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001. memo	Taping with Senator Leahy at 7:00 p.m. (2 pages)	9/21/93	P5

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[HSA] - Senator Leahy (VT)

gf142

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
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Howard Dean, M.D.
Governor

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TO: Theresa Alberghini

FROM: Anya Rader ARR

DATE: June 9, 1992

RE: DGA Meeting

I spoke with Katie Whelan, Executive Director of the Democratic Governors' Association, about the agenda for the 18th. Apparently Congressman Gephardt is now planning to attend and Katie had envisioned Leahy and Gephardt both talking about health care reform from the congressional perspective. The agenda is tentatively as follows:

8:00 - 9:30 Governors only breakfast (no staff, no press) with Ira Magaziner, Mandy Grunwald, Stan Greenberg

9:30 - 12:00 HEALTH CARE SESSION (open to press)

9:30 - 10:00 Mandy Grunwald, Stan Greenberg presentation

10:00 - 10:30 Governors Discussion:
Governors describe state efforts, ask questions, etc.

Leahy in Wednesday.

10:30 - 11:00 Senator Leahy and Congressman Gephardt on the congressional perspective, state role in health reform, etc.

11:00 - 12:00 Hillary Clinton and Ira Magaziner join the session

12:00 - 1:00 Governors only lunch with Mrs. Clinton

I should emphasize that this is all tentative. I think what you can count on is the Senator giving a brief presentation at some point during the morning, and he should probably talk about the concept behind State Care and the fact that he sees that as very consistent with the thrust of the administration's plan. You should probably coordinate

mental task to gather the information necessary to accomplish that goal.

Mr. WELLSTONE. Mr. President, I am very pleased to support the reauthorization of the Agency for Health Care Policy and Research as an original cosponsor. Congress has charged this Agency to carry out some of the most critical work on health care reform before us today. The task of identifying effective treatments for a range of health care conditions, and developing standards the health care professions can rely on, is key to the efforts we will make to provide quality health care at a reasonable cost.

The Agency's Medical Treatment Effectiveness Program [MEDTEP], using Patient Outcome Research Teams [PORT's] and the current literature, has the potential to expand our knowledge of what quality care really is.

The Agency has a related mission: To demonstrate and evaluate new ways to organize, finance, and direct health care services to improve the delivery, access to, and outcome of such services.

I believe the Agency can make a significant contribution by focusing on primary care, both in terms of treatment and in terms of organization of services. I recognize that current funding levels limit what the Agency can accomplish. But it would be helpful if the report of the Committee on Labor and Human Resources were to urge the Agency to make progress in this area during the coming year.

Primary care is the linchpin to improving care and controlling costs in the United States. Studies show better health care outcomes and higher levels of patient satisfaction in countries where a generalist model of health care predominates, and that generalists are by far the most cost effective. In most countries at least 50 percent of physicians are generalists—family physicians, general internists, and general pediatricians. But the United States has 70 percent subspecialists and only 13 percent general family physicians/general practitioners.

Nurses, nurse practitioners, dentists, and physician assistants are other important primary care practitioners.

Certainly we can concentrate on increased funds to train primary care practitioners. In addition, primary care research can encourage and support primary care practitioners by studying and disseminating information on effective treatments and organization of care.

There are two areas that a primary care research agenda must address: First, studies on the problems that people present with in primary care; and second, studies on the effective organization and delivery of primary care services.

STUDIES ON THE PROBLEMS THAT PEOPLE PRESENT WITH IN PRIMARY CARE

We need better information about the course of problems at all stages of development.

The growth of knowledge about fully developed diseases and the molecular basis of disease has not been balanced by a similar commitment to an understanding of health, the concerns that bring people to doctors, and the processes whereby people with symptoms become patients with diagnoses. The general problems people present to their doctors are met too often with knowledge based on experience with hospitalized patients and studies from controlled experiments. This may not be at all relevant to the entry level of medical service and treatments. As a result we have health care skewed toward highly technological care for catastrophic illnesses.

Patients come to doctors with clusters of ill-defined symptoms, labelled diseases. They may differ by age, gender, and ethnicity from the narrowly defined groups usually studied in controlled experiments.

Primary care research could provide new tools to primary care practitioners, including improved diagnostic accuracy. Such research can assist in streamlining the diagnostic process and increasing accuracy, while reducing the use of expensive and potentially dangerous medical tests.

It can better inform primary care practices in which a variety of interventions are available, including drugs, education, reassurance, diet, exercise, and watchful waiting.

Research that helps primary care practitioners set rational priorities among competing prevention strategies would greatly improve the effectiveness of clinical prevention in actual practices

Medical research now provides little information about the natural history of many of the more common ailments that afflict people, and is largely silent on the best ways to tailor existing treatments to the needs of the individual. With information of this sort on hand, practitioners can collaborate with patients to design effective treatment plans that reconcile the idiosyncracies of patients and their environments with the realities of the disease process.

STUDIES ON THE EFFECTIVE ORGANIZATION AND DELIVERY OF PRIMARY CARE SERVICES

Our research investment has led to remarkable advances, such as immunizations for the prevention of infectious diseases, cures for several cancers, and successful treatment of hypertension to prevent heart attacks and strokes. But we need more: We need to know how to organize and provide primary care so that children get immunized, curable cancers are detected early, and care is delivered to vulnerable populations.

The organization and settings in which health care is provided exert substantial influence on the outcomes of that care. We need to know more about the organization and settings of health care that promote or retard the effect of interventions. For example, what do primary care practitioners do when they function as gatekeepers to other services? How might they be used in more fundamental ways to coordinate care and use health care resources more judiciously?

We need to understand why certain individuals do or don't seek care, and the role they think they might play in their own recovery.

The Agency can contribute to progress by considering how to develop a research agenda in each of these areas. In addition, systems needed to train and support primary care researchers could be identified and proposed.

It is my hope that the Agency will address the need for primary care research more methodically in the coming year, and that the Congress will be in a position to offer a higher level of financial support for these expanded responsibilities by the time of our next reauthorization.

By Mr. LEAHY (for himself, Mr. PRYOR, Mr. MITCHELL, Mr. ROCKEFELLER, Mr. RIEGLE, Mr. CHAFEE, Mr. DANFORTH, Mr. KERREY, Mr. WELLSTONE, Mr. ADAMS, Mr. AKAKA, Mr. BINGAMAN, Mr. GRAHAM, Mr. INOUYE, and Mr. JEFFORDS):

S. 3167. A bill to amend the Social Security Act to provide grants for the establishment of State demonstration projects for comprehensive health care reform, and for other purposes; to the Committee on Finance.

[redacted]

Mr. LEAHY. Mr. President, today my good friend from Arkansas, Senator DAVID PRYOR, and I are introducing legislation that gives States the tools they need to try out bold new approaches to providing affordable health care to their citizens.

We are pleased to be joined in this effort by the majority leaders, Senators ROCKEFELLER, RIEGLE, CHAFEE, DANFORTH, KERREY, WELLSTONE, ADAMS, AKAKA, BINGAMAN, GRAHAM, INOUYE, and JEFFORDS.

The State Care Act of 1992 builds on legislation I introduced last year, S. 1972. It is the product of months of negotiations with other Senators and Representatives of States, consumers, businesses, and a broad range of other interested parties. The State Care Act incorporates many of their changes that significantly improve the bill. The bill has been endorsed by the National Governors' Association.

Mr. President, our current health care system needs fundamental change. Skyrocketing costs are hurting families, ruining businesses, and leaving millions of Americans without adequate care.

Generations of proud Vermonters—those who traditionally care for their own families—are now finding that a single illness can wipe out years of hard work and savings.

Universal health care is our goal, and we cannot rest until we have achieved it. I strongly support the majority

leader's effort to build consensus on a comprehensive health care reform bill we can move this year.

But in the absence of a national plan, States are moving ahead with their own comprehensive programs to provide affordable health care to their citizens. We cannot afford to discourage them.

It is significant that almost all proposals that offer a comprehensive national solution to our health care crisis recognize the important role States play in successful reform. The majority leader's bill offers States considerable flexibility, as do the bills introduced by our cosponsors, Senators WELLSTONE, KERREY, and CHAFEE.

Earlier this year, I worked with Senator MITCHELL and Senator KENNEDY to include in the HealthAmerica bill the opportunity for States to develop their own innovative approaches to providing affordable health care to their citizens. I strongly believe that State flexibility and innovation will be necessary to ensure the success of any comprehensive national health care plan.

Traditionally, States have played a vital role in shaping this Nation's health and welfare policies. Social Security and child labor standards are just two examples of the many beneficial Federal laws that emanated from the States.

Twenty-four States had parts of the Social Security law on the books before the national act passed in 1935.

Twenty-eight States had child labor laws on the books before Congress passed legislation in 1912.

That tradition continues today as many States tackle the difficult task of reforming their individual health care systems. In this year alone, Vermont, Florida, and Minnesota broke the health care deadlocks in their States and built consensus around programs to provide affordable care to their citizens. Many other States are undertaking similar efforts.

Earlier this year in a Finance Committee subcommittee hearing on State experimentation, the Governor of Hawaii, John Waihee, gave powerful testimony on his State's highly successful health care program. I know that his testimony, and that of my good friend from Florida, Governor Lawton Chiles, contributed significantly to the growing support in Congress for giving States more flexibility in the area of health care reform. Governor Chiles has been a strong ally and I appreciate all that he has done to bolster support for the State Care legislation.

I am particularly proud of Vermont's effort. Under the strong leadership of Governor Howard Dean—the only physician Governor in the country, and the new chair of the National Governors' Association's health care task force—Vermont enacted one of the most sweeping universal access plans yet. The law passed with overwhelming support from both houses of the Vermont Legislature. Many statewide organizations, including the Vermont State Medical Society, backed the plan.

Most importantly, the people of Vermont support the plan, and there is great determination in our small State to push ahead to see that every Vermonter has affordable care by the end of 1994.

But to reach this goal, Vermont and the growing number of other States courageous enough to pioneer universal health care, need support from Washington. Unfortunately, the General Accounting Office and the Employee Benefit Research Institute concluded, in recent reports, that State health care reform initiatives are constrained by Federal statutory and regulatory roadblocks.

That is where our legislation comes in. The purpose of State Care is to remove those roadblocks for States that are committed to overhauling their health care delivery systems.

Through a new Federal commission, our bill sets up a streamlined, "one-stop-shop" waiver approval process that provides narrowly-crafted, but important, waivers from Medicare, Medicaid, and the Employee Retirement Income Security Act [ERISA]. To be eligible for the waivers, States must submit a plan to the Federal commission that is comprehensive, and meets strong access and cost-containment goals. Our bill authorizes up to 10 State demonstrations.

Waiver authority under Medicare will strengthen States' negotiating hand with health care providers. For example, States could develop an all-payor reimbursement system, similar to one used in Maryland, to help contain health care costs. This authority would be extended only to States that continue to provide Medicare services to Medicare beneficiaries.

Our legislation streamlines the existing Medicaid waiver process and expands waiver authority so that States can cover additional low-income, unemployed, or part-time workers. New waiver authority also will allow States to implement innovative reimbursement, cost containment and other reforms. States must continue to provide federally mandated Medicaid services to Medicaid recipients.

With regard to both the Medicare and Medicaid Programs, strong quality assurance provisions are required.

By far, the most important provision in this legislation is the narrowly crafted wavier authority under ERISA that removes one of the greatest roadblocks to reform. Specifically, this legislation enables States to develop a basic benefit package for all without running afoul of ERISA. In addition it provides States the ability, if necessary, to raise funds to support access initiatives by allowing for the establishment of a broad-based revenue raising mechanism.

Mr. President, this bill is not flawless and it is not set in stone. It is our best effort to date to strike a fair balance among interested parties. Senator PRYOR and I will continue to seek the comments of all interested groups in an effort to address outstanding concerns about the bill.

Mr. President, there are many people to thank for their work on the State Care Act. I am grateful to the majority leader for his support and advice in shaping this legislation. He has long been sensitive to the States' concerns in the health care reform debate and his HealthAmerica legislation reflects that sensitivity.

I am pleased that the chairman of the Finance Committee, Senator BENTSEN, intends to hold a hearing in September to further explore State health care reform initiatives and consider the State Care bill. Senator BENTSEN and his staff have contributed significantly to this legislation. I appreciate the technical advice they have given us and their many improvements to the bill. I look forward to continuing our work together on this initiative.

I am delighted that Senator ROCKEFELLER, who has done so much to move the health care reform debate forward, has joined us in this effort. His advice has been and will continue to be invaluable as we refine this legislation.

Senator KERREY and Senator GRAHAM offered their support for this legislation very early in the process and for that I am very grateful. I also want to thank Senator WELLSTONE and his staff for their many helpful suggestions on this legislation. Senator WELLSTONE has provided an important link for us with Minnesotans who are concerned about the success of HealthRight and the MinnesotaCare program.

My friend from Vermont, Senator JEFFORDS, recognizes the importance of the work being done on health care in the States, especially Vermont. I am glad he is a cosponsor of this bill.

Mr. President, I also want to thank the National Governors' Association [NGA] for their tireless efforts on behalf of this legislation. The NGA has forged a strong working relationship with Congress on health care reform issues and I appreciate their many contributions to the bill.

Many other organizations, in particular, Families USA, have lent their expertise and to improving this legislation. We look forward to continuing this working relationship to ensure the strongest bill possible.

Mr. President, finally, I want to thank Senator PRYOR and his staff for their work on this legislation. I could not have asked for a more knowledgeable and skillful partner in this effort. Senator PRYOR is committed to solving the problems that are putting health care out of the reach of America's families, and I commend him for his leadership. It is a privilege to work with him on this initiative.

And Theresa Alberghini of my staff has worked days and nights to help craft this legislation. She cares deeply about the health care crisis and the people of her home State of Vermont. She is a true professional, and deserves

much credit for this State Care initiative.

Mr. President, Senator PRYOR and I believe the State Care Act of 1992 works equally well as part of a nationwide comprehensive reform plan or as a way to achieve statewide, comprehensive reforms.

But whatever we do this year, we can no longer, stand in the way of States that are committed to providing affordable health care to their citizens.

Mr. President, I ask unanimous consent that the bill, a detailed summary of the legislation, and a letter of support from the National Governors' Association be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 3180

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "State Care Act of 1992".

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) up to 37,000,000 Americans are without health insurance;

(2) health care costs the average American family more than $4,300 a year;

(3) a single serious illness can financially devastate all but the wealthiest families;

(4) preventive medical care is a cost-effective way to reduce medical costs; and

(5) as with Social Security and child labor protections, States can lead the way in testing ideas for national application.

(b) PURPOSE.—It is the purpose of this Act—

(1) to test ways to provide a more equitable, rational, and cost-effective system of health care; and

(2) to remove Federal statutory and administrative barriers that currently block efforts by States to provide health care coverage to individuals residing in such States.

SEC. 3. AMENDMENTS TO SOCIAL SECURITY ACT.

The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following new title:

"TITLE XXI—STATE COMPREHENSIVE HEALTH COVERAGE AND COST CONTAINMENT DEMONSTRATION PROJECTS

"TABLE OF CONTENTS OF TITLE

"ESTABLISHMENT OF STATE CARE DEMONSTRATION PROJECTS

"SEC. 2101. There is hereby established a program under which the State-Based Comprehensive Health Care Commission shall select States to participate in demonstration projects designed to provide health care coverage to eligible State residents and to contain health care costs in such States.

"ESTABLISHMENT OF STATE-BASED COMPREHENSIVE HEALTH CARE COMMISSION

"SEC. 2102. (a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is hereby established a State-Based Comprehensive Health Care Commission which shall be composed of—

"(A) the Secretary,

"(B) the Secretary of Labor, and

"(C) 11 members to be appointed by the President, within 90 days of the enactment of this title, by and with the advice and consent of the Senate.

"(2) MEMBERSHIP.—The members of the Commission appointed under paragraph (1)(C) shall include individuals with national recognition for expertise in health insurance, health economics, health care provider reimbursement, and related fields. In appointing individuals, the President shall assure representation of consumers of health services, large and small employers, State and local governments, labor organizations, health care providers, rural areas, and health care insurers.

"(b) TERMS.—The members of the Commission appointed under subsection (a)(1)(C) shall be appointed to serve for terms of 3 years, except that the terms of the members first appointed shall be staggered so that the terms of no more than 4 members expire in any one year. Any individual appointed to fill a vacancy created in the Commission shall be appointed for the remainder of the term of such individual's predecessor.

"(c) DUTIES.—

"(1) GRANTS.—The Commission shall—

"(A) provide guidance to State health care authorities regarding applications for grants under this title and exchange information with, and otherwise assist, such authorities upon the request of the authorities;

"(B) develop a model benefit package that may be used by State health care authorities in applying for a State care demonstration project grant under this title;

"(C) develop guidelines to assist State health care authorities in providing data base infrastructure as described in section 2105(b)(15);

"(D) set application procedures;

"(E) review and approve applications for State Care demonstration project grants under section 2104;

"(F) review and approve applications for development and implementation grants under section 2106;

"(G) provide appropriate levels of funding for such approved applications;

"(H) conduct such evaluation, monitoring, compliance, and other review functions as may be appropriate, including such as are required under section 2109; and

"(I) implement any other requirements or activities necessary and appropriate under this title.

"(2) ANNUAL REPORT.—The Commission shall report annually to the President and the Congress. Such report shall be submitted not later than March 30 of each year and shall include information concerning States that receive grants under this title and the effectiveness of any health care programs assisted by such grants.

"(d) MISCELLANEOUS.—

"(1) AUTHORITY.—The Commission may—

"(A) employ and fix the compensation of an Executive Director and such other personnel (not to exceed 25) as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

"(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5)); and

"(D) make advance, progress, and other payments which relate to the work of the Commission.

"(2) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission appointed under subsection (a)(1)(C) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from the member's home and regular place of business, any member appointed under subsection (a)(1) may be allowed travel expenses, as authorized by the Chairperson of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as such subsection applies to the Tennessee Valley Authority.

"(3) ACCESS TO INFORMATION, ETC.—The Commission shall have access to such relevant information and data as may be available from the Physician Payment Review Commission, the Prospective Payment Assessment Commission, and other appropriate Federal agencies and shall assure that its activities, especially the conduct of original research and medical studies, are coordinated with the activities of such Commissions and Federal agencies. The Commission shall be subject to periodic audit by the General Accounting Office.

"(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

"STATE HEALTH CARE AUTHORITY

"SEC. 2103. (a) ESTABLISHMENT.—A State that desires to receive a grant under section 2104, shall establish a State Health Care Authority as provided in subsection (b) which shall prepare and submit to the Chief Executive Officer and the State legislature of that State a comprehensive recommendation for the State plan described in section 2104(b). The preceding sentence shall not apply to any State which has enacted a State plan described in section 2104(b) within 12 months of the date of the enactment of this title.

"(b) COMPOSITION.—The Authority shall be composed of individuals appointed by the Chief Executive Officer of the State equally from among representatives of—

"(1) health care providers;

"(2) consumers and labor;

"(3) the State health department;

"(4) the State legislative leadership;

"(5) insurance providers operating in the State;

"(6) low-income advocacy organizations;

"(7) senior citizen organizations;

"(8) business, including small business entities and self-employed individuals; and

"(9) other organizations determined appropriate by the Chief Executive Officer.

"(c) REPORT OF STATE HEALTH CARE AUTHORITY.—The Authority shall prepare and submit to the Chief Executive Officer of the State and the legislature of the State, a report containing a copy of the proposed State plan.

NATIONAL GOVERNORS' ASSOCIATION

Roy Romer
Governor of Colorado
Chairman

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August 12, 1993

The Honorable Patrick J. Leahy
United States Senate
433 Senate Russell Office Building
Washington, D.C. 20510-4502

Dear Senator Leahy:

On behalf of the National Governors' Association, we support the legislation introduced by you and Senator Pryor that would assist states in developing and implementing state-based comprehensive health care reform initiatives.

As you are well aware, Oregon, Hawaii, Florida, Minnesota, and your home state of Vermont have taken important steps toward changing their health care systems by enacting and implementing state-based health reform strategies. In the next year we expect several more states to develop such comprehensive approaches. States are poised to move. However, most are prevented from making significant progress because of various federal statutes and regulations that limit state action. States cannot make the sweeping changes necessary without the help of Congress.

At a meeting with you and other members of Congress last June, Governors talked about the need for a state and federal partnership. We are pleased to see that your legislation recognizes that important relationship. Moreover, you have captured an essential component of the partnership -- state flexibility and accountability within a vision of comprehensive health care. You and Senator Pryor are to be congratulated.

Waiver authority is key to affecting the needed changes. The legislation establishes streamlined waiver authority in Medicaid and Medicare and gives states the authority to test strategies that are currently precluded under the Employee Retirement Insurance Security Act (ERISA). Without such authority states cannot be expected to meet the goal of a comprehensive plan.

The legislation also removes a significant roadblock to state reform by establishing a commission that will facilitate the waiver approval process as well as give states a single place to secure waivers and receive technical assistance in the development of their demonstration applications. We believe that this is significant.

The National Governors' Association supports the legislation; however, several Governors have expressed concern about certain provisions. For example, ten demonstrations might be too few and federal cost neutrality over the five-year waiver period may be too limiting. We look forward to working with you in the next few weeks to address these concerns. Finally, you have crafted a careful balance between state flexibility and accountability. If this legislation is to have its intended effect, that flexibility must be not be eroded.

The nation's Governors are committed to making quality health care affordable and available to all. We believe that through this legislation you have reaffirmed your commitment to that goal as well. We thank you for all of your efforts and look forward to working with you and other members of Congress to assure that this legislation becomes law.

Sincerely,

Governor Roy Romer
Chairman
National Governors' Association

Governor Howard Dean
Co-Chairman
Task Force on Health Care

Governor George S. Nickelson
Co-Chairman
Task Force on Health Care

cc: Senator Pryor

THE STATE ROLE IN COMPREHENSIVE HEALTH CARE REFORM

THE STATE CARE ACT

SUMMARY OF MAJOR PROVISIONS OF LEAHY/PRYOR BILL

PURPOSE: To encourage and assist state-based comprehensive health care reform efforts by developing a streamlined and expanded "one-stop-shop" waiver approval process that removes overly burdensome administrative, regulatory and statutory Medicare, Medicaid and ERISA (Employment Retirement Income Security Act) requirements.

1. STATUTORY AUTHORITY

Adds new Title to the Social Security Act establishing demonstration projects.

2. WAIVER AUTHORITY

Establishes a Federal Commission to review, approve and oversee State Care demonstration projects. The President will appoint, and the Senate shall confirm, members of the Commission. The Commission will be made up of representatives of: consumers of health services, small and large employers, state and local governments, labor organizations, health care providers, health care insurers, experts on the development of medical technology, as well as the Secretaries of Labor and Health and Human Services.

3. STATE CARE DEMONSTRATION GRANT APPLICATIONS

Establishes standards for approval of up to ten state demonstrations. Each application must have:

* Statewide applicability.

* Universal access for state residents, as defined by the state having to increase, by the end of the five-year period, the percentage of the insured to at least 95 percent of the population OR increase the population of insured by 10 percentage points. (For example, from 82 percent to 92 percent; the 10 percentage point increase clause is designed to be fairer to states with higher numbers of uninsured.) States applying would also submit a plan outlining how any remaining uninsured would be covered following the conclusion of the 5 year demonstration.

* Effective cost containment mechanisms that assure that health care inflation within the state does not exceed the average annual percentage increase in the gross domestic product plus 3.7% for 1994, 2.7% for 1995, 1.7% for 1996, .7% for 1997, and for each year thereafter, 0 percentage points.

* Federal budget neutrality over the five year demonstration period, although need not be budget neutral in individual years as it relates to Medicaid. In no year, however, can Medicare spending exceed projected expenditures under current law. (Constant and Possibly Improved Federal Funding Stream: States that have approved comprehensive health reform plans will be assured of at least the same Federal Medicaid match as would have otherwise been made over the five year period. As a result, any future Federal savings from Medicaid cuts/policy changes/reforms for that state would accrue to that state's benefit.)

* Inclusion of a common benefit package which is at least equal to one of the two benefit packages (standard -- with Rx drugs and basic) included in S. 1872 and which requires the inclusion of certain preventive services. Preventive and primary care services should be emphasized.

* No alteration of Medicare benefits and mandated Medicaid services to required populations.

* Strong quality assurance provisions for both the Medicare and the Medicaid programs.

* Provider licensing, quality control/assurance procedures, and transition procedures.

* Specific recommendations as to how state will meet long-term care service needs of chronically ill citizens of all ages.

* Specific recommendations as to how state will address its medical liability issue.

* Working in conjunction with the Commission, a health care data base/infrastructure to gather data on cost, coverage, resources (i.e., availability and distribution of health care personnel and technology), health care needs, and medical outcomes.

* A list of all Federal waivers necessary to achieve access and cost containment goals identified, with rationale for needing such waivers.

4. STATE REFORM PLAN DEVELOPMENT AND APPROVAL PROCESS

Requires states developing State Care demonstration projects to do so through a State Health Care Authority, or some equivalent body, composed of representatives of affected interests, including small and large business, consumers and labor, health care providers, insurers, state legislative leadership and other organizations determined appropriate by the governor.

States that have enacted comprehensive health care laws within 12 months of enactment of this legislation are exempted from this provision.

Requires state legislative approval of its comprehensive reform plan.

5. DEVELOPMENT AND IMPLEMENTATION GRANTS

The Commission is authorized to provide up to $2 million per approved state for one or more of the following purposes:

1. Establishment of infrastructure necessary to measure and evaluate success in achieving cost containment and access goals; and/or

2. Consolidation of health care budgeting, regulating, financing, and delivery responsibilities of state.

6. APPROVAL OF DEMONSTRATION PROJECTS

The Commission will give preference to state applicants that present a wide variety of characteristics, including states:

-- from a variety of geographic areas
-- with a high percentage of the total population living in rural areas
-- with a high percentage of the total population living in urban areas
-- with large and diverse ethnic populations
-- with large and small populations of people
-- which demonstrate an especially useful or novel approach to health care financing and delivery.

The Commission will provide for timely approval of demonstration projects. Specifically, the initial review by the Commission must be completed within 40 days of the original receipt of application. At that time, the Commission will notify the state about likely final approval status of application and request any additional information necessary to improve likelihood for approval. Final decision by Commission will be made within 60 days of receipt of additional state information following initial review.

7. MEDICARE, MEDICAID and ERISA WAIVERS

For states with approved applications, the Commission has the authority to waive certain requirements and/or other provisions of Medicare, Medicaid and the Employee Retirement Income and Security Act (ERISA) for the entire period of the demonstration (five years). More specifically, with regard to this streamlined and expanded waiver process:

1. Medicare: Affirms and assures states' ability to utilize Medicare waivers to strengthen the negotiating hand of the states with its health care providers. (E.G., an all payors mechanism, similar to the Maryland model, could be used and expanded for containing provider costs). AGAIN, NO ALTERATION OF BENEFITS WOULD BE PERMITTED.

2. Medicaid: Eliminate complex applications and renewal processes within the Medicaid program for existing waivers. In addition, expand Medicaid waiver authority to allow states to implement innovative reimbursement, service delivery, cost containment, and other reforms.

3. ERISA: In order to provide necessary financing and regulatory flexibility to states committed to comprehensively addressing cost containment and access problem, a narrowly crafted ERISA waiver authority would be granted by the Commission to qualifying states. Specifically, eligible states would not have the following reform provisions of a state law preempted by current ERISA law:

   A. Financing authority used to:

      1. Collect assessments for purposes of equalizing contributions across health care plans.

      2. Provide subsidies to persons without insurance and/or who are difficult to insure.

      CURRENT LANGUAGE:

      "Section 524(b) of ERISA is amended by adding:

      "(9) Nothing in this section shall be construed to preempt state laws which cause equitable fees, taxes, charges, or other payments to be paid by employers, providers, or other entities; even though the incidence of such payments may eventually be on employee benefit plans; so long as the incidence of such payments is not solely on employee benefit plans, or solely on goods or services purchased exclusively by employee benefit plans."

B. Requirements that set forth the manner and contents that a standard benefit package is offered or provided by employers. A self-insured benefit plan (both multi-state and in-state) would be exempted from fulfilling requirement of this standard benefit if it meets a minimum per-employee dollar value standard. Specifically:

A state standard benefit package would not apply to an employee benefit plan "that is not fully insured (self-insured) and that is a plan for which state laws would otherwise be preempted under Section 514, provided that such employee benefit plan has a benefit package for which the employer's per-employee contribution is determined by the Commission to be equivalent within that state to a national average value of at least $1,250 for an individual and $2,500 for a family (indexed to the state's wage growth)."

C. The development and implementation of a common administrative procedure (i.e., uniform claims forms and billing systems), an electronic claims processing procedure, hospital and other health care provider data collection mechanism, and a utilization review, quality assurance, and medical outcomes mechanism.

D. Negotiated health care provider reimbursement rate/system.

E. **THIS WAIVER AUTHORITY COULD ONLY APPLY TO HEALTH BENEFITS AND NO OTHER ERISA PREEMPTIONS, SUCH AS PENSION AND NON-HEALTH WELFARE BENEFITS, COULD BE WAIVED.**

8. EVALUATIONS, MONITORING AND COMPLIANCE

Approved states shall submit an annual report on their progress in meeting the cost containment and access requirements detailed in their plan. For states who are not meeting plan requirements, the Commission shall develop, in conjunction with the states, a corrective action plan. For good cause, the Commission has the authority to revoke waivers and terminate demonstrations. Should the Commission choose to take this course of action, states may ask for reconsideration within 30 days of announcement of proposed termination. The Commission then has 30 days to make final decision.

9. COST

As previously mentioned, the State Care plan is subjected to strict annual Federal budget neutrality as it applies to Medicare, and Medicaid expenditures will be no more than the current projected amount over the period of demonstration. (States may use savings derived from the changes in the Medicaid program for use in expanding coverage, to the extent that the overall Medicaid expenditures for the duration of the demonstration are no greater than what they would have been without the demonstration.)

Commission is directed to make recommendations about advisability of increasing Federal financial assistance for state comprehensive health care reform initiatives, and to make recommendations with regard to the amount and source of financing.

For states who have submitted a State Care application which does not meet the Federal budget neutraliy provisions described previously, and for whom the Commission views the application as meritorious and deserving of approval, the Commission is directed to make a specific recommendation to the Congress for the appropriation of additional funds for this project. (Nothing in this section precludes a state from directly petitioning Congress for financial support for their program.)

10. OTHER RESPONSIBILITIES OF FEDERAL COMMISSION

The Commission is required to develop a model benefit package that could be used by states applying for this demonstration.

The Commission is required to develop guidelines for a health care data base/infrastructure to gather information on cost, coverage, resources (i.e., availability and distribution of health care personnel and technology), health care needs, and medical outcomes.

If, at the conclusion of the 5-year demonstration, no national, comprehensive health care system has been established, the Commission is required to make specific recommendations to the President and the Congress on establishing a national health plan, which utilizes the experiences of the state demonstrations.

Begala
cwlrtte

June 17, 1993

MEMORANDUM FOR HILLARY CLINTON

FROM: SECRETARY ROBERT REICH

SUBJECT: GRANT AWARDS FOR VERMONT'S DISLOCATED WORKERS

Within the last week the Department of Labor has received two emergency applications to assist dislocated workers in the State of Vermont. I am pleased to inform you that the Department has approved these two grants to help Vermont's dislocated workers.

* The first Title III grant authorizes $775,000 in funding for a dislocated worker project for IBM's Semiconductor Development and Manufacturing facility in Essex Junction and B.F. Goodrich's Simmonds Precision Facility in Vergennes. The project will be operated by the Vermont Department of Employment and Training and will assist 525 of the 1,026 workers who are being laid off from these two facilities.

  The State grantee was notified on May 27th of a June 30th layoff affecting 900 employees of IBM's Semiconductor Development and Manufacturing facility in Essex Junction. No Worker Adjustment and Retraining Notice (WARN) was provided for this layoff. In addition, on June 10th, Simmonds Precision, a division of B.F. Goodrich, announced that it would be releasing 126 workers from its Vergennes facility on July 2nd.

  The emergency application proposes providing basic readjustment, retraining and supportive services to 525 of the affected workers.

* The second grant authorizes $450,000 in funding for a dislocated worker project for St. Johnsbury Trucking Company Inc., to be operated by the Vermont Department of Employment and Training. The grant will assist 300 of the 500 workers who are being laid off from St. Johnsbury Inc. in Caledonia, Chittenden, Rutland and Windham Counties.

  The State grantee was notified on June 14th of an immediate layoff at St. Johnsbury Trucking, Inc., affecting 500 employees in Vermont. No WARN notice was provided for this layoff.

  The emergency application proposes providing basic readjustment, retraining and supportive services to 300 of the affected workers.

In total, the State of Vermont will receive $1,225,000 to assist its dislocated workers. The dislocated worker program is a comprehensive retraining approach to assist workers who have been, or are about to be, laid off for reasons such as technological change, foreign competition or government actions. Generally such workers are eligible if they are unlikely to return to their previous industry or occupation.

John Hart

[802] 457 3490

457-1100

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Taping with Senator Leahy at 7:00 p.m. (2 pages)	9/21/93	P5

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]