent Estimates: Lower Cost of Medicaid Coverage
Unofficial Preliminary Illustration of Counts of Newly Insured Under the Dole Plan
(Dollars in billions, fiscal years, persons in millions)

	1997	1998	1999	2000	2001	2002	2003	2004
Funds Available For Subsidies (1)	63.2	70.2	82.4	93.5	105.3	119.4	135.6	151.5
Costs: Purchasing Policies for AFDC & Non-Cash (2)	(40.5)	(46.2)	(48.6)	(53.3)	(58.4)	(64.0)	(70.2)	(77.0)
Net Funds Available for Subsidies After Covering Medicaid Population(3)	22.7	24.0	33.8	40.2	46.9	55.4	65.4	74.5
Numbers of Low-Income Persons Covered (millions)								
1. Senate Finance Premiums (4)	6.5	6.4	8.2	9.0	9.7	10.6	11.6	12.2
Uninsured (5)	33.5	33.6	31.8	32.0	32.3	32.4	31.4	31.8
Total Population (5)	266	266	268	270	272	274	276	278
Insured as a Percent of Total	87%	87%	88%	88%	88%	88%	89%	89%
2. Senate Finance Premiums + 5% (4)	6.2	6.1	7.8	8.6	9.3	10.1	11.0	11.6
Uninsured (5)	33.8	33.9	32.2	32.4	32.7	32.9	32.0	32.4
Total Population (5)	266	266	268	270	272	274	276	278
Insured as a Percent of Total	87%	87%	88%	88%	88%	88%	88%	88%

(1) Full amount of cap (from bill language) net of: residual Medicaid, baseline Medicare, and program managment.
(2) From OMB calculation of cost of subsidies; assumes 95% participation.
(3) Net funds available to subsidies minus the costs of tax break and the costs of purchasing policies for the AFDC and non-cash populations.
(3) 1997 estimate from the Urban Institute, growth at private premium per capita plus 1.5% population growth.
For the subsequent year, growth was assumed to private premiums per capita times a population growth of 1.5%
(4) The net funds available for subsidies was divided by the weighted average premium for family units < 200% of poverty to estimate the number of contracts that may be purchased.
Since there are an estimated 2 persons per contract for this income bracket, the estimated number of contracts was multiplied by 2 to get persons covered.
Two sets of premiums were used: premiums estimated by CBO for the Senate Finance Bill, and the Senate Finance premiums increased by 5% due to potential adverse selection.
Two-thirds of low-income, non-elderly, non-Medicaid persons are uninsured; thus, the number that can be
covered by the net funds is multiplied by 0.67 to estimate the number of newly covered.
(5) Uninsured and population projections from CBO.
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Unofficial Preliminary Illustration of Counts of Newly Insured Under the Dole Plan
(Dollars in billions, fiscal years, persons in millions)

	1997	1998	1999	2000	2001	2002	2003	2004
BASELINE UNINSURED	40	40	40	41	42	43	43	44
Numbers of Low-Income Persons Covered								
High Estimate								
Uninsured (5)	31.9	32.4	31.5	30.4	29.9	29.0	27.9	27.1
Total Population (5)	266	266	268	270	272	274	276	278
Insured as a Percent of Total	88%	88%	88%	89%	89%	89%	90%	90%
Low Estimate								
Uninsured (5)	38.0	37.7	36.3	36.5	36.8	36.9	35.8	36.1
Total Population (5)	266	266	268	270	272	274	276	278
Insured as a Percent of Total	86%	86%	86%	86%	86%	87%	87%	87%

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To CHRIS JENNINGS | From THOMAS

Dept./Agency | Phone #

Fax # | Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

Preliminary Estimates of the Financing of the Dole Plan
(Dollars in billions, fiscal years)

	1997	1998	1999	2000	2001	2002	2003	2004
Funding Cap (1)	311	341	381	421	466	518	576	640
Expenditures Counting Toward Cap (2)	247.8	270.8	298.6	327.5	360.7	398.6	440.4	488.5
Funds Available to Cover Uninsured and Medicaid	63.2	70.2	82.4	93.5	105.3	119.4	135.6	151.5
Net Change in Deficit After Covering the Uninsured & Medicaid	0	0	0	0	0	0	0	0
Medicaid Part C (3)	12.0	13.0	14.1	15.3	16.6	18.0	19.4	21.0
Self-Employed Tax Deduction	1	1	2	2	3	3	3	3
Individual Tax Deduction								
Net Change in Deficit With New Spending Programs	13.0	14.0	16.1	17.3	19.6	21.0	22.4	24.0

(1) From legislative language.
(2) Medicare and Medicaid baselines minus savings
(3) Supplemental services for Medicaid recipients

16-Aug-94

Dole File

COVERAGE UNDER THE DOLE PLAN

Under the Dole Plan, coverage of the uninsured would be increased through subsidies for low-income families for the purchase of health insurance premiums. Individuals and families with income up to 150 percent of poverty would be eligible for these subsidies. However, the cap imposed on the total amount of Federal funds available for subsidies would allow no expansion until 1999, and limited expansion in subsequent years.

WHO IS COVERED:

A preliminary analysis of the Dole Plan found that:

- The Dole Plan would cover no additional low-income people in 1997. A CBO analysis states that an additional 27 million Americans will be covered in 1997 due to the Mitchell Plan.

- By the year 2004, 30 million Americans will have been covered for nearly 7 years under the Mitchell Plan. The Dole Plan will only have just begun to cover 8 million of the uninsured.

- The most that the Dole Plan would cover with the low-income subsidy program is 87 percent of the U.S. population in the year 2004. This compares to the 95 percent of the population covered before the year 2000 by the Mitchell Plan.

- The Dole Plan is underfunded, since the caps on Federal spending permit only a fraction of those eligible for subsidies ever to receive them. In 2004, when the Dole Plan's coverage is at its peak, the subsidies will be enough to cover families up to 50 percent of poverty-- a third of those reportedly eligible in the Plan's provisions.

WHO IS NOT COVERED:

- ***Low-Income, Working Families:*** Because working families have income, they are not the very poor that the Dole Plan's subsidies cover. Thus, there is no assistance for two-parent working families in the Dole subsidy program.

  Under the Mitchell Plan, working families with incomes up to 200 percent of poverty will be eligible for subsidies. For families with children, there are additional subsidies. This will help a significant number of the 80 percent of the uninsured who have jobs.

- ***Children:*** Less than one-fourth of the 9 million uninsured children would be eligible for subsidies under the Dole Plan.

  The Mitchell Bill guarantees that low-income children with family incomes up to 300 percent of poverty -- over $44,000 for two-parent families -- will receive assistance in purchasing health insurance policies. These subsidies extend to 8 out of the 9 million uninsured children.

- ***Temporarily Unemployed***: Since most temporarily uninsured people have some annualized income from their previous job, few will be eligible for subsidies under the Dole Plan.

  The Mitchell Bill allows for temporary assistance for the temporarily unemployed to ensure continued access to affordable coverage.

Dole comes down on side of reformers in health-care debate>
by Peter G. Gosselin
Boston Globe

HAYS, Kan. Gloria Dole Nelson came out to the airport last week to see her famous brother. There was only time to give him the oatmeal raisin cookies she'd baked and a little gossip.

Then Senate minority leader, Bob Dole, turned back to the twin-engine plane that would carry him away. As he did, he remarked that Gloria recently has had cancer.

So, for that matter, has Gloria's husband, Larry, and the son of Norma Jean, Dole's other sister. And so has Dole.

As he prepares for what promises to be a spectacular battle over the nation's health care, Bob Dole has a peculiarly personal interest in the outcome: American medicine has kept his family and him alive.

That may be why for all his recent rumblings about throwing in with GOP conservatives to block President Clinton's massive health proposal he sounds an awful lot like a man who is ready to deal.

``I don't think you take a walk on this issue,'' he said during a day of Rotary Club luncheons and medical society meetings in his home state.

``I can get up, give a great speech, talk about `socialized medicine.' But when you think about it and look at your family I mean look at my own family and the people who've had cancer, heart attack, stroke, bypass ... we got to do something,'' he said.

Of course, the ``something'' Dole has in mind is most definitely not the Clinton plan, as he will make clear during his televised response to the president's State of the Union address Tuesday night.

The Kansas Republican is sure to lash out at the proposal for its price and bureaucracy, and warn that its sheer size threatens the quality of care.

But Dole's recent attacks on the White House plan seem as much gauged at making sure he is in on the bargaining over the proposal as they are at killing the measure outright. Quizzed about those blasts during his visit here, he did not sound nearly so hostile to the idea of major change as he has recently been portrayed.

Indeed, he seems to have decided where he stands on what is quickly emerging as a fundamental division in the national health debate between those who support only relatively minor changes to assure that people who can afford health insurance can get and keep it, and those who want to tackle the much thornier issue of insuring those who can't afford it.

However reluctantly, Dole comes down on the side of the ambitious reformers.

That's surely good news for the president who has set universal coverage as the one unalterable goal of his overhaul drive. Dole is well-placed both as opposition leader and a member of the Senate Finance Committee, which must pass on large parts of the Clinton plan, to advance the cause or trip it up.

``We can't prevent people'' from getting sick and dying, Dole said. ``It's going to happen. But you can see how it can devastate some families, the ones that maybe aren't old enough for Medicare. We have some responsibility to do something for the ones that aren't covered.''

Dole's interest in helping the nation's health care ``have-nots'' does not mean that the often acidic Republican leader and the inveterately affable Democratic president are headed for quick agreement on health. Far from it.

Dole started playing hardball politics almost as soon as Clinton took office last year, rallying Republicans to unanimously oppose the president's tax-boosting budget bill, and helping to kill an economic stimulus package that included money for many of Clinton's favorite projects.

If there were lingering doubts about his ability to play the political game, he put them to rest recently, first, by successfully demanding a wider investigation of the Clintons' involvement in the Whitewater controversy, then by scaring the daylights out of White House aides by appearing to retreat on health. His handling of the health-care issue is a case study in maintaining clout.

Until last month, the Kansas Republican was the picture of accommodation in his dealings with the White House on health. But then the administration stumbled in the effort to sell its plan. GOP conservatives began wondering aloud what all the fuss about health was, and even some moderates suggested that Washington might be better off approving a few modest changes and leaving it at that.

Suddenly, there was Dole on national television, announcing that the country did not have a health ``crisis'' after all, but only a ``problem,'' and appearing to join the ranks of those advocating modest changes.

During his visit here, Dole acknowledged he had changed his tune recently, and hinted that he may not yet be finished crossing up the administration. Nevertheless in several hours of talking, he seemed to return to his original position that Washington should try tackling universal coverage this year.

He conceded that approving easy-to-pass reforms as some have suggested would severely damage chances for major change (``If you've got good stuff, you don't want to pass that and save the tough stuff for all.''). He said that most of the compromise measures suggested so far don't go far enough (``You've got to go farther; otherwise you

leave a lot of people out of the system.'').

Dole carefully hedged about how far is far enough. When he finally makes that decision, his own history of medical problems could weigh substantially in the balance.

Dole rarely misses the chance to tell an audience ``I've had a lot of health care in my life.'' He's not talking about his prostate cancer, from which he has recovered. He's talking about his right arm.

The arm was practically shot off by a German machine gunner in northern Italy during the last weeks of the war in Europe. Dole was shipped home to die, and came close to it twice.

Virtually every pundit who has written about him has sought to find in the wound the key to Dole's often-bitter personality, a flaw many believe has so far kept him from his dream of being president. Dole dismisses the connection. But since beginning to talk about the wound for the first time in recent years, he has made unnervingly revealing comments. During a TV interview last fall, he burst into tears.

The arm has had at least one clear effect on his politics. Despite railing against big government, he has consistently supported legislation to help the handicapped, including the Americans With Disabilities Act, which vastly expands government regulation of everything from building access to job availability.

Asked last week how his problems have affected his views on health care, Dole said, ``I know people get sick. I know some, probably more than before, worry about affordability. Some people don't know that.''

(EDITORS: STORY CAN END HERE)

Although he would be 73 by 1996, he is considering another run his third for the presidency. But his chief Republican rivals, Sen. Phil Gramm, R-Texas, and former Bush administration officials Dick Cheney and Jack Kemp, think little or nothing needs to be done to the nation's health care system, and would happily roast him for going too far in seeking change.

On the other hand, he is aware that his party could suffer grievously if the president and the Democrats comes up with a popular solution to the health problem and pass it, as they did last year's budget, without Republican help.

There may be something else going into Dole's equation as well a desire to set down a record for history.

As he hustled to his plane at the Hays airport last week, he was asked how his sister, Gloria, and her husband paid for their health care. Medicare, he answered. ``Whatever its shortcomings, it's been a real lifesaver.''

Reminded that he voted against the program when Congress approved it in 1965, he said that he had been worried about the costs. But he added, ``We've had a lot of votes on health since then; we've done a lot of things.''

If all goes as expected, Bob Dole will get a chance to do still more things potentially a great many more things on health in 1994.

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Dole

Melanne FYI Pam

Dole aide earns praise for aptitude on health reform

Kansas City Star 10/11/93

By JAKE THOMPSON
Washington Correspondent

WASHINGTON — Hillary Rodham Clinton was testifying before the Senate Finance Committee, and Sheila Burke had a question.

She leaned forward and whispered to her boss, Sen. Bob Dole. Then she moved down the table to Sen. John Chafee, who posed the question, Burke's question.

Congressional Democrats had criticized Republicans for proposing a mandate that individuals pay for health insurance and for proposing to tax benefits of so-called Cadillac insurance plans. So Chaffee asked Hillary Clinton to acknowledge that the Clinton plan had similar elements but with a lighter impact.

"That's absolutely right, senator," Hillary Clinton responded. It was the answer Burke wanted to hear publicly.

Burke's partisan-edged input illustrates the behind-the-scenes power that some congressional staffers wield. And in the months ahead, few will play a larger role than Burke, as Dole and other Re-

See **AIDE, A-14,** Col. 1

PATSY LYNCH/Special to The Star

Sheila Burke, administrative assistant to Republican Sen. Bob Dole of Kansas, talks with a fellow staff member.

K. C. Star 10-11-93

Aide to Dole has won a reputation for being astute

Continued from A-1

publicans decide whether they'll continue supporting parts of the president's health care reform.

"She's extraordinarily important," Chafee said. "Important because she has, rightfully so, Bob Dole's confidence. And how he goes, influences matters."

Chafee has led a Republican task force on health care the last three years that fashioned a Republican alternative endorsed by Dole.

"Sheila Burke has very good judgment," he said, "judgment based on considerable experience around this place and savviness from having observed things carefully."

A White House aide who has worked with Hillary Clinton on her health-care task force and with Burke echoed that sentiment.

"In general, she is viewed within the White House and Congress as being one of the most influential and knowledgeable staff people on the Hill," the aide said. "If you're picking for teams, she's one you want on your side.

> "Sheila Burke has very good judgment, judgment based on considerable experience around this place and savviness from having observed things carefully."
>
> *Sen. John Chafee*

"She's a tough opponent and a wonderful ally."

An aide to a Democratic congressman who has worked on health matters with Burke said, "Clearly, her fingerprints, her tracks will be all over the negotiations."

Sitting in her Capitol office, with its vaulted ceiling, Burke, 42, talked last week about her role and approach to health care.

On her office walls she has hung portraits of American women who she says, "have accomplished something in the public sector in their own right, rather than as a spousal unit."

They include Martha Washington, Red Cross founder Clara Barton; Eleanor Roosevelt; Mary McCleod Bethune, a black educator and adviser to presidents Roosevelt and Truman; and novelist Willa Cather.

Nearby, a desk is piled with files and note pads, another with reference books and reports. On her own busy desk were photographs of her husband and three young children, all born conveniently during congressional recesses.

Burke, born in San Francisco and a graduate in nursing from the University of San Francisco, has a master's in public administration from Harvard University. She has been a public health nurse in a Berkeley, Calif., hospital and has worked for a nurses' association.

She began working for Dole 16 years ago in health care. She became chief of staff in 1986.

Along with handling legislative issues and the staff, she also spends her time boring into such intricacies of health care as tax treatment of fringe benefits, Medicare, Medicaid, health-care research and treatment. The gritty details.

She and Dole pushed the Bush White House to propose a substantial health-care reform plan, but the suggestion was shot down. A "mistake," she says.

Now the Clintons have the upper hand on reform, and Burke is trying to help Dole stay in the game. He believes the issue shouldn't be just a "Democratic issue," but should have broad political backing to succeed, she said.

Burke has helped Dole build an argument that health-care reform should maintain flexibility and choice, cut costs and provide universal care without heavy mandates.

In shaping the Chafee-Dole bill, Burke sought one key modification. She wanted business participation in proposed health insurance cooperatives to be voluntary and not mandatory, an important point for small businesses. Chafee relented and Dole signed on as a co-sponsor.

In the broader context, Burke believes the American health-care system should be modified to help people, working with their family doctors, to "use the system more reasonably."

She believes Medicare has been successful because most elderly people who need medical care now get it. But it hasn't instilled "reasonable limits," and consequently costs too much.

From her background as a public health nurse, Burke sees a gap they could fill.

"I think there is an underutilization of professional nurses," she said. "I think they could do far more and could help resolve a lot of the access issues in rural and inner-city areas."

She also says there has been an institutional bias, pushing people toward hospitals and the elderly into long-term care facilities, when they might be better helped in clinics and at home.

Burke would like to help dispel the notion that people can't make the right decisions about their own health needs, that professionals are the best judges.

"You have to give them th right tools and help them mak decisions not at high anxiet times," she said. "You want t help people become more co scious of what's available and th questions they ought to ask, an help people be aggressive consun ers and not simply take what given to them."

Curtailing costs and empowe ing consumers are points of agre ment among politicians th Burke believes could help Co gress pass a bipartisan reform b next year.

"You would hope none of the would risk doing a one-party b only to have it fail," she said. think they'll have sensitivity t their side for people who have s rious concerns and hopeful they'll work out some comm ground."

Dole 5.11 File

See 2nd page

THE WHITE HOUSE

Office of the Press Secretary

EMBARGOED FOR RELEASE
UNTIL 10:06 A.M. EDT
SATURDAY, JULY 2, 1994

RADIO ADDRESS BY THE PRESIDENT TO THE NATION

The Roosevelt Room

THE PRESIDENT: Good morning. On Monday, July 4th, we celebrate America's birth. Two hundred-eighteen years ago, our founding fathers pledged their lives, their fortunes and their sacred honor to the untested ideas of liberty, equality and democracy.

Those ideas have survived and thrived because they're at the heart of the only system of government we know that produces wisdom from debate, and consensus from division. Indeed, right now, we're seeing how our democratic process can produce results that constantly renew the pledges of our founders; and we're making substantial progress.

I sought the presidency because our economy was in trouble and because our government wasn't working. We put in place an economic plan designed to restore the middle class and guarantee growth and jobs. By cutting over $250 billion in spending, reducing over 250,000 government positions, offering tax cuts to 15 million working families, 90 percent of our small businesses and increases to about 1.5 percent to our people to ask them to help pay down the deficit.

The result has been a remarkable recovery -- 3 million jobs, a 1.7 percent drop in unemployment, three years of deficit reduction in a row for the first time since Harry Truman was President of the United States. But the agenda for change requires more. It requires us to empower the people of the United States to do well in a world filled with change and competition.

That's at the heart of the crime bill we're about to pass in Congress that will put 100,000 police officers on the street, enact a law that says three strikes and you're out, ban assault weapons that go with the Brady Bill; and at the heart of our efforts to reform the college loan program to make interest rates lower and repayment terms better so that no young person will ever not go to college because of the cost of a college education. We're going to make 20 million young college graduates eligible for these better repayment terms, and issue $1 billion of college loans next year under the better terms.

And we're on our way to providing the security of health care to keep all our families whole and give Americans the confidence and security they need to compete and win in a changing world. This is especially important now, when 81 million of us live in families with preexisting conditions -- people who could lose their health insurance when they change their jobs. And we know the average American will now change jobs seven or eight times in a lifetime.

The real choices on health care reform facing the Congress are becoming quite clear. For many, many months now, I have been fighting for private insurance coverage -- not a government program -- for all Americans, along with provisions to make health care affordable to small business, to farmers, to the families with preexisting conditions. Interest groups and members of Congress in

MORE

the other party have criticized my plan, while many of them have said that they, too, are for full coverage for all Americans; but they offer no alternative to guarantee it.

Now, I have been working on our plan to make it even less regulatory and more friendly to small business, to guarantee that no one would lose any benefits because of the plan's requirements.

Finally, after months of criticizing our plan, the Republican leader, Senator Bob Dole, has finally proposed an alternative. Unlike our proposal, his idea of reform is really more politics as usual. It gives a little help to the poor; it's paid for by cuts in Medicare to the elderly; it requires no contribution from the interest groups that are making a great deal of money out of the health care system now, and no contribution from those who are not paying anything now into the system; and it gives absolutely no help and security to the middle class, to small businesses, and no guarantee of coverage to anyone.

Estimates are that more than a million Americans would continue to lose their health insurance every month under this plan -- most of them from hard-working, middle-class families. It will help you a little bit if you're poor. It won't affect you if you're wealthy. But if you're in the middle, you can still lose your health insurance; and if you don't have it, it won't do much to help you.

One aspect of the Dole plan is particularly disturbing. It was brought home to me this week when small business people from all over America came to the White House and urged us to reject this approach. They don't want any plan that will make it harder to do right by their workers. The Dole alternative leaves small businesses at the mercy of insurance companies that can still charge them more than big businesses or government. And small businesses that do offer insurance will continue to pay much higher rates, because they'll have to give a free ride to their competitors who don't make any effort at all.

Now, more than 620,000 small businesses have joined together to support the idea that we ought to have full coverage -- universal coverage for all Americans -- and one that requires the employers and the employees to contribute to that coverage. They know that without guaranteed private insurance for every American, small businesses that do cover their employees will have a harder time competing here at home and across the world.

There's simply too much at stake as we try to prepare our citizens to take advantage of our global opportunities. We can't continue to handicap ourselves in that way. And not only that, it simply won't work. We know from the experience in some states that if you try to reform insurance practices and you don't do anything to help small business and individuals, what will happen is that more and more people will give up their coverage because it will get more and more expensive.

For the last 50 years, our country has come close to health care reform a time or two, but we failed every time. Congressman Sam Gejdenson of Connecticut said this week that during that 50 years, our country has gone from the propeller to the jet airplane, from adding machines to computers, from the radio to virtual reality. But our health care system has actually gone backward in guaranteeing security to middle-class families. That's right. In the 1980s, about 87 percent of our people had guaranteed health insurance. Now, only 83 percent of our people are covered.

That's why the vast majority of Americans agree that universal coverage must be our goal. This time, we have to move forward in health care as in crime and education. Our democracy is

producing solutions that hold fast to our time-honored values, building on what has always been our greatest strength -- people helping one another to take responsibility for themselves and their families, their communities and their countries.

On July 4th, we'll celebrate with family and friends at picnics and parades. But if you find a quiet moment, I hope you'll reflect on the lessons of our history, and make this promise to yourself -- to do the best you can to be a good American; to rebuild the safety of our communities, the sanctity of our families, the strength of our schools, the vitality of our economy.

The best way to celebrate our freedoms is by renewing our democracy. We're trying to do that here in Washington by facing up to our responsibilities. I hope you'll urge us to do that, as well.

Thanks for listening, and best wishes for a wonderful holiday.

END