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United States Senate

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

TELECOPIER COVER MEMORANDUM

TO: Chris Jennings

FAX NUMBER: 456 7739

FROM: David Nexon

DATE AND TIME: 10/01/93 4:00

NUMBER OF PAGES: COVER + 20

RETURN FAX NUMBER: (202) 224-3533

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TO: Ira Magaziner

FROM: David Nexon

DATE: 9/16/93

SUBJECT: SUGGESTIONS FOR HEALTH PLAN REVISIONS

Congratulations! The plan is terrific. You have done a brilliant job of accommodating the key political interests while putting together a proposal that will achieve the essential objectives. I know that Senator Kennedy is delighted with the program, and so am I.

We do have some additional suggestions, as described below. Most are possible technical changes designed to improve the functioning of the program or our ability to sell it politically. There are also a couple of substantive issues that are significant concerns for Senator Kennedy.

1. Expanded public health initiatives. The additional funds allotted for public health initiatives have great potential to actually improve health status. During the course of your sail with Senator Kennedy, he offered to provide you a list of the ones we thought were working well and should be expanded. These programs are listed in an attachment, along with some new initiatives that we would like to see included in the program

We are very concerned that the latest round of estimates shows net new expansions for public health initiatives of only $1 billion, rather than the $5-6 billion previously assumed. New annual spending for the school-based clinics alone will be an additional $900 billion, net of third-party payments. Expansion of the National Health Service Corps to appropriate levels would require close to $600 million in additional spending. An additional $1 billion annually could be spent effectively on targeted and population-based prevention activities and infectious and chronic disease control services. Full funding of Ryan White could require as much as $1 billion by the year 2000, net of third party reimbursement and current appropriations levels, given the projected expansion in the AIDS population. The Secretary of HHS has proposed substantial additional spending on prevention research.

The $1 billion net figure carried in the current round of estimates

assumes the netting out of $2-$3 billion from current activities, presumably from expanded availability of third-party reimbursement. There are unquestionably substantial offsets for current appropriated funds that will become available as the result universal coverage. The problem with assuming that these full amounts will be available to finance new initiatives, however, is that the targeted service programs have been starved for so long that the capacity expansion we will need to assure that the needs of the currently underserved are met will require maintaining appropriated funds for many programs.

HHS has estimated, for example, that expanding community health centers to provide adequate capacity in currently underserved and poor areas would require an additional $150 million in appropriated funds, net of third party reimbursements, in order to provide outreach, transportation, and other services not covered under the benefit package. While this estimate may be high, substantial sums clearly will be necessary for capacity-building and enabling services.

Sums for these activities are much more likely to shrink rather than expand once the program comes up to the Congress and competing priorities emerge. Including a significant new net spending assumption in the program as submitted is critical if we are to take advantage of these important opportunities to improve health care. Senator Kennedy has sent a letter to the First Lady, attached, raising this issue.

I hope that you can provide some help on this. These funds really do represent major opportunities to improve health care, and the current budget situation means there is almost no likelihood of funding these initiatives through the normal appropriation process. Of course, the funding increase can be phased in, so that it reaches its peak around the year 2000, when there is more room in the budget.

In addition to the overall dollar total, we are concerned that HHS currently intends to fund all the new activities, other than the medical research, out of three new funding authorities, rather than building more explicitly on what is already in place. We are trying to work this out with Phil Lee, but we hope you will keep an eye on this issue.

2. Academic health centers. We are pleased with the general structure that has been worked out to assure that academic health centers are able

to compete effectively in the new environment, while re-orienting training toward primary care. The major structural issue that remains unresolved is whether residency slots--which will drive the availability of funding--will be allocated on an institution-specific or regional basis. Our concern is that a regional allocation system will be too subject to pressures to equalize training across the country, rather than recognizing regional specialization in academic medicine and existing centers of excellence. Again, we are trying to work this out with Phil.

A huge problem in the current plan, however, is the extraordinarily deep cuts in Medicare reimbursement to academic health centers that are included in the draft plan. As you know, Medicare pays its share of teaching hospital expenses in two ways. First, there is a cost-based payment for direct expenses like salaries of interns and residents and supervisory time of faculty. This will be $1.9 billion in 1994. Cuts in this payment do not appear to be assumed.

Second there is a much larger payment ($4.2 billion) that is sometimes referred to as "indirect medical education" expenses (IME). This payment is in the form of an add-on to the normal DRG payment for each patient. The add-on is based on a the number of interns and residents per bed in the particular institution and is meant to cover the higher costs associated with the greater number of tests and procedures that residents tend to order, the cost of unfunded research, and the higher costs that are inherent in maintaining an advanced tertiary care facility. In the major academic health centers, the add-on tops 30 per cent and is a very significant part of institutional budgets.

The formula for the IME add-on was based on a teaching hospital factor in the original regression equations that were used to develop the DRG payment system. Because of studies showing that the original formula would adversely affect some teaching hospitals--particularly large public urban teaching hospitals with high uncompensated care loads--the factor produced by the regression equation was doubled, to 11.6 per cent. At this level, it provided windfalls for teaching hospitals that did not have high uncompensated care loads. Over time, and as the disproportionate share adjustment was established, the adjustment has been pared back. It is now at 7.7 per cent, although it is supposed to return to 8.3 per cent in 1996. The most recent studies show that running the regression equations today produces an adjustment of 5.5 per cent.

The draft proposal would cut the adjustment to 5.65 per cent in 1995 and 3 per cent in 1996 and subsequent years. This cut--more than 60 per cent--is far too deep to be either good politics or good policy, particularly since it is in addition to the other Medicare cost restraints that will be applied to academic health centers along with all other hospitals. While it is possible to create a regression equation that would get the adjustment close to the three per cent level, such an equation would involve factors that are not currently in the Medicare payment formula, such as size of institution, or are being phased out, like disproportionate share payments.

From the policy point of view, these cuts are too steep and abrupt--even if they were scientifically justified. From the political point of view, we are likely to get strong support from the teaching hospitals for the program--support that provides important cover on the rationing/quality charge--but it will be difficult if cuts this deep are included.

This policy should be changed so that reductions in the IME payments are phased down over time to a level that is no lower than 5.5 per cent--which would still be a 30 per cent cut compared to the current level. Even without the full IME cut, there are additional teaching hospital savings that are not currently factored into our estimates that arise from the reduction in the number of residency slots as the result of the new manpower policy. This reduction lowers both DME and IME payments.

3. Freedom of choice option. We all know how crucial it is to the politics of this proposal that people be guaranteed the availability of a plan that will give them free choice of a doctor and hospital. The current policy, however, allows this requirement to be waived if "the fee-for-service plan is not financially viable, if there is insufficient provider interest in participating in a fee-for service plan, (and) if there is insufficient enrollment to sustain a fee-for-service plan."

The first exception is a huge loophole. People already fear that they will be forced into HMOs and that fee-for-service plans will be too expensive for them to afford; if we also say that we would allow elimination of fee-for-service plans if they can't keep their premiums within the budget--which I assume is what is meant by not being

financially viable--we are really leading with our chin. In fact, the CNN report on the plan last night highlighted this exception in its story on the choice issue.

One of the major reasons for giving alliances back-up rate-setting authority is to assure that there is a fee-for-service plan that is within the budget. This exception should be dropped. (I personally would drop the other two as well; we can always legislate this later if fee-for-service really dries up over time. At most, providing a fee-for-service plan under these circumstances would be an administrative inconvenience).

4. Cap on total premium liability as a per cent of income. We have talked previously about the desirability of including in the plan a cap on the per cent of income that any American would ever have to pay for health care. This is analogous to the guarantee we are giving business, and would be a significant help in selling the plan--particularly in competition with Republican alternatives that will give vouchers up to 240 per cent of poverty, approximately the same level at which our subsidy phases out. Ideally, this cap should be in a range that sounds very affordable--under 8 per cent, if possible.

Given that no worker above 150 per cent of poverty is likely to hit a cap of this kind with only a 20 per cent obligation, that we have already provided a subsidy that is almost equivalent to the self-employed, and that retirees over 55 would not be affected, it is hard to believe that layering this limit over the subsidies we have already assumed would cost very much. Ken has told me he will run some sensitivity analyses on this. I hope you will check to see this happens and incorporate a cap in the plan if the fiscal effect is not too great.

5. Waiver for states to include Medicare in the program. One of the main problems we have in selling this program is fear of the unknown--people's concern that they will lose something they now have. This is particularly true for the elderly, who depend so heavily on Medicare and are much heavier users of medical services than the rest of the population. The plan includes a number of provisions that make it easy for Medicare enrollees to join the new system, and, if it works as well as we hope, the Medicare program will wither away over time.

In my view, we are simply giving our opponents more ability to play

on fear if we allow states to force senior citizens out of Medicare, without getting any policy benefit. We have a heavy enough load to carry trying to get the elderly to understand that the Medicare cuts will not hurt them without having to add this additional burden.

Once the new system is in place and fear of the unknown is not a factor, we can always legislate this change. Since the governors no longer have budget responsibilities, it is hard to see the argument for giving them control over Medicare, even if the politics were not an issue. This option should be dropped, except perhaps for single payer states.

6. Children's mental health. We are delighted that you have included comprehensive mental health services in the year 2000 as part of the plan. It would be terrific if comprehensive services for children could come in immediately, both to get the services out right away and to give Mrs. Gore some additional accomplishments to point to. I suspect the cost of this addition would be quite low.

7. Non-physician providers. I have raised this point with you before without much luck, but I thought I would try one more time before the plan is finalized. The non-physician providers--nurses, social workers, psychologists, chiropractors--are potentially vocal supporters of the plan. They are far less concerned than the doctors and hospitals about cost controls, and some of them carry a surprising amount of political weight. They have managed to obtain mandated reimbursement in many states, and it is really their highest priority.

As I understand our current program, plans have total freedom to decide not to reimburse them, although the plan language is somewhat ambiguous in the case of a fee-for-service plan. If we do not fix this problem, these providers will spend all their energy trying to get this provision changed, rather than working for the passage of the bill.

I think we could get their enthusiastic support by simply putting in a non-discrimination clause that says plans may not discriminate against categories of providers. We could write this quite narrowly, so that the effect would be that plans could not have a policy of excluding nurse-practitioners as a class, but would not be required to hire any particular nurse-practitioner or to maintain any specific staffing ratios.

Many thanks for considering these request. I will try to call you tomorrow or over the week-end to check in on where you are on these issues.

KENNEDY PROPOSALS

	Additional Funds Needed Full implementation ($ in millions)
CENTERS FOR DISEASE CONTROL*	
Preventive Health Block Grant	150
Breast and Cervical Cancer Screening Program	100
Tuberculosis Control Program	150
Injury Prevention and Control/domestic violence	50
Sexually Transmitted Diseases Prevention Services	110
CDC intramural programs	75
Childhood Lead Poisoning Prevention	50
Smoking initiative	
--counter-advertising	50
--smoking initiative	75
Violence prevention	60
chronic disease initiative	140
TOTAL	**1010**
NATIONAL HEALTH SERVICE CORPS	
scholarship awards/loan repayment	300
field placement	300
TOTAL	**$600**
PRIMARY CARE TRAINING AND RECRUITMENT	
Health Careers Opportunity Program	$ 30
Area Health Education Centers	$ 27
Family Medicine/Gen. Medicine/Pediatric Residency	$ 50
Nurse Practitioners/Nurse midwifes/Physician Assistants	$ 40
TOTAL	**147**
DIRECT AND ENABLING SERVICES	
Community and Migrant health Centers	--**
Title X Family Planning Clinics	--**

*Offsets for third-party reimbursement for cancer, tb, and std programs not calculated
**Expansion financed through reallocation of appropriated funds offset by third-party reimbursement

RYAN WHITE

Full funding in year 2000	1,000*

SCHOOL-BASED CLINICS

full implementation*	900*

* Funds are net of third-party reimbursement. Ryan White numbers based on growth of AIDS population, assumes utilization of program services by all AIDS patients

1. Preventive Health And Health Services Block Grant

The Preventive Health Block Grant is the primary source of federal funding to states for health education/risk reduction activities, chronic diseases, cholesterol and hypertension screening, emergency medical services, and sex offenses prevention programs. It is also a leading sources of funds to support laboratories, dental health/fluoridation, environmental health, rodent control programs. The flexible provisions of the grant allow states to address health problems peculiar to the state and to target populations most in need.

$134 million was appropriated for FY 1992.
$149 million was appropriated for FY 1993.

The President's FY 94 budget request is $149 million.

An appropriation of $300 million would allow the States to improve the public health infrastructure and expand nonreimbursable disease prevention and health promotion services (disease survéillance, epidemiology, disease outbreak control, outreach, health education, environmental health) to improve the health of its vulnerable citizens.

2. CDC Breast and Cervical Cancer Program

In 1993, CDC entered into the third year of the program.

$72.5 million was appropriated for FY 93. At the current funding level only thirty states can participate in the program.

The President's FY 94 budget request is $85 million.

An appropriation level of $200 million would enable CDC to implement the program in all fifty states.

3. TUBERCULOSIS CONTROL AND PREVENTION

Funding cutbacks at the federal, state and local levels have worsened poverty, homeless, shelter and prison overcrowding, and other conditions that foster the spread of communicable diseases. These conditions have fostered in the reemergence of tuberculosis (TB), once a well controlled disease in the U.S.

There are almost 26,000 new active cases are reported each year with over 1,700 deaths. Hardest hit have been persons infected with HIV, immigrants and refugees, people living in institutional settings, substance abusers, the homeless, and person living in crowded, substandard conditions. Health officials are frustrated by the fact that most of the people at the highest risk for contracting and spreading TB are the ones hardest to reach for treatment. The epidemic is also spreading among health care personnel and patients, particularly in

urban hospitals treating large numbers of poor, HIV-infected, or substance abusing patients.

Recent outbreaks of multi-drug resistant strains of TB have heightened the urgency of addressing the treatment needs of TB patients. Drug-resistant strains of TB can cost up to $150,000 to treat and can be fatal even with treatment.

The President's FY 94 request of $129 million, $50 million more than FY 1993, will support an intensive effort to control and prevent TB.

In April 1992, a federal TB Task Force published the National Action Plan to combat Multidrug-resistant Tuberculosis. In 1989, the Department of Health and Human Services issued a Strategic Plan for the Elimination of Tuberculosis in the United States. Full implementation of the recommendations of the plan is estimated to cost approximately $484 million.

4. CDC Injury Prevention and Control Program

The CDC Injury Prevention and Control Program provides assistance in developing and implementing a national program for injury prevention and control with state and local agencies, community-based, non-profit and for profit organizations. The Injury Control Program supports research and intervention in injuries from motor vehicle crashes, falls, poisonings, fires and burns, drownings and violence, such as homicide and suicide.

$32 million was appropriated for FY 93. At the current funding level, there are thirty-seven injury control research project grants, eight injury control research centers in universities, fifteen state/local capacity building grants, and seven injury surveillance grants.

The President's FY 94 request is $42 million.

An appropriation level of $60 million would enable CDC to expand its current capacity-building and surveillance grants in 27 states to 50 states.

We have developed a Domestic Violence Prevention Initiative. The legislation would establish a domestic and partner violence prevention program within the Center for Injury Prevention and Control. The goals of the program would be to: identify effective strategies to prevent domestic or partner violence; expand the development and evaluation of programs for the primary prevention of violence against women; and broaden public awareness of the public health impact of domestic violence.

5. Sexually Transmitted Diseases Program

The Sexually Transmitted Disease (STD) Program provides states and technical assistance to states, local health agencies and community-based organizations to prevent the spread of STDs.

More than 12 million cases of STD occur in the U.S. every year. An estimated 3 million teenagers are newly infected annually. The program has historically focused on controlling the disease through education, behavior modification, early diagnosis, and treatment. With a steady rise in the number of STD cases, and serious complications of STDs in women additional resources are needed. Authority for this program expired in 1991 and without reauthorization, efforts to increase appropriations for the program has been unsuccessful.

The FY 1993 CDC budget for the STD program is $90 million which represented only a $2 million increase over FY 1992.

The President's FY 94 request is $104 million.

In order to meet the service needs and reduce the morbidity associated with STDs, the program would require an appropriation of $220 million.

6. CDC intramural programs

The laboratories at the CDC have been responsible for major public health break-throughs (identification of hepatitis C as the cause of non-A, non-B hepatitis, development of antibodies against rabies viruses) and the training of state and local public health personnel. Inadequate laboratory facilities and equipment may limit CDC's ability to develop and evaluate improved diagnostic tests for emerging infectious and opportunistic infectious diseases, improved rapid laboratory diagnostic tests for TB, improve tests for Lyme disease and measles, conduct surveillance of foodborne diseases, provide necessary training to public health surveillance and laboratory personnel, or surveillance of drug resistance in TB.

It is estimated that $75 million would be necessary to implement these needed changes.

7. Childhood Lead Poisoning Prevention Program

In February 1991, the Department of Health and Human Services issue a strategic plan for the elimination of childhood lead poisoning. The plan outlines the first five years of a 20-year effort to eliminate the disease. The plans calls for targeting neighborhoods that need more intensive, community-wide interventions for preventing lead poisoning, a nation-wide lead-based paint abatement program using safe and effective methods, ongoing efforts to limit children's exposure to lead from water, food, air, and soil, and the workplace, a national surveillance system to identify areas in need of further evaluation or interventions, and evaluating exposures of persons performing abatement and other workers, and research on cost-effective methods for screening children, testing paint and dust for lead, and reducing the sources of lead to which children may be exposed.

The FY 1993 budget for the Childhood Lead Poisoning Prevention Program is $30 million.

The President's FY 94 request is $30 million.

In order to meet the service needs and reduce the severe morbidity associated with lead poisoning, the program would require an appropriation of $80 million.

8. Tobacco Initiative

This proposal would provide grants to states to assist in enforcing laws prohibiting the sale of tobacco to minors and take other measures to reduce adolescent smoking. In addition it would provide funds to launch a national anti-smoking ad campaign. Smoking is a huge health problem, and both these efforts would make a significant contribution to reducing tobacco use, particularly among young people.

9. Violence Prevention Initiative

Homicide is the 10th leading cause of death in the United States. Men, teenagers, young adults, minority group members, particularly blacks and Hispanics, are most likely to be murder victims. As the second leading cause of death for young adults, and the leading cause of death for black males between the ages of 15 and 34, , it is clear that violence is a public health problem we must do more to combat.

The CDC National Center for Injury Prevention and Control has applied a public health approach to this epidemic of violence, using prevention, acute care, and rehabilitation strategies with encouraging results. Although progress is being made in confronting the problem, more must be done. New injury prevention initiatives must spotlight domestic violence, acquaintance rape, date rape, and all forms of violence which target women and intentional injuries in racial and ethnic minority populations.

Effective strategies to prevent violence must be identified and implemented. A national campaign to prevent violence, especially against women, is needed. This campaign would build upon existing efforts by the CDC to create a comprehensive violence prevention program. This campaign will be a vital step toward reducing violence targeted at women by demonstrating and evaluating promising intervention strategies, by conducting a nationwide education, training, and public awareness effort, and by expanding our knowledge base through data collection and research.

The violence prevention initiatives would require an additional increasing $60 million would allow CDC the ability to support community-based educational programs to prevent violence, including school-based curricula, adult education, parent skills training and public awareness.

10. Chronic Diseases Initiative

Reducing the costly and largely preventable burden of chronic disease has been a growing area of U.S. health policy since the mid-1970s. Many improvements have been made in the last decade. Death rates have declined significantly for three of the leading causes of death - heart disease, stroke, and unintentional injuries.

In a 1991 report, " Reducing the Burden of Chronic Disease: Needs of the States," the Association of State and Territorial Chronic Disease Program Directors highlighted the role of the state health agency chronic disease programs play in preventing chronic diseases and the resources needed by states to meet the challenges. In 1989 State Health Departments spent a total of $9.5 billion, only $245 million was spent on activities related to chronic diseases. The top state health agency chronic disease priorities for the 1990's are cancer, cardiovascular disease, cardiovascular disease, tobacco, diabetes, unintentional injuries and minority health.

Programs have the potential to reduce health care cost associated with chronic diseases include cholesterol screening and good nutrition, smoking cessation, hypertension screening, exercise, and alcohol consumption reduction. Federal funding for chronic diseases activities comes primarily from the preventive health block grant program ($150 million). In order to meet the state needs for health promotion and disease prevention programs targeted at the prevention of chronic diseases an additional $150 million would be needed.

11. National Health Service Corps (NHSC)

The National Health Service Corps (NHSC) program assists in the development of stable, high quality systems of primary health care in Health Professional Shortage Areas (HPSA) by supporting the recruitment, placement, and service of physicians and other health professionals in these areas.

The National Health Service Corps Recruitment program recruits primary health care practitioners through the use of scholarships and loan repayment awards in exchange for service commitments to HPSAs throughout the country. Preference is given to disadvantaged health professions students and practitioners to assure culturally sensitive providers in underserved areas.

The FY 1993 appropriation levels for NHSC Scholarships and loan repayment programs was $76 million and for the NHSC field support $67 million. At this appropriation level, the NHSC will eventually be able to turn out about 500 physicians per year - 300 through scholarships, 200 through loan repayment, and 250 nurse practitioners, nurse midwives, and physician assistants leading to a field strength of about 1552 primary care providers.

The increased funding levels would allow the NHSC to deliver approximately 1,700 new physicians per year by 1997 - 1,341 through scholarships, 1,242 through loan repayments, and 900 nurse practitioners, nurse wives, and physician assistants, leading to a field strength of approximately 4500 primary care providers.

12. Health Careers Opportunity Program (HCOP):

Since HCOP began in 1972 over $338 million has been invested in more than 700 career opportunity programs in health and allied health professions schools. The program seeks to recruit individuals from minority/disadvantaged backgrounds for health professions education and training, provide preprofessional education to help them gain admission to schools, and provide academic and counseling services to retain students through to graduation.

In FY 1992, 164 HCOP grants totally $24.2 million were awarded to Institutions and community-based programs in 36 states, the District of Columbia, Micronesia and the Virgin Islands. The programs benefit 9,173 disadvantaged students in structured academic programs and 18, 761 students in unstructured (recruitment, tutorials, and health careers counseling) activities. Overall, about 60 percent of HCOP participants are African American, 18 percent Hispanic, 6 percent Native American, 6 percent Asian American and/or Pacific Islanders and 10 percent disadvantaged whites.

Increase funding for HCOP and the Disadvantaged Assistance Program from the FY 1993 appropriation of $30 million to 60 million in order to expand programs that will increase the number of minority health care providers. The Association of American Medical Schools has developed an initiative which would double the number of minority students entering medical school by the year 2000. The Health Task Force and Council on Graduate Medical Education has recommended increasing the ethnic diversity of the health care workforce.

13. Area Health Education Centers and Health Education and Training Center

In the early 1970's, the Area Health Education Center (AHEC) Program, along with the National Health Service Corps and the Community/Migrant Health Center Program, provided a tripartite approach to issues of health access and health personnel distribution. The AHEC program began as an effort to attract and retain health care personnel in underserved areas, utilizing educational system incentives.

The Health Education and Training Center (HETC) program was added as a separate section of the basic AHEC program in 1988 to provide special support for communities and populations suffering from acute, persistent health professions shortages. This new activity has two categories. The first responds to the needs along the U.S. Mexico border for which 50% of the funds are allocated. The second part of the program provides for projects in underserved areas such as inner-cities, frontier areas and Appalachia.

Recent evaluation studies have shown that AHEC trained individuals have a greater propensity to practice in medically undeserved areas, and that AHECs have facilitated the growth of primary care training programs both at the graduate and undergraduate level. It is reported that over 184,650 health professionals in primary care received educational support services during fiscal year 1990 as a result of the AHEC program.

It is important that support be expanded for development of service-linked education networks that provide training in the following target areas: HPSAs, CHCs, MHCs, State designated sites (i.e. rural clinics, rural and urban health centers, health departments); opportunities for under represented minorities; and reducing infant mortality. Priority funding linked with the expanded authorization will be used to develop those service-linked education networks which include minority recruitment programs, more aggressive placement of health student health personnel at community sites, and documented effectiveness in the target areas.

We propose increasing funding for AHECs from the current $19 million appropriation to $40 million. Increase funding for HETCs from current $3 million to $9 million.

14. Primary Care Physicians

Today, only-third of all physicians generalists. A rational health care system must be based upon a majority of generalist physicians (family physicians, general internists and general pediatricians) trained to provide quality primary care to meet the need of the Nation.

Funding for the Family Medicine Training program for fiscal year 1993 was $38.2 million. This program supported- (1) 96 six predoctoral training programs and 37,000 trainees; (2) 140 residency programs and 3,360 residency positions, and (3) 33 faculty development programs and 1,914 faculty trained.

Funding for General Internal Medicine and General Pediatrics for fiscal year 1993 was $17 million. This program supported- (1) 83 residency programs and 1,743 residency positions, and (2) 23 faculty development programs and 1,426 faculty trained.

An increase in Federal funding is needed to fund primary care activities, improve the primary care infrastructure, and increase the number of primary care physicians. An additional $50 million dollars would triple the number of family medicine, general internal medicine and general pediatrics first year training slots from 1,700 to 5,100.

15. Nurse Practitioners/Nurse Midwives/Physician Assistants

There are 22,000 nurses enrolled in Master's programs. About 3,000 of these are in nurse practitioner training programs. There are 2,000 students are enrolled in physicians' assistants programs. The shortage of advance practice nurses is expected to worsen as a larger share of Americans receive health services in managed care arrangements.

The Federal government has been instrumental in the development of advanced practice nurses through direct student educational subsidies and grants to schools of nursing to develop training programs.

Advanced practice nurses and physicians' assistants can be trained much more rapidly than primary care physicians. Advanced practice nurses and physician assistants can be trained at a fraction of the cost of training primary care physicians. An increase in nurse practitioners, nurse midwives, and generalist physician assistants will enhance the delivery of primary care.

Doubling the annual number of graduates of nurse practitioner, physician assistant and nurse midwife training programs would cost about $70 million per year.

EDWARD M. KENNEDY
MASSACHUSETTS

United States Senate

WASHINGTON, DC 20510-2101

Philip Lee, M.D.
Assistant Secretary of Health
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

September 29, 1993

Dear Phil:

I am very pleased that the Clinton health reform plan recognizes the key role of the public health system in assuring access to health services for medically underserved populations and in protecting all Americans against communicable diseases and other preventable public health hazards. I have reviewed the Adminstration's preliminary reform proposals for the public health system and would like to offer my views on them.

Core Public Health Functions: The administration's proposal to "improve the performance of the core functions of public health" is a worthwhile effort to consolidate federal programs in this area. I would propose to incorporate the Preventive Health and Health Services Block Grant and some of the currently authorized disease and injury prevention programs within the Centers for Disease Control for which the state is the grantee.

The latter programs include the Sexually Transmitted Disease, Tuberculosis, and childhood immunization programs. These programs are currently grants to states and, in some instances, to large cities. I would propose to include major metropolitan areas as grantees under the new competitive grant program. The Administration's program should include funds for new initiatives in smoking, violence and chronic disease prevention. These initiatives offer an opportunity to address vital health needs, and they need to be separately identified and funded.

In addition, I would like to spell out clear performance standards and outcome measures for the use of these funds in order to maintain and improve accountability as we move to consolidate and expand current programs.

Health Care Access: I support the Administration's desire to ensure that low income individuals and disadvantaged populations have access to health care services by integrating the community-based clinics that have traditionally served this population into practice networks. However, I am concerned about the proposal to overlay a new consolidated program on top of existing categorical project grants to

community-based health service providers. Rather than streamlining the programs, this approach would require already thinly-stretched local clinics to apply to the federal government twice for their core support funds. In addition, such an approach lacks the specificity needed to respond to clearly identified national priorities.

I strongly believe that at least half of any urgently needed additional resources should be added to existing programs that have a history of servicing hard-to-reach and at-risk individuals and their families. Such programs would certainly include Community and Migrant Health, Homeless Health, Substance Abuse and Ryan White (AIDS). It is critical that adequate resources be made available for new school-based clinics and occupational health and safety programs. School-based clinics, in particular, are a high administration priority and need adequate funding.

The remaining funds, not earmarked for current categorical programs, should be provided to grantees contingent on their agreement to include all categorical grantees within their service area in any new practice network.

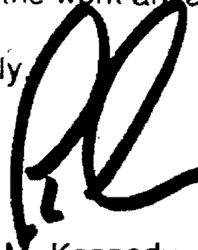
Enabling Services:
I also do not support a large, new formula grant program to states to "enable" low income individuals to receive necessary health services. Again I would like to see the bulk of new funds directed to existing programs. A small, competitive program to fill in gaps would be one alternative. Another approach would be a limited program of matching grants to states to extend Medicaid ancillary services such as transportation and other medical or support services beyond the scope of the guaranteed minimum benefit package to low income individuals who are ineligible for Medicaid.

Funding: I am very concerned about new resource allocations for the public health system. The latest administration proposal is for net additional spending of only $1 billion annually, when earlier administration estimates of need were $5 - $6 billion per year. The funds required to support dramatic public health initiatives are small compared to the overall cost of the reform program -- only about 1% of the total cost of health reform. If overall funding for the public health programs is in the low range, priority should be placed on programs that directly expand access to health care for the most vulnerable groups.

I am pleased that the administration is proposing mandatory funding for these new initiatives. Subject to agreement from Senators Byrd and Harkin on the Appropriations Committee, I would propose that we establish a mandatory "capped entitlement" fund for public health initiatives which would be subject to appropriation. This would assure an on-going source of funding while permitting annual Congressional oversight of the use of funds.

I want to move forward as rapidly as possible -- ideally, prior to the legislation's submission to Congress -- to work out the details of the public health proposals. My staff will be in contact to follow-up on this letter. I greatly appreciate all that you and your staff have done thus far and I am optimistic about the work ahead.

Sincerely,



Edward M. Kennedy

We need some help on this -

from the office of

Senator Edward M. Kennedy

of Massachusetts

FOR RELEASE: September 15, 1993
CONTACT: Theresa Bourgeois
Kevin Winston
202-224-4781

STATEMENT OF SENATOR EDWARD M. KENNEDY ON THE INTRODUCTION OF THE REPUBLICAN HEALTH PLAN BY SENATOR JOHN CHAFEE

I want to commend Senator Chafee and his Republican colleagues for the hard work and commitment they have shown in developing the health reform proposal that they announced today. This proposal, along with comprehensive proposals previously introduced by Senator Jeffords and Senator Kassebaum, shows that there is commitment to reform on both sides of the aisle.

I am pleased to see that the plan introduced today has many points in common with the plan that President Clinton will announce next week.
Both proposals share the same goal of universal coverage and affordable health care for all Americans. Both proposals encourage the use of market forces to control health care costs. Both proposals provide assistance to low income Americans. Both proposals enable small businesses and individuals to join purchasing alliances to obtain coverage at an affordable cost. Both proposals include measures to prohibit abusive insurance company practices. Both proposals simplify reporting and data requirements, and reduce the paperwork and red tape that plague the current system and make it so wasteful and inefficient.

Both proposals include measures to reform medical malpractice liability, to provide greater flexibility in the application of the anti-trust laws to health care, and to improve the quality of care.

The shared goals and the many points in common between President Clinton's plan and the Republican proposal are a positive sign that bi-partisan cooperation is not only possible but probable in this all-important debate that is now underway, and I look forward to working closely with Senator Chafee and other Republicans on legislation to achieve our goals.

TO: Ira Magaziner/Judy Feder

FROM: David Nexon (Senator Kennedy)/Darrel Jodrey (Senator Wofford)

DATE: 5/17/93

SUBJECT: LONG-TERM CARE PACKAGE

Over the last few weeks, we have been talking to the elderly groups whose support is most important in moving the health reform package: AARP, National Committee to Preserve Social Security and Medicare, and Alzheimer's Association. Like these groups, Senator Kennedy and Senator Wofford strongly prefer a social insurance approach to long-term care needs. For both policy and political reasons, a program that relies solely on means-tested services and private insurance would not be desirable

Based on our conversations with the groups and preliminary costing by the long-term care cluster group, it appears that a long-term care package that will be expansive enough to meet their needs and point to a long-run social insurance program can be put together for a reasonable cost. The package would include a number of elements developed by the long-term care work group as part of options #2 and #3 of tollgate 5. The elements of the program include:

I. Home care

o Coverage of all disabled Americans regardless of income

o Services available to those disabled on three or more activities of daily living or serious level of cognitive impairment (possibility of phasing in coverage by disability level and future lowering of degree of disability required for coverage)

o Program provides coverage based on assessment and plan of care. Services tailored to individual needs. State flexibility in administering the program.

o Cost control through aggregate budget limit based on estimated average cost of services to eligible individuals/could be supplemented by cap in individual costs related to cost of nursing home care.

II. Nursing home care

o Medicaid improvements as described in option #1 of the tollgate (improved personal needs allowance, improved asset protection, universal spend-down, closing of loopholes).

o Voluntary public insurance program (see attached)

o Standards for private long-term care insurance.

The major change from the option #3 as presented in the tollgate 5 document is the inclusion of a voluntary public insurance program, a variant of which was included in option #2 of the tollgate paper.

This kind of a package has a number of advantages. First, it provides what all the elderly groups say is their highest priority: social insurance protection against the high cost of in-home services. Moreover, the home care services are structured in a way that make it possible to phase them in by disability level and, if resources permit in future years, to provide for broader coverage.

Second, it establishes a government program that guarantees the availability of nursing home care for those who need it, through the universal spend-down program.

Finally, it provides substantial asset protection against the cost of nursing home care for those who need and want such protection. Protection against the high cost of nursing home care ranks a close second to home care in most surveys of elderly desires for comprehensive health reform; in some surveys, it ranks first.

Because the insurance program under this proposal is established, operated and guaranteed by the government, it has the same aura of dependability and universality that Medicare provides. The administrative costs of a government program are substantially less than for equivalent private coverage. Because it is a government-run program, it can be presented to the senior groups as the base for a future, more expansive social insurance program if economic conditions permit.

The political advantage of the voluntary public insurance program is that is allows us to offer a universal, non-means tested benefit for both home care and nursing home care. Without it, we have the base for a social insurance program only for home care.

Cost estimates for the voluntary public insurance program are still being developed. An unsubsidized program would entail no government costs, but might result in premiums that are too expensive for a credible program. Additional alternatives that should be costed out include:

o a subsidy for some portion of the premium, e.g., the government pays 25 per cent; the enrollee pays 75 per cent.

o a subsidy for some portion of the premium, with premiums established on a pay-as-you go basis, similar to Medicare Part B, rather than on a pre-funded bases. The effect of this is to depress premiums (and government costs) in the earlier years and to raise them in the later years, when additional savings from Medicare cost restraint will be available to help fund the program.

KEY CONSIDERATIONS

--If the long-term care program included in the bill consists primarily of means-tested benefits, it will buy little support from the important senior citizens organizations or the elderly themselves.

--State flexibility in the design of the home care program should relate primarily to administration. A minimum package of benefits available to the elderly, based on the plan of care, should be specified in the legislation (the cluster group proposal implied somewhat less specificity about what the benefit actually entailed than seems to us appropriate and politically viable).

--Private long-term care insurance is not trusted by the elderly; its encouragement will add little to the political attractiveness of the program; and its main advantage is that it potentially minimizes Federal costs. To the extent that favorable tax treatment is required to make private insurance attractive, it will result in some Federal costs. As a policy matter, private insurance that must be sold on an individual as opposed to a group basis is generally associated with extraordinarily high

administrative costs.

--While we think this kind of package--in conjunction with Medicare drug coverage--will result in strong endorsement of the bill by senior groups, the package, as we are sure you intend to do, needs to be negotiated in advance of the bill's release so that endorsements are nailed down.

VOLUNTARY PUBLIC INSURANCE PROGRAM

Eligibility

--One-time opportunity to enroll for all individuals currently 65-75

--One-time opportunity to enroll for every individual turning 65

--Coverage could be established for individuals at younger ages with reduced premiums

Coverage

--$30,000 in coverage for nursing home care for those meeting 3 ADL/cognitive impairment requirements, indexed to the rise in nursing home costs.

--An additional $30,000 in Medicaid spend-down protection, for a total of $72,000 in asset protection ($30,000 through insurance; an additional $30,000 through Medicaid; $12,000 in Medicaid available to all under Medicaid improvements). An additional $30,000 in Medicaid spend-down protection (for a total of $$72,000) should also be costed, since preliminary estimates indicate it would add little to public costs but would substantially increase the attractiveness of the package to the elderly).

--coverage available after a two to three year waiting period for current seniors (original proposal required five years) and immediately for those turning 65

--Could also provide a "cadillac option" with $100,000 coverage for a higher premium.

Premiums

--Currently estimated at approximately $60-70 per month, indexed to the Social Security COLA. Premium would be reduced for those buying at younger ages.

--If premium estimates remain at this level, they will likely be perceived

as being too high. A government subsidy for a portion of the premium should be costed, both on a prefunded and pay-as-you-go basis.

Private Insurance

--Private insurance would be available as supplementary coverage to the public insurance package.

CC: Chris Jennings ✓
Christine Heenan