To: Bo Lie
From: Bob

Num/Domenici R/L

United States Senate

WASHINGTON, DC 20510

FOR IMMEDIATE RELEASE:
August 12, 1994

Contact: Bob Stevenson (Domenici) 224-5989
Cathy O'Brien (Nunn) 224-0075
Nick Hathaway (Boren) 224-4721
Mary Jane Collipriest (Bennett) 224-5444

SENATORS TO INTRODUCE BIPARTISAN HEALTH CARE SOLUTION

WASHINGTON -- A group of Democratic and Republican U.S. Senators said today they are preparing to introduce a bipartisan health care plan next week.

U.S. Senators Pete V. Domenici, R-N.M., Sam Nunn, D-Ga., David Boren, D-Ok., and Robert Bennett, R-Utah, met today and issued the following statement:

"We have been working together toward fashioning a health care reform plan that is fiscally sound and will win the support of the American people. We have been encouraged by the work done and the principles announced by our colleagues in the House of Representatives led by Congressmen Rowland and Billrakis who introduced the 'Bipartisan Health Care Reform Plan of 1994' this week. We are studying this legislation and it is our intention to introduce it in the Senate next week.

"This is a measured, targeted, fiscally-responsible plan which preserves and builds upon the high quality of our present health care system - the best health care system in the world. This plan puts our nation on the road to accessible, affordable, and effective health care.

"The plan is a voluntary, market-oriented approach with no employer mandates, no new massive entitlement programs, no new taxes, and no government price controls or excessive government bureaucracy.

"It is a positive plan that focuses on reforms the American people desire - the ability to change jobs and not lose their health insurance, a ban on pre-existing condition clauses, small business insurance reforms, and voluntary small business purchasing cooperatives. Although it does not promise universal coverage and new open-ended entitlements that some desire it is a measured step achieving real reform.

"Furthermore, it provides new assistance for low-income and working families who currently cannot afford private health care insurance.

"Above all we believe a major change in social policy of this magnitude should not be decided upon party lines. Comprehensive health care reform should be built upon a broad, bipartisan foundation."

--30--

U.S. Senator David Boren of Oklahoma

459 Russell Building
Washington, D.C. 20510

FOR IMMEDIATE RELEASE
FRIDAY, AUGUST 12, 1994

contact:
Nick Hathaway (202) 224-4721
Joshua P. Galper

STATEMENT BY SENATOR BOREN ON THE BIPARTISAN HEALTH CARE PLAN

"A major change in social policy of this nature should not be decided upon party lines," Boren said. "Let us not destroy the quality of health care in this country by passing a partisan bill, by having 51 votes and ramming it through, and then waiting until the next election and have it reversed as the political fortunes of one party or another change."

-30-

M E M O R A N D U M

TO: "Mainstream" Senators

FROM: The Staff

SUBJECT: Key Issues

DATE: August 11, 1994

At the close of your meeting Tuesday, you asked us to identify a list of key issues. Staff have divided key issues into two categories:

> Category I includes issues which must be changed in the Mitchell bill and which have the best chance of broad support within the mainstream group;
>
> Category II contains issues importance to more than one member of the mainstream group but for which you probably will not be able to achieve complete consensus.

It is our hope that members can agree on what constitutes a Category I issue. Staff can then begin to develop legislative language. Attached is a single page with our attempt to categorize the major issues. Following that attachment is a one or two page issue paper on each of the Category I issues.

MAINSTREAM MEMBERS – KEY ISSUES

CATEGORY I

1. TITLE I REVISIONS

   e.g. health plan standards, benefits, purchasing cooperatives, community rated pool, federal-state oversight and regulation

2. HIGH COST PLAN ASSESSMENT

3. FAIL SAFE

4. MEDICAL LIABILITY

5. REMEDIES – CLAIMS DISPUTES

6. INTEGRATION OF MEDICARE

CATEGORY II

1. NEW ENTITLEMENTS

   a. Medicare prescription drugs;
   b. long-term care;
   c. public health programs

2. QUALITY

3. ADMIN. SIMPLIFICATION/ PRIVACY

4. REMEDIES – ENFORCEMENT AND CIVIL RIGHTS

5. SUBSIDIES
   a. employer
   b. Indiv./family

6. GRADUATE MEDICAL ED.

7. EMPLOYER MANDATE

#1

TITLE I ISSUES

Title I defines the structure of the health care market. It establishes health plan standards (i.e. insura reforms --Sub. B); defines covered benefits (Sub. C); and sets forth employer, federal, and state responsibilit (Subs. D. E. and F). It differs from the Mainstream proposal in important respects, some of which are highlig below. In short, the bill relies too much on regulation and bureaucracy and too little on the private market to promote quality, cost-effective care. Specifically, the federal government overregulates both states and employers.

Staff recommend pursuing a coherent, extensive amendment to Title I for three reasons. First, while some subtitles could arguably be amended line-by-line (e.g. health plan standards) parts of the title may requ wholesale rewriting (e.g. to clarify federal and state roles). Second, parts of the title are interdependent (e.g. lowering the threshold for the community-rated pool has implications for "risk adjustment" as well as for the division of oversight responsibilities between federal and state governments). Third, Sen. Mitchell's language a moving target -- it has been revised twice and may be revised again.

Option 1: Seek agreement on a comprehensive amendment, taking as reference points the Mainstream proposal and the Jeffords-Durenberger-Kassebaum amendment offered to the Labor bill.

Option 2: Seek agreement on a subset of the issues noted below.

ISSUE	MITCHELL	MAINSTREAM
Health plan standards	Applied to supplementals	Supplementals exempt
Benefits	Benefits explicit in legislation: 16 categories with references to Medicare; Board can require specific services.	12 broad coverage categories; Board clarifies Congressional intent.
Employer requirements	Employers must offer one coop and FEHBP; States must form coops.	Employers must offer three plans, including point of service option.
FEHBP	OPM must make available in all markets; public is blended into government risk pool.	FEHBP must be offered at community rate where otherwise available to federal workers.
Threshold for community rating	Employers of 500 or fewer must community rate; experience-rated plans help finance pool through "risk adjustment."	Threshold at 100; permitted existing association plans.
Essential Community Providers	Over 20 mandated	Community and Rural Health Centers, others by criteria defined in statute.
Federal-State Programs and Regulations	HHS sets prescriptive requirements for state programs, approves plans, and sanctions non-complying states; states must create certain new bureaucracies. NOI regulates multi-state plans.	Federal Gov't sets market rules and States enforce, with Federal oversight; states submit plans describing program to HHS
State Flexibility	Single Payer option with no opt-out for large employers; Fast-track for implementation of Act, including employer mandate.	Single-payer option.

#2

DECISION PAPER: ALTERNATIVE HIGH COST PLAN ASSESSMENT

REVIEW THESE OPTIONS IN THE CONTEXT THAT CHANGES IN THE MITCHELL HIGH GROWTH TAX WILL RESULT IN THE NEED TO RAISE REVENUE. CBO ESTIMATED THAT EVENTUALLY ALL PLANS WOULD BE SUBJECT TO THE MITCHELL TAX WHILE THE FINANCE COMMITTEE BILL TAXED ONLY THE TOP 40%.

MITCHELL HIGH GROWTH TAX- $70 BILLION OVER 10 YEARS
FINANCE HIGH COST TAX- $13 BILLION OVER 10 YEARS

OPEN ISSUES

I. COMMUNITY-RATED TARGET PREMIUMS.

A. Set prospective targets based on weighted average of prior year's premiums.

B. Set target premiums based on 110% of current year's bids.

Issues: a. Is it more fair if the targets are set prospectively?

b. Is it more competitive if companies are seeking to price below a published target or setting premiums without knowing what the reference premium will be?

II. EFFICIENT MARKET CARVE-OUT.

A. Retain lowest 25% exemption.
B. Include exemptions for regions that hold inflation down to CPI plus 2% IN 2004 (in order to allow costs to equalize nationally).
C. Combine (A) and (B).
D. Retain provision from original Mainstream proposal and defer action on revising the efficient market exemption pending receipt of Commission recommendations.
E. Target premium set at 110% of average.

Issues: a. Is it more fair to set carve-outs based on national ranking of cost or growth targets in the future?

III. TREATMENT OF SUPPLEMENTALS.

A. Leave supplementals out of high cost plan assessment. Adopt Mitchell tax cap in 2004 (or earlier).
B. Tax supplementals if attached to a high cost plan.
C. Offer separate floor amendment and leave out of Mainstream proposal.

Issues: a. Will we achieve additional cost containment if we include supplementals, e.g. by discouraging the purchase of supplementals.
b. Do we want to discourage the purchase of supplementals not in the standard benefit package, e.g. dental, vision and first-dollar coverage?
c. Potential tax avoidance issue.
d. What do proposals mean for generating broad-based support?

IV. SETTING REFERENCE PREMIUM IN THE EXPERIENCE-RATED MARKET.

A. Use rolling average of actual costs plus inflation factor to establish reference premiums for experience rated market.
b. Use community rated average to establish reference premiums for experience-rated market.

Issues: a. Using actual costs as a basis for the reference premium may lock inefficiencies into the current base.
b. The community-rated target as applied to the experience-rated market may penalize companies whose health care costs are higher because they have a sicker population since it is administratively impossible to risk adjust for health.

#3

Title XI Member Issues

Issue 1: If the deficit increases as a result of increases in non-health reform related expenditures (such as Medicare and Medicaid) should there be automatic cuts in the new programs under this bill (such as low-income subsidies)?

Options:

(1) Allow for automatic cuts in the new programs if non-health reform related expenditures exceed their baselines-Mainstream Proposal.

(2) Do not allow for automatic cuts if programs like Medicare and Medicaid exceed their current projections-Mitchell.

Issue 2: Should Medicare itself be held accountable for any deviations from its initial baseline?

Options:

(1) Require the President to compare the most recent projections of Medicare with those included in the initial fail-safe baseline. If the current baseline is higher than the initial baseline, then the President would submit specific legislative proposals to Congress to bring Medicare in line with its initial baseline.

(2) Do not require any specific report on Medicare.

Note: Option 1 can be combined with either option 1 or option 2 from issue 1.

#4

MAINSTREAM MALPRACTICE DECISION PAPER

We would strike and replace the Mitchell Medical Malpractice Section with the Mainstream Medical Malpractice agreement. The following issues remain to be resolved:

1. HOW TO DEFINE A MEDICAL MALPRACTICE CLAIM AND A MEDICAL MALPRACTICE LIABILITY ACTION: The Chafee bill defines these terms to mean a causes of action against a health care professional, health care provider or any defendant joined in the action. The Mitchell bill defines these terms as a cause of action against a health care professional or health care provider. The impact of the difference is that the cap on noneconomic damages may not apply to every defendant in a malpractice suit under the Mitchell bill and may apply to non medical professionals and providers under the Chafee approach. The members must decide the scope of these definitions.

2. HOW TO STRUCTURE A DAMAGES CAP: One member may propose a sliding scale cap on damages depending on the injury rather than a single $250,000 cap for all types of injuries. One issue to be addressed is the status quo in effect until the sliding scale system is developed.

3. DEMONSTRATION PROGRAM ON PRACTICE GUIDELINES: Senator Cohen proposes that we retain the Demonstration program for Practice Guidelines in Senator Mitchell's bill. Under that demonstration program, the Secretary would be allowed to award grants to one or more states to conduct a pilot program in which compliance with practice guidlines would be given a presumption for or against liability in a subsequent malpractice action.

#5

Decision Paper
Title V, Subtitle F (Part 1)
Health Plans Claim Procedure

Description of Mitchell Bill

Under the Mitchell bill, individuals who are denied health benefits could file a complaint in state or federal court, or at newly-established State Complaint Review Offices and receive "any appropriate relief." (This would most likely be construed as unlimited punitive and compensatory damages.) Thus, the Mitchell bill substantially changes existing law regarding an individual's right to dispute a health plan decision to deny benefits.

Decisions

1. Adopt Mitchell approach;

2. Strike this section of Mitchell bill and return to claim review procedure and standards available under current law;

3. Strike this section of Mitchell bill and replace with modified claim review procedure and standards based on Jeffords-Dodd amendment in Labor Committee; or

4. Strike this section of Mitchell bill and replace with claim review process originally proposed by President Clinton.

Staff Working Group: Elaina Goldstein (Sen. Jeffords); Dean Rosen (Sen. Durenberger); Peter Leibold and Laura Steeves (Sen. Danforth); Craig Obey (Sen. Conrad).

#6

TITLE IV -- MEDICARE AND MEDICAID
SUBTITLE A -- PART 1
PAGES 746-752

DECISION: Accept Mitchell provisions regarding Medicare integration and coordinated enrollment; or

Substitute with Mainstream proposal to improve Medicare risk contracting program.

Key Issues for Mainstream Group:

* Medicare spending continues to grow at unsustainable rates.
* Real reform is needed to control costs, not arbitrary spending cuts.
* Guarantee all beneficiaries access to a private plan.
* Expand choices for Medicare beneficiaries.
* Medicare markets should work like non-Medicare markets.
* Payment to plans should be based on efficient delivery systems.

Medicare reform:

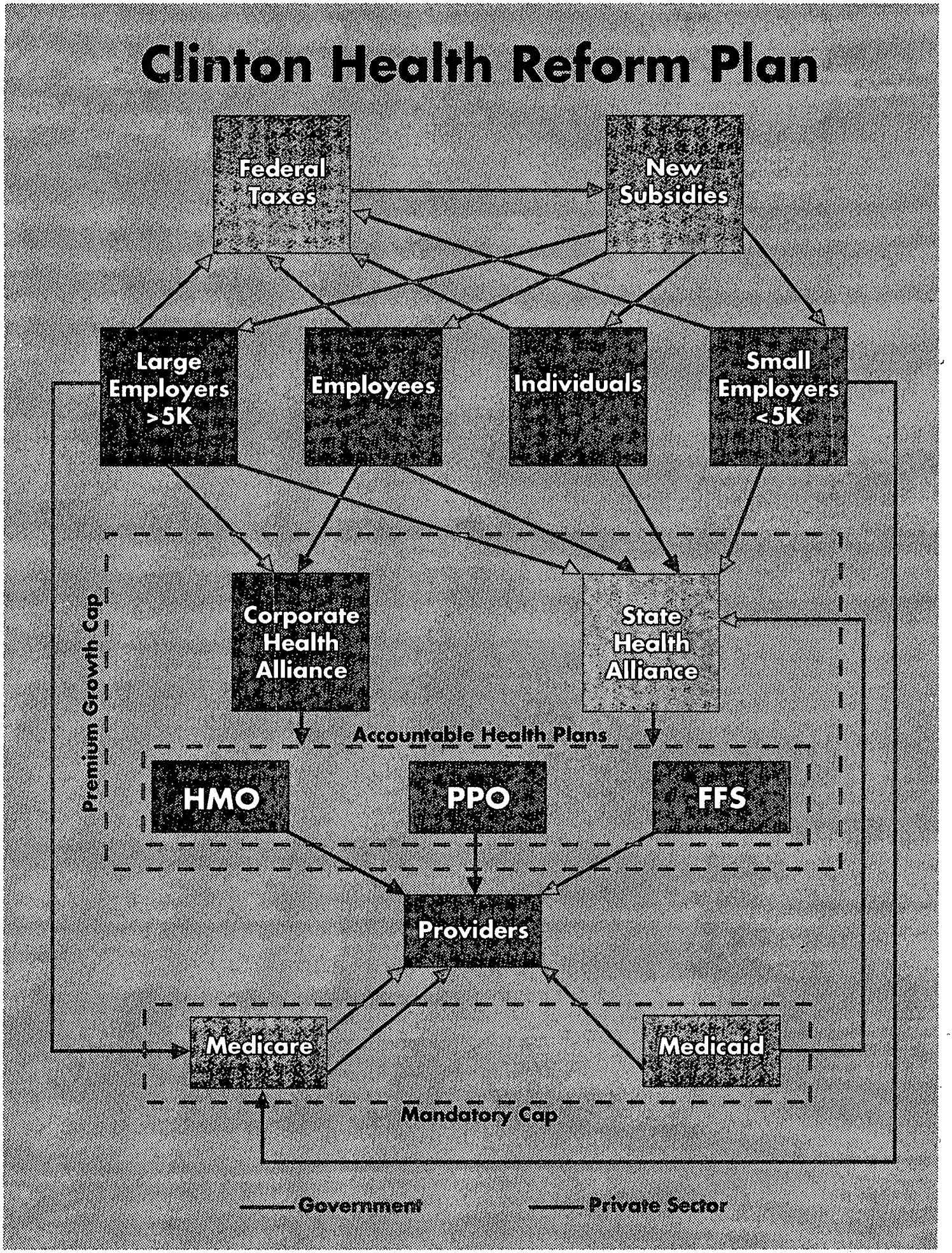
* Medicare beneficiaries:
  - Retain the right to stay in fee-for-service;
  - Retain the same plan from age 64 to 65;
  - Control where their share of Medicare dollars goes;
  - Choose their own physician;
  - Choose plans with more benefits and lower out-of-pocket costs;
  - Have equal access to all plans, regardless of health status;
  - Have better information to judge the value of plan options; and
  - Will not be penalized based on their county of residence.

* Plans are encouraged to participate with Medicare because:
  - Medicare moves to market rating areas, rather than counties;
  - All accountable health plans may contract with Medicare;
  - The current calculation of FFS cost is improved;
  - Plans may charge the federal government less than FFS; and
  - May compete based on quality, price and supplemental benefits.

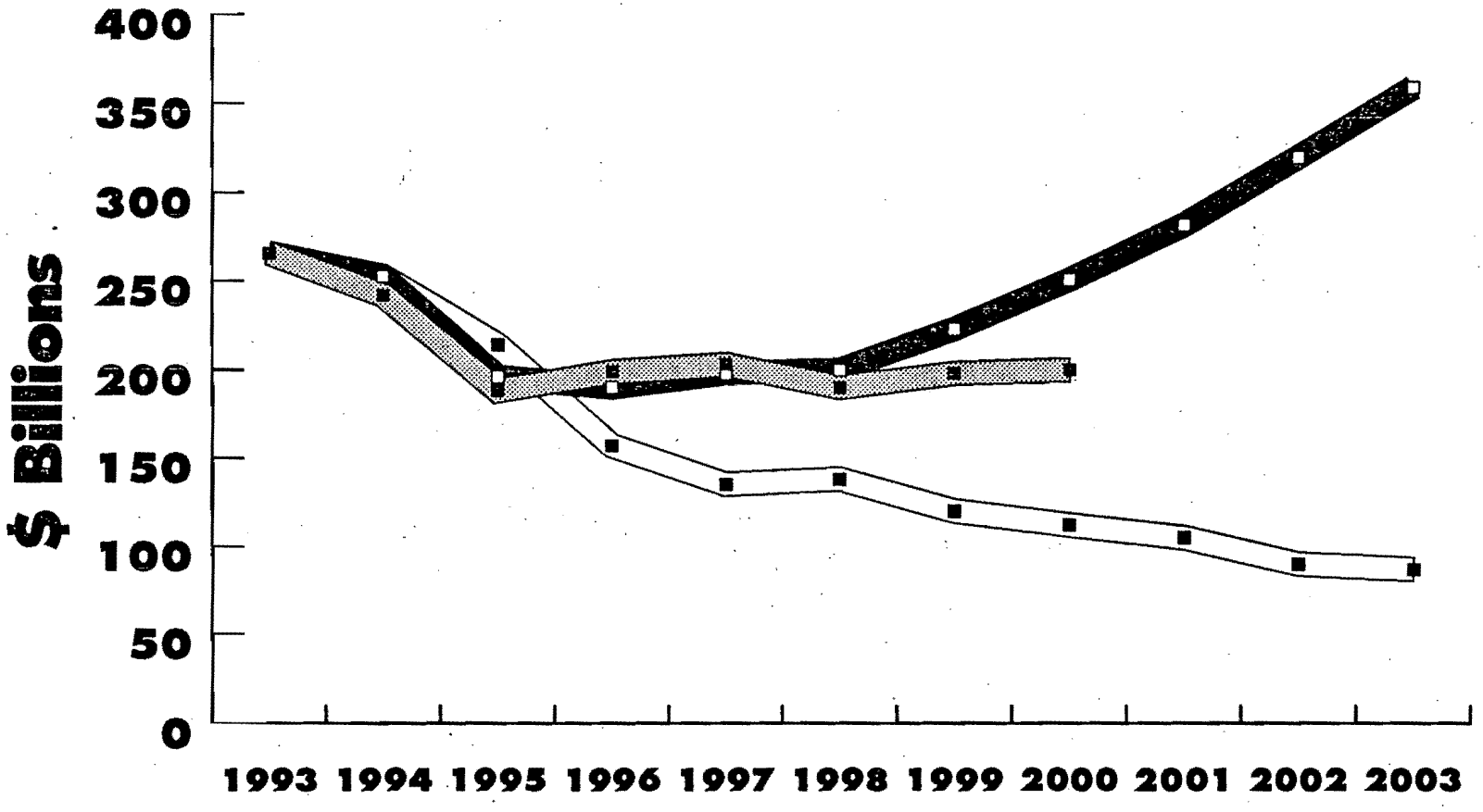
THE PRESIDENT'S HEALTH REFORM PROPOSAL
FEDERAL BUDGETARY EFFECTS
(Administration Preliminary Estimates, $ Billions)

	1994–2000
NEW SPENDING	
Subsidies	419
Early Retirees	?
Medicare Prescription Drugs	72
Long–Term Care	73
New Public Health Initiative	18
Administrative Costs	11
Subtotal, New Spending	593
SPENDING CUTS	
Employed Medicare/Medicaid in Alliances	*–186*
State Medicaid Maintenance of Effort	*–73*
Medicare/Medicaid Caps	–238
Other Federal Programs	–47
Subtotal, Spending Cuts	–544
TAXES	
Self–Employed Deduction/Long–Term Care	–23
Sin Taxes/Corp. Assessment	105
Effects of Mandate on Taxes	51
Subtotal, Tax Increase	140
DEFICIT	–91

Clinton Health Reform Plan



Deficit Estimate
With and Without Health Care Reform



SOURCE: Senate Budget Committee, Minority Staff 9-15-93