Rockefeller

MEMORANDUM

To: Hillary Rodham Clinton

From: Jay Rockefeller JDR IV

Thank you, Mrs. Clinton
Jay

Subject: Health Care Reform and National Workforce Policy

Date: March 24, 1993

I am writing to share my thoughts on what I regard as one of the essential pieces of the health reform puzzle -- a strategy for building a health care workforce in the United States that meets the needs of our citizens. Through my work on health reform, and especially as Chairman of the Senate Medicare and Long-Term Care Subcommittee, I have become increasingly convinced that health reform provides a critical opportunity to improve the supply, geographical distribution, and nature of our future health care workforce.

Therefore, I encourage the Health Care Task Force to give its serious attention to these issues, and to recognize that we also must act to ensure that a much more appropriate supply and distribution of health care providers can and must be pursued to achieve health reform's overarching goals of access and cost control.

I am enthusiastic about the progress that has been made thus far in developing a health care reform proposal. However, a new health care system that tries to move people rapidly into managed care networks could face a shortage of as many as 55,000 primary care providers by the end of the decade. We should not miss this important opportunity to address the serious issues related to our health care workforce. Comprehensive health reform won't work if this piece of the puzzle is not addressed.

This question has been of particular interest to me for quite some time. I held a hearing last year in my subcommittee and have been closely following the deliberations of the Physician Payment Review Commission (PPRC). After three years of careful study, the PPRC will release their report later this month which will include specific recommendations on health professions education. Over the next month or so, I intend to introduce legislation, with Congressman Waxman, along the lines of PPRC's recommendations.

The issue already enjoys bipartisan support. Senator Durenberger, ranking member on my Medicare and Long Term Care subcommittee, has spoken for years of the need develop a more rational health care workforce policy. I should point out that Senator Kennedy has expressed concern about providing transitional assistance to ease any potentially adverse affects on academic health centers.

It is also important to note that a broad range of key professional organizations have expressed support for addressing the issue of workforce policy, including the A.M.A., Association of American Medical Colleges, Association of Academic Health Centers, American College of Physicians, and the American Nurses Association. Traditionally, teaching hospitals and their leadership have expressed concern about their ability to function in the new system being developed.

This memo outlines a few ideas for improving our supply of primary care health professionals. But first, I would like to summarize what are some of the major challenges:

- While total numbers suggest that we are heading toward an oversupply of physicians, only 1/3rd of all physicians are now in primary care practice, and the proportion of students graduating from medical school expressing interest in primary care has been declining precipitously.

- Even if interest in primary care practice changed so that starting this year 50% of graduating medical students chose primary care, the "pipeline" of medical training is so long that we would not achieve a more desired 50:50 ratio of generalists to specialists until the year 2040.

- As you know, a chronic shortage of physicians in rural America and in inner cities persists. Primary care physician-to-population ratios in rural counties are only about 1/3rd of those in urban areas.

- Federal spending on medical education includes not only over $5.5 billion from the Medicare program, but also over $600 million from the Public Health Service and from the Departments of Veterans Affairs and Defense. In addition, the nearly $10 billion that goes to the National Institutes of Health indirectly supports much of the medical education in our Universities and teaching hospitals. Even so, we do not have a coordinated national policy that oversees this spending to make sure that it is in keeping with our current and predicted health care workforce needs.

- While medical specialists deliver a considerable amount of primary care to their patients, studies have shown that this care is substantially more costly than care provided by primary care doctors, and no better medical outcomes are derived. As we gain more experience with managed care, it has become apparent that primary care providers are the best "managers" of patient care.

- We know that nurse practitioners and physician assistants not only can provide primary care services with great skill and at cheaper costs but they have been more willing than physicians to practice in rural and inner city areas. Yet a number of restrictions, including state scope of practice acts and federal reimbursement policies, limit optimal use of these so-called mid-level practitioners.

From what we have learned so far, I strongly believe that several major initiatives to improve our supply of primary care health professionals should be included in comprehensive health care reform legislation:

1. Medicare graduate medical education payments should be used to serve our country's workforce needs. The number of medical specialty residency positions should be reduced, and the money should be re-directed from tertiary care teaching hospitals to consortia of these hospitals, medical schools, community clinics, and other ambulatory care activities to be sure that trainees have more exposure to primary care delivery sites, especially those serving the neediest communities.

2. The "culture" of academic health centers must change if students are to find the role models that will influence them toward primary care. Academic research that focuses on primary care areas is already supported by the HHS Agency for Health Care Policy and Research and, to a lesser extent, the National Institutes of Health, but this $200 million is dwarfed by the other N.I.H. research programs. Increased support will provide a more favorable academic environment for primary care. It will also yield much needed data on these topics and provide assistance with some of the important developments for health care reform such as practice guidelines.

3. Programs for the retraining of specialists as primary care providers have been discussed as one way to improve our supply of primary care providers quickly, without waiting for the long pipeline to deliver them. There has been some early experience with this, but these activities deserve support through the Public Health Services's demonstration and evaluation programs. I know that Phil Lee has expressed considerable interest in this potential solution.

4. Advanced practice nurses and physician assistants are an underused and a potentially powerful way to increase primary care services. A number of initiatives could be undertaken to increase support for their training and to remove practice barriers.

5. Efforts to enhance the ethnic and racial diversity of our health care workforce, particularly physicians, have fallen short. We can not only increase the recruitment of minority students to health careers through targeted programs, but we should also strive to recruit students from rural America as they have historically been more likely to return to rural communities to practice.

6. The National Health Service Corps was originally conceived as a means to encourage physicians and others to locate in rural and urban underserved areas. Unfortunately this program was gutted over the last twelve years by two Administrations who cared not a bit about either national service or the disadvantaged. A renewed call for national service should encourage not only the renaissance of the NHSC program but also the creation of a "National Service Program/Health" to recruit

undergraduates to serve in health care programs in needy areas, many of whom will then go on to pursue health careers in primary care.

7. The Department of Veterans Affairs provides support for a considerable proportion of medical education. Over half of the graduates of training programs in the U.S. spend part of their training in V.A. hospitals. There has already been some effort by the V.A. to move both health care and training to ambulatory settings and to provide greater emphasis for primary care. These efforts should be supported and expanded.

8. Oversight of medical training is now left to a crazy quilt of 126 medical schools, 26 medical specialty societies, and over 1000 teaching hospitals. Absent any attempt to coordinate their efforts, the natural tendency has been toward relative disorder, allowing specialty training to dominate the thinking of academic health centers. For this reason numerous groups and most recently the editor of the New England Journal of Medicine have endorsed the creation of a National Health Care Workforce Commission. This would not only oversee medical training but would also ensure adequate support for the training of other health care professionals.

9. Medicare has been the only payer to explicitly support medical education. The PPRC report contains a concept worthy of consideration, that is to develop an "all-payer" contribution to support health professions education. Its amount and use would need to be specified, but there are a lot of reasons why other payers should do what Medicare has been doing for 27 years.

10. Finally, we must keep in mind the important resource, the "social good" of our academic health centers. They are the sites of the biomedical research and education that will support our health care system in the future. As important, these are also the sites of health care not only for "cutting edge" services but also often for the inner city underserved that have been neglected by much of the private health care system. As we move toward reform these resources deserve our support.

We have an extraordinary opportunity to develop a coordinated effort to provide the nation with the health care workforce it needs. I look forward to working with you in bringing this to pass.

Senator Jay Rockefeller
VFW National Conference Dinner/Award
Washington, D.C.
March 2, 1993

Thank you, Commander Jack Carney. Larry Rivers; Chairman Montgomery and my other colleagues from Congress; West Virginia Commander Tom Caldwell and Vice-Commander Bob Kesling; and other distinguished guests, including the others here from West Virginia and my own staff: thank you from the bottom of my heart.

In my thirty years of public service, this is one of the most gratifying honors that I have ever received.

Being a Rockefeller, I am not exactly unaccustomed to calling myself privileged. But receiving this award from the Veterans of Foreign Wars brings a whole new meaning to that word. I am deeply moved by your support and your confidence.

Tonight is a chance for me to pay tribute to you, as well. I have always felt it is important to take the time to remember, and to honor, the role of veterans in our beloved nation's history. Your sense of duty, your patriotism and your bravery set an example for all Americans -- in times of war and peace, here within our borders, and on fronts all over the world, against menaces from Adolph Hitler, to Saddam Hussein, to terrorists that strike cruelly in the shadows.

I represent a state where military service is held in the highest esteem. Ever since I entered public life, to serve the people of West Virginia, that meant working very closely with -- and for -- our veterans and their families.

I have been inspired over and over again by the courage of West Virginians. I think of Woody Williams, from the town of Ona in Cabell County. A marine barely out of his teens, who forty-eight years ago, served his country by leading a charge at Iwo Jima -- in the stench and smoke of one of the bloodiest battles of World War II. I think of Stanley Bender, from Scarbro in Fayette County. Who single-handedly took out a German nest of machine guns. Both decorated and heroic men, lucky enough to make it out alive, in one piece. Able to return home and pick up the pieces. And able to turn to the VA, as they should, for care when they need it, and the repayment that we owe them for the rest of their lives.

As some of you know, when I arrived in the U.S. Senate in 1985, I immediately asked for the seat on the Senate Veterans' Affairs Committee that had been held for so long and so well by Jennings Randolph, West Virginia's Senator. That was eight years ago. Ever since, I have tried to be a dutiful, contributing member of the Committee.

During those years, I have been part of valiant fights led by both committees to stand up for veterans, working along side the VFW and other veterans organizations. We fought off efforts by two Administrations to slash veterans benefits and health care -- and we won some tough, tough battles. We waged a fight to rescue the new GI bill, veterans employment programs, and the VET Centers -- and we won. We put our foot down for veterans suffering from atomic radiation and Agent Orange -- and we won again.

And just last year, with Chairman Montgomery, I helped to lead the battle of all battles against the big drug companies, who were saddling our VA hospitals with huge price increases -- and on the last night of the 102nd Congress, I am proud to say that we won that, big.

This victory taught me an important lesson. At first, I was told this would be impossible -- that it couldn't be done. But through my years in public service, I have found something out: if your compass is pointed to what you believe is right, you can get to where you want to go. Following that compass gives you the strength to chop down the fiercest obstacles -- apathy, unfairness, greed. You can turn that compass into a magnet for bringing people together. And in the end, the reward of succeeding -- doing what's right -- is the motivation you need to go out and try to do even more.

Thoroughly satisfied with being "just" a member of the Senate Veterans' Committee, I was thrilled to have fate go to work, and give me the chance to be Chairman. I want you to know how proud I am to assume this important position -- one that's important to you and to the country. I want you to know how determined I am to be the best Chairman ever.

And to do that, I made sure to get in touch right away with the leadership of the VFW -- I have already sat down with Jack Carney and Larry Rivers here in Washington, and "my" state Commander Tom Caldwell and his fellow VFW leaders back in West Virginia, getting their sage advice and counsel.

Listening to you and the other veterans groups, I am working hard to become more knowledgeable about your concerns. I respect your fears, I share your hopes. And I always want to know what's on your mind, what you have to suggest, what priorities you want to see the Committee set.

My first official duty was to chair the nomination hearing of Jesse Brown for Secretary of Veterans Affairs. In spending time alone with him and at the hearing, it was clear to me

that Jesse is a fighter for veterans. He is a tough Marine. He was wounded in combat and left the service to become a veteran's advocate in Chicago. He has dedicated his life to serving his country and serving veterans. He knows how a veteran feels fighting for benefits that are deserved. He wants to be a strong, effective Secretary for veterans -- and we must help him be just that.

And I want the Senate Veterans Committee to do its part. We are hard at work. Our agenda is to focus on the key issues that affect the every day lives of veterans and their families -- benefits and compensation, job training, homelessness, and in this historic year, health care.

This is the year when health is America's agenda. President Clinton has followed through on his campaign promise with great courage. He has made a firm commitment to reform our country's battered health care system. He knows it will be tough -- that it means challenging the status quo and powerful interests who are quite happy about the profits they're making at our expense. But he has his compass out. President Clinton recognizes that, in order to chart a future of prosperity and security for all Americans, we simply must wage the battle for health reform. And having been in the trenches on this issue for years, I am determined to help our President win this battle hands-down.

Every American deserves affordable, accessible health care. And who deserves it more, than the men and women who fought for their country and bear the scars of battle?

As we wade into the process of health reform, we can see dangers or we can see opportunities for veterans and the veterans health system. I suggest we see the opportunities. This is our chance to make policymakers acutely aware of the many strengths of that system.

It's also our chance to air the problems that frustrate and even threaten veterans: like the lines at the outpatient clinics which are ridiculous, the paperwork and red tape which are outrageous, and the questions about quality which are alarming. We have to show the consequences of short-shrifting our VA hospitals from the funds they and you deserve.

Most of all, this is our chance to work directly with the President and Congress to chart the future of the veterans health system, so veterans will get the best care possible throughout their lives.

That is why my highest priority is to make sure veterans

get a seat at the table of health reform. In December, in my first official meeting with the President-elect, I made this very point. And Bill Clinton responded immediately and forcefully, by saying he agreed. He came through by putting Secretary Jesse Brown on the White House Task Force on Health Care.

I have met with Mrs. Clinton, who's in charge of the Task Force, and I reiterated the importance of the veterans health system -- and of involving groups like yours in making the tough decisions that await us.

Now, our job is to organize our thoughts, and to be as creative and helpful as possible to the White House, to the VA, and to Congress. You can count on the Senate Veterans' Affairs Committee to help lead the way, with our House counterpart. We will provide a forum for veterans, for experts, and for the VA to think through how we continue to meet the health care needs of veterans -- today and tomorrow.

And in this period of a budget deficit -- another fierce enemy to conquer -- it means taking a tough look at how we spend our dollars. Where there's waste, let's eliminate it. Where there's a need for reform, let's make the changes. But when there's a reason to fight for the resources and commitment to live up to the promise made to veterans, let's fight and let's win.

As its new chairman, I want the Senate Veterans' Affairs Committee to be ambitious and productive. A President was just elected in a call for change. We all have a role in making this change for the good, in writing the next great chapter of our country's history. A chapter when we must pull together, as patriots and citizens, to make our country more secure, more prosperous, and more compassionate.

As veterans, you have always made it clear that you are prepared to do your part. I pledge to you that I will do my very best to do mine.

I ask for your help, even your patience. And I thank you again for this splendid award that has made me so very proud.

Senator John D. Rockefeller IV
Bureau of Health Professions 25th Anniversary Conference
Washington, D.C.
February 26, 1993

I am very honored to be asked to join you today for the Bureau's Silver Anniversary. Just last year, my wife and I celebrated one of those -- pretty impressive, aren't we? And to be in a line-up of luminaries such as Marian Wright Edelman, C. Everett Koop and Steve Schroeder. That's <u>really</u> impressive.

In fact, we all have at least two things in common: a burning desire to see Americans get the health care they need and deserve; and a very special interest in seeing that the right mix of health care professionals are educated and prepared for the challenges of the 21st century.

Most of you have dedicated your lives to public service, striving to improve the health of your fellow citizens. Words don't exist to properly thank you for your contributions. But this is a time to ask you for even more. In order for health care reform to work in the real world, policymakers -- and I include myself -- need to draw on what you have learned, what you know, and what you recommend based on your extensive experience in that very real world.

Health care reform, at long last, appears to be close at hand. The President's economic message contained a significant, memorable call for immediate action to reform our health care system -- without which, he declared, "all of our efforts to strengthen the economy will fail."

Hillary Clinton, my heroine, is equally committed. Just as my work in West Virginia and on the Pepper Commission brought me into the health care reform movement; her experience as Arkansas' first lady have left her with a determination to fix a system that is failing so many people.

She is leading a task force that is pragmatic to its core. It is no exercise in ideology, it is a meticulous search for real-life solutions; one that is doing its very best to consider, but not be dominated by, outside opinions and the many interests with a stake in the health care system; one that is using the honest facts and measuring the real costs.

We have to act now. At 14 percent of Gross Domestic Product and climbing, the cost of health care is crushing families; dragging down small businesses at home and making American products uncompetitive abroad; and practically bankrupting governments at every level. Business executives,

union members, the self-employed, and legislators on both sides of the aisle -- all are eager, almost desperate, for change.

Real cost control measures will take immediate action -- and President Clinton has cut to the core of the problem. He has offered an overall framework for reform, combining the market-oriented idea of "managed competition" with strict budget discipline.

Managed competition is designed to reverse the current balance of power. Now, insurance companies have the luxury of picking and choosing whom they will cover, rejecting the people who need insurance most, and offering others outlandish rates and daring them to walk away. The Clinton proposal brings consumers together into vast purchasing pools, forcing insurers to compete fiercely for business or lose huge blocks of customers. Buyers, instead of sellers, will drive decisions about prices, services and quality.

An assumption common to both parts of the President's two-pronged approach, is that the medical infrastructure we need will exist to provide quality, low-cost service. And that is what I want to talk about very specifically today.

As you know, while we are heading towards an oversupply of physicians in the United States, in rural America and in our inner cities, a chronic doctor shortage exists. Primary care physician-to-population ratios in rural counties are still only about one-third those in urban areas. West Virginia is a vivid example of how people are suffering and occasionally even dying, because doctors are quite literally too few and far between.

Worse, for years we have seen primary care physicians -- GPs, internists, family physicians -- shrink as a percentage of the total number of doctors. Only one physician in three has a primary care practice -- the single most cost-effective means of delivering health care. And the proportion of students graduating from medical school expressing interest in primary care has dropped dramatically.

At the same time, it is evident that specialists are providing a lot of primary care services to their patients -- care that is substantially more costly than that given by primary care physicians, but no more effective. The HMO experience has demonstrated beyond reasonable doubt that primary care providers are the best managers of care.

In our anxiously-awaited new health care system, it seems certain that there will be an even greater demand for a well-trained primary care workforce. And therein lies the problem:

an increasing demand for primary care physicians, but with fewer students choosing this career path.

Much has been much written about the reasons for this -- probably the best has been penned by some of you: the "culture" of specialization that exists in medical education at both the undergraduate and graduate level: the emphasis on specialty care; the lack of role models among faculty; the minimal experience of students in ambulatory and other non-hospital settings.

The crushing debt that falls on young people finishing their training lures them to choose the route of the specialities. Plus, for years, our government's system of reimbursing physicians for their services has been heavily weighted toward compensation for procedural services, as opposed to cognitive services. Having led the battle to reform Medicare's payment system for physicians, I am doing my best to rework this part of the equation.

I am convinced that just as the federal government has played a part in creating the current problems, it must develop means for solving them -- to shape the health care workforce of the future to meet the needs of a more effective health care system. This must be a part of the comprehensive health reform we enact this year. Now is the time for concerted action on several fronts.

Many physician groups have worked for years to enhance the attractiveness of a career in primary care -- both in our medical schools and through our nation's health policy. There are outstanding private groups, like Dartmouth's Koop Institute on whose Board I serve; and the Robert Wood Johnson and Kellogg Foundations, that are doing what they can to eradicate bias against primary care. And to put in a plug for an organization that I even founded, the Alliance for Health Care Reform is hard at work on a project in this area as well.

My own interest in this issue comes straight from many years of confronting the way these trends affect West Virginians. Supporting three medical schools, even our small state doesn't have enough primary care providers where our people need them.

As the chairman of the Senate's Medicare Subcommittee, I am more determined than ever to address this problem. That means working hand in glove with the Administration to incorporate the right steps into the health reform plan they are putting together. We should use the help coming from the Physician Payment Review Commission, through the recommendations they plan to release in March.

First, that means taking a hard look at the support provided to graduate medical education from the federal government. To understand why we have problems with distribution and mix of providers, we should remember what Deep Throat told Woodward and Bernstein, "follow the money."

Medicare provides over $5.5 billion to teaching hospitals through direct support and the indirect adjustment they receive under the Prospective Payment System. Over $600 million is provided through the Department of Veterans Affairs, the Department of Defense, and the programs of the Public Health Service. And, although it is difficult to account for, at least some of the $10.5 billion budget for the N.I.H. indirectly supports medical education.

We don't want to undermine the vital and successful efforts of the biomedical research establishment. However, it would be irresponsible not to look at these sources of financing, and see whether they can be better used to answer the growing demand for primary care. If we are truly serious about increasing the number of primary care providers we have, then the federal government will have to target -- and re-target -- its resources to accomplish that goal.

I am considering several possibilities, some or all that may belong in the overall reform package that we better enact this year. These include limiting the number of residency positions supported by Medicare dollars; sending those dollars directly to the institutions that provide the training, rather than funneling every dollar through the hospitals; and increasing the support for health services research as a way to enhance primary care faculty.

We might improve the loan repayment terms for students who commit themselves to primary care training and service. And you know about the National Health Service Corps -- now only a shell of its previous and laudable self, when it deployed vitally needed doctors to underserved areas throughout the country. My guess is that the NHSC fits right into President Clinton's plans for promoting national service.

Finally, we have to make the practice of primary care more attractive. I intend to continue my fight to reverse the disparity between reimbursement for procedural and non-procedural services, and help eliminate the "hassles" and administrative costs of practice.

Ultimately, given the premium which managed competition places on cost-effective providers -- the way it will favor HMOs and efficient organizations -- the demand for primary care doctors should increase and market forces will lure more medical students into that field.

But we can't wait that long. With the time it takes to educate health professionals, combined with the disproportionate number of primary care physicians reaching retirement age, and the large pool of specialists currently in practice, avoiding a serious shortage demands action right away.

If, for example, beginning in 1993 half of all graduating medical students chose careers in primary care, it would take until the year 2040 when we would achieve what some believe to be the ideal 50:50 ratio of generalists to specialists! Some creative minds are suggesting that offering "re-training" to qualified specialists wishing to return to their primary care roots could help alleviate some of our more immediate needs by drawing on the existing pool of practitioners.

It is time to draw a new map. We have a tremendous opportunity to include the short-term and long-term changes in the plan for health reform that will restructure our workforce to meet the needs of our "new and improved" health care system.

It's a job that will require all of our collective energy and ingenuity. I am deeply committed to working with you to chart this part of the future -- because we know that it's essential to making our health care system better and more helpful to the people it is supposed to care for.

Senator John D. Rockefeller IV
National Federation of Independent Businesses
Washington, D.C.
June 28, 1993

Thank you Debbie. I feel very bipartisan just sharing this space together with you and John. Actually, John and I are getting to be almost a routine. I keep expecting CNN or PBS to call and offer a show just for us. Forget Shields and Gergen. Chafee and Rockefeller has a nice ring to it, doesn't it?

I say that, of course, because the issue that we are here to talk about -- health care reform -- is where the action at least should be.

Like the rest of America, you have watched the health care issue move to the top of the agenda. From a time not that long ago when it was someone else's problem -- to the situation today, when the vast majority of Americans -- <u>especially</u> small business owners -- say it is <u>the</u> problem that worries them emotionally, burdens them financially, and scares them from head to toe. In chairing the Pepper Commission, and in my travels through my state, that is what small businesspeople have told me over and over again.

Let me describe something really terrifying. Let me describe for you the health care system that is the likeliest <u>alternative</u> to the President's proposal -- the status quo. Bear with me, because it is a lot more complicated to explain than "competition within a budget."

What benefits will be covered? For most people with coverage now, a little bit less than last year. Stiff co-payments and deductibles. Less of everything at much higher premiums.

Insurers will continue to charge you whatever they want -- based on health status, where you live, where you work, or whatever.

Cost controls? It will be every-man-for-himself. <u>Big</u> employers and the government will have the clout that comes with size, to force price controls on health care providers. But those providers will just turn around and jack up rates on everyone else to compensate.

Insurers also will pressure doctors and hospitals by micro-managing and second-guessing every decision, and by making them jump through complicated administrative hoops -- sort of rationing by red tape -- with every insurer designing its own forms and claims procedures, thousands in all.

Small business will continue to pay up to 40 percent more than big businesses just to cover the administrative overhead and the cost-shifting.

Policing the system against incompetence will be left to a medical malpractice system that rewards many frivolous claims and ignores thousands of legitimate ones.

The status quo plan is employer-based, so most people will continue to get covered through where they work. It goes without saying that there is no universal coverage under the status quo plan. Businesses that do offer coverage -- which is the vast majority -- will continue to give those who don't, a free ride.

Up to a quarter of those on welfare will remain stuck there solely to keep Medicaid benefits.

What will this all cost? An extra $100 billion in the first year, even more in the future. It doesn't call for new taxes at the moment -- it just adds to deficits. In fact, government's share of this system's cost will eat up more than 60 cents of every new dollar of federal revenue over the next five years. But the bulk of these new costs will fall squarely on business. The biggest can expect their costs to go up 12 percent to 15 percent a year; smaller businesses, more like 20 percent to 30 percent -- if they're lucky.

Some plan, right? Well, I promise you, that is what we'll get if the President's plan fails. If anyone with any clout insists on changing the status quo only in ways that protect their sole interests, that is the alternative that will win in the end.

I think that when the President's plan is introduced, there will be a huge national sigh of relief. As we all begin to explore it and analyze it in terms of what it will personally mean to us, I think we will be able to put the costs and the sacrifices in perspective with what we stand to gain. I'm convinced most Americans will conclude that it's a pretty good deal for them personally and a great deal for our nation as a whole. Most of all, I hope that small business leaders and owners like you will judge the plan in terms of alternatives like the status quo, or nibbling at the edges.

Yes, it will be complicated and tough to grasp at first. Simple solutions to complicated problems are rarely fair, and what's fair is rarely simple. The President's plan will be fair. It will be inelegant and complex because it is rooted in an idea that is itself a grand compromise, what the President has called "competition under a budget." It proposes a marriage of free-market dynamics and regulatory discipline that gives total reign to neither, but rather seeks to balance each with the other -- a very American approach,

given that Americans, in poll after poll, say they trust neither government nor private enterprise enough to hand health care completely over to either one.

It should be clear when the President's plan is put forward that he has rejected the idea of socialized medicine, of government assigning you to a doctor, of long waiting lines. The health care system will remain privately run and largely privately financed. Incentives will be changed around to get the private health care system to work more effectively and efficiently -- and to respond to demands of newly empowered consumers that quality and satisfaction go up and costs stay down.

These are the same demands consumers make of every other industry. As every other industry knows: run up prices too much and you price yourself out of customer's reach; cut quality in the name of cost and you lose customers that way, too. Health care providers will prosper only by performing that same balancing act. The regulators' job will be to see to it they cannot compete in other, more destructive ways.

Will there be new costs? Of course. This new system is designed to squeeze out waste and abuse, but that takes time. For one thing, most of those "wasted" dollars go into somebody's paycheck somewhere in the health care system. Changing to a new system will mean shifting many health care jobs around -- fewer paper pushers and more health educators, for example. That will take years. But bringing all Americans into the system is something that cannot wait that long, for compelling moral reasons, let alone political ones.

This plan will not be perfect. But that's an unreasonable test. We should concentrate on expecting a basic framework, direction and principles that will produce sound results. We must not let fear of the unknown -- or bickering over ideology -- paralyze us again.

This country can produce a better health care system. We can make choices about our future, and decide to reject the consequences of allowing the status quo to run the show. But it will take honesty about the work involved. If it's only someone else's job to shoulder the responsibility, then we won't succeed.

Many people tend to think of business as guardians of the status quo. But we know that there are few walks of life where change is so constant a presence. The skillful management of change is the very essence of business success.

You know what is at stake if we fail to begin building a health care system that works better for everyone while curbing its appetite for money -- a ball-and-chain on your competitiveness, an unproductive and unhappy work force, a drain on your earnings and investments.

Study the President's plan -- and the others that will be offered. Voice your legitimate concerns about their weaknesses. But don't let the advocates for the status quo take over. You can overcome them better than any of us on this panel.

I know, I recognize, I respect the dilemma you face as individual businesspeople and as an organization in considering your role in the battle for health reform. Just in running your enterprises, you have enough responsibilities and hassles. But I ask you to also recognize and respect the sense of responsibility that I, as an elected official, feel when faced with a health care system in crisis.

The best way for both of us -- small businesspeople and politicians -- to do our job would be to do it together. To agree on the goals of controlling costs and expanding coverage, and the principles of shared responsibility and collective gains. And together, to join forces for a health care system that works for business, for families, and for America's future.

Thank you.

Democratic Caucus Notes
6:00 p.m.
JDR 6/16/93

I am now prepared to defend, work for, and fight to pass this package -- with the additional $19 billion in Medicare cuts. And I urge every single one of you to look at this package in its entirety.

Think about its goal -- over $500 billion in deficit reduction and getting the country moving again. Think about what it could have been -- let's face it, many of you think Medicare and Medicaid should have taken a far bigger hit. Focus on the ways that we are going to propose to come up with the total $67 billion in Medicare cuts over five years -- at the Chairman's insistence, we have spread the burden fairly so no one takes it on the chin, so Medicaid is shielded from any extra cuts, and so seniors aren't hit with any extra out-of-pocket costs.

It is time to come to closure. We know there are no good choices. But through all the battling and negotiating that have taken place over the past weeks, it's clear the only way we can pass a deficit reduction plan is for us to accomodate one another -- make the compromises, the concessions that will add up to the right number, and again, that's a historic $500 billion in deficit reduction.

For those of you who care most about the health care cuts, first the facts:

If this package holds together, it will consist of the $56 billion in Medicare and Medicaid cuts that the President proposed -- and we, in essence, blessed that number when we passed the budget resolution -- and another $19 billion in additional Medicare savings.

It wasn not numbers alone that drove our decisions in coming up with the additional $19 billion. We stuck to the principle of shared responsibility and sacrifice -- among all providers, hospitals, the different categories of doctors, clinics, you name it. The Chairman didn't even insist on special protection for his teaching hospitals in New York. The burden is spread, and it's spread fairly.

The elderly -- and the AARP knows this -- are not getting hit directly. The only piece of this package even dealing with premiums is to extend the law saying they'll continue to pay one-fourth of the costs of Medicare's Part B program, the program that pays for doctors services.

We kept as much special emphasis and help as possible -- through better payments -- for primary care and for rural

hospitals.

And then, let's look at what we rejected:

We rejected Boren's proposal for an entitlement cap to the tune of $114 billion.

We rejected Breaux's proposal for an extra $31 billion in Medicare cuts.

We rejected the idea of means-testing Medicare premiums, or any other extra hits on seniors.

We rejected the idea of an extra $35 billion that was the starting point in this process, and the result of a very successful campaign against the BTU tax.

And we rejected anything that would do the cutting on automatic pilot -- like simply freezing payments or capping entitlements. We were elected to make choices, and set priorities, and that's how we settled on the extra $19 billion. We stitched together the savings that make the most sense and are the most fair.

In the end, when I had to decide whether to accept the extra $19 billion, I had to once again consider what the whole point of this is.

We don't like it, but we have to reduce the deficit, big-time. And we have to recognize that Medicare and Medicaid costs are exploding, and we have no choice but to get those costs under control. That's why more and more of you are interested in entitlement caps and ideas that would force even bigger cuts.

And I might add, it is why a bunch of you have voted at least once for a balanced budget amendment. If you are for that idea, then you are for whopping cuts in entitlements. There's just no way to get the deficit way down without including Medicare in any serious, effective effort.

We can only settle on a deficit reduction package if we come together, and find the middle ground.

Personally, I think the time and the place for controlling the health care entitlements is through comprehensive health reform. You know President Clinton feels the same way, and it is one of driving forces in the First Lady's superb work in crafting together a plan of action.

But we won't have a prayer of ever getting to that part of our agenda unless and until we pass a serious deficit reduction package -- and I argue to you, it's this deficit reduction package. If we throw this chance away, or refuse to accept that we have to come to closure, we will never get on to health reform.

Each of us are only one of 56, and we represent very different points of view, about taxes, about these health programs, about defense, farm subsidies, you name it. We can't run from this. The President gave us a budget plan that was progressive, spread the burden, and to remind everyone, included over $200 billion in spending cuts and $91 billion in entitlement cuts. A lot of people lost sight of that, and it's why we had to make so many adjustments and have suffered through so much difficult debate.

I think the health care community -- the seniors and providers -- are ready to help us pass this budget. They sure helped the House step up to the plate, and make some very tough decisions. I can look all of you in the eye, and say this is AOK and it's time to come together and get the job done.

5/10/93

To Chris J.
From: MEP

Senator Rockefeller personally invited Mrs. Clinton to participate in tomorrow's state-wide forum on health care following his last appt. with Mrs. Clinton in her office. This is an important opportunity for WVians to provide input into the formulation of the White House's Task Force health care plan, and for Mrs. Clinton to learn (more) about health care problems unique to Appalachia and rural areas in general. The forum will be covered live by 6 tv stations. Every media market in the state will have live coverage.

Given that Senator Rockefeller intends to be heavily involved in pushing for enactment of the President's plan it it very important for his own state to feel that it played a role in its development and feel pride of authorship. Acknowledgement by the First Lady of Senator Rockefeller's leadership on health care reform would be very important for WVians to hear. When the First Lady was appointed to head up the White House Task Force, JDR got a couple of press calls from WV asking if he was angry that he wasn't asked to head up the Task Force (!) -- of course he wasn't and he was thrilled that Mrs. Clinton was named to head it up and has said so many, many times. But some WVians evidently expected him to assume some type of "designated" role in the creation of the Adminstration's health care plan. So it will be important for WVians to know that Mrs. Clinton and Senator Rockefeller are closely working together on comprehensive health care reform. Again, it will be important for Mrs. Clinton to emphasize her understanding of the special needs of rural areas and to comment, if possible, on how President Clinton's health care plan will help rural, underserved areas.

As a reminder, JDR spoke to the Business Council on Friday evening. Mrs. Clinton spoke earlier in the day. On Thursday, JDR followed IM in speaking to the Lehman Brothers, and was surprised that IM spoke only about mandatory price controls. The audience told JDR that he was the first person all day who even mentioned voluntary price controls. He felt a little off message. I have since talked with JF who didn't know of a specific change in policy or message, so I just want to relay our confusion.

As you know, we want to be compatible with the Administration, appreciate that things change daily, but JDR doesn't want to take a misstep in pressing for the President's plan or be viewed as being out of the loop. Again, I know how difficult this is, but JDR wants to be on top of everything as much as possible.

o Sally Richardson, a WVian, is a member of the White House Task Force's working group, focusing on rural health issues. Sally is a member of the WV Health Care Commission and runs the WV state employees health benefits agency (PEIA). Sally has a close relationship with JDR and worked for him on health care when he was Governor.

** **Medicaid Funding:** Funding for WV's Medicaid program has been one of the most contentious issue this year for Governor Caperton and WV legislators. Immediately after the conclusion of this year's regular legislative session, a special session was called try to to reach an agreement on Medicaid funding. The special session ended 2 weeks ago without any agreement on Medicaid. The Governor will be calling another special session sometime later this month to try to deal once again with finding additional funds for the Medicaid program.

West Virginia must significantly alter its current Medicaid provider tax program to comply with Federal legislation enacted in 1991 that requires, among other things, that all Medicaid taxes be broad-based. West Virginia hospitals and doctors are currently resistant to most of the proposed versions of a new provider tax, and there is a reluctance on the part of legislators to raise other taxes to replace the current provider tax. In addition to needing to find an additional source of financing, Medicaid reimbursement rates were cut by 30% to save $400 million and some benefits, including adult dental and vision care, were scaled back.

Negotiations are currently ongoing between HCFA and NGA on Bush regulations that were published late last year implementing the Medicaid provider tax legislation. During the bill's enactment in 1991, Senator Rockefeller was able to get an extention of West Virginia's current program to July 1, 1993.

** **Health Care Reform Efforts:** Following up on the recommendations of the WV Health Care Commission (almost a 2-year effort), Governor Caperton introduced legislation this past session to establish a new "Health Care Authority" to set health care policy, coordinate existing state health agencies, and develop all-payer reimbursement rates beginning Sept. 1994 for hospitals, and for doctors a year later. A global budget would be set for all providers by 1996. A $4 million expansion of Medicaid was included to provide Medicaid coverage for pregnant women and children up to 6 with incomes up to 200% of poverty. Both chambers passed a version of the Caperton health care plan, but the bill died in conference. Unlikely to see further action this year.

Recent WV health initiatives:

o **Primary and Rural Health Care:** $6 million Kellogg Foundation grant to establish rural academic health centers; $6 million matching Rural Health Initiative grant (called the "Caperton" plan) to compliment the Kellogg grant. Involves all 3 medical schools in the state, and includes nursing, dental, pharmacy and physical therapy programs.

* the goal of these programs is to place medical, nursing and other health profession students in rural, underserved areas during a portion of their training. Transforms primary care centers to "academic training centers" and emphasizes multidisciplinary teamwork. A training site, located at Cabin Creek, WV, will be highlighted during the video presentation.

o **WV Health Care Planning Commission**

After 2 years of intense work including a series of public hearings, the WV Health Care Planning Commission issued a report last November. In their report, the Commission noted that their plan is flexible enough to fit with whatever federal plan is eventually enacted. It has been criticized because it did not specifically recommend a financing strategy. And, since the recommendations head in the direction of a job-based system the single payer crowd have been critical of the recommendations. Briefly, they recommended the following:

1.) **State purchasing pool:** All state-financed health care would be pooled together. This will include state workers (PEIA), workers compensation beneficiaries, and Medicaid patients. This will give the state new bargaining power. Consolidation of these programs will cut down on paperwork and administrative costs. A HIPC-like (health insurance purchasing cooperative) entity.

2.) **Community Rating:** Gradually phase in a community rate requirement for all insurance companies doing business in West Virginia.

3.) **Benefit and Administrative Reforms:** Forms would be standardized and other measures would be taken to eliminate paperwork and streamline bureaucracy.

4.) **Global Budgeting and Rate-Setting:** A new Commission would set a global budget for West Virginia and determine rates to meet that budget.

5.) **Provide coverage for pregnant women and children.** Medicaid expansions.

6.) **Establish Community Care Networks** with a heavy emphasis on managed care. The goal is to have a managed care option in every community. Health care leaders and other leaders in the community would sit down to figure out how to integrate and coordinate health services. Eliminating duplication and encouraging coordination.

Federal Health Initiatives in West Virginia:

o Medicare Alzheimer's Disease Demonstration Project: West Virginia is operating 1 of 7 demonstration sites across the country and is the only rural site. Currently in its 4th year of providing services to Alzheimer's disease patients and their families. The demonstration sites were scheduled to shut down on May 14, 1993 but HCFA just announced an extension until the end of November. Extension will improve the ability of the sites to evaluate those types of services which are most beneficial to helping patients stay at home rather then being forced to enter a nursing home.

o Essential Access Community Hospitals(EACH)/Rural Primary Care Hospitals Grant Program (RPCH): WV was 1 of 7 states that was awarded funding ($1.4 million) to develop rural provider networks through the EACH/RPCH program. Created new category of "limited service" hospital (RPCH) which must establish a network relationship with a larger, supporting EACH hospital. RPCHs will be linked up by referral agreements, communication systems, and emergency transportation to larger EACH hospitals. A RPCH must limit its scope of inpatient services in exchange for less restrictive licensure requirements and more generous reimbursement (cost-based) from Medicare.

Rockefeller

MEMORANDUM

TO: Ira M. Magaziner

FROM: Jay Rockefeller and Henry Waxman

SUBJECT: **Recommended Strengthening Amendments to the Legislative Language on Workforce Policy Priorities**

DATE: November 4, 1993

As promised, we are giving you this memo discussing and laying out our recommendations for achieving the health care workforce that will be needed in a reformed system. We believe the President's bill, as unveiled on October 27, lacks the commitment to achieve the needed workforce. We present these thoughts and ideas with the hope that they will be taken very seriously, and that you will keep in mind our level of interest in this aspect of health reform. We should note that we intend to pursue these objectives throughout the process of health reform, and will do everything possible to build public awareness and support for these changes.

We both strongly believe that health care workforce reform which emphasizes the critical importance of primary care providers is essential to the success of our ultimate reform goals. It is the sole issue this year where we, as subcommittee chairs with jurisdiction over these matters, made a decision to produce comprehensive legislation of our own. We put forth our bill with the explicit purpose of giving clear direction on how we believe the federal government should handle these important issues.

Throughout the Task Force process, we thought that our views and policy concerns were being considered and taken into account. Every public and private indication, from the First Lady, to the members of the Task Force and officials in the Department of Health and Human Services, including our personal conversations, led us to believe that we were very much on parallel tracks in our thinking. The leaked September 7, 1993 draft confirmed that we were in agreement on the fundamentals of the workforce provisions. So, we were especially disappointed that the President's legislative language omits some basic provisions and, therefore, in our view, does not adequately reflect some of most important considerations that our legislation addresses.

We ask that you consider addressing some of these deficiencies as you make final revisions to the President's legislative proposal.

Unless we change the incentives in our current system and set up a process that makes sure the federal government will

only pay the training costs for the kinds of providers that we need, and takes the right steps to make sure that primary care providers are available in underserved areas, all our other efforts in reform will impede our ability to assure that health care services are truly accessible to all.

Here, we underscore the point that underserved areas are urban areas and rural areas. They can be found all over this country. Every member of the committees of jurisdiction, and the Congress, for that matter, should care deeply about whether their constituents have access to primary care providers. Without more primary care providers, we will not be able to provide real access to care once universal coverage is in place, nor will we be able meet our cost containment goals. Timely and substantive workforce reform is vital if the rest of reform is to succeed.

The following is a list of suggestions that would significantly strengthen the workforce title in the President's bill. We stand ready to assist you in any way possible and we very much hope you will use us as a resource. Our staffs are available to work with you on these issues so that we can significantly improve this aspect of the bill.

A Few Major Recommendations:

1. A cap should be placed on the total number of residencies that is equal to the total number of U.S. medical graduates plus 10%.

As endorsed by PPRC, COGME, ACP, ASIM, AAFP, and the Association of Professors of Medicine.

An overall cap is critical because the aggregate supply of physicians and their specialty distribution have very important consequences for health expenditures and the delivery of appropriate care. Only addressing the specialty mix ignores the impact that each additional physician will have on the nation's total health bill.

While data indicate that we are heading toward an oversupply of physicians in the United States, a new health care system that rapidly moves people into managed care would face a shortage of as many as 40,000 primary care providers. Only one-third of all physicians are now in primary care practice, and the proportion of students graduating from medical school expressing interest in primary care has been declining precipitously. In addition, it has been estimated that specialists will be in oversupply to the tune of 80,000 to 100,000 by the year 2000. The incentives in the current system serve to

encourage the continued mass production of specialists in our major teaching hospitals -- it's too lucrative to train specialists at the expense of primary care.

Alternative Option:

1. a. Cap the total number of specialists trained at 45% (under your formula) of all U.S. medical graduates.

Capping the number of specialists will not control the volume of services as effectively as an overall cap, but it will at least insure that if we continue to produce physicians in oversupply, at least we will be producing more of the kinds of physicians we need most -- primary care practitioners.

2. Require that the number of entry positions in all approved medical residency programs for residents who begin their initial residency period on or after June 1, 1998, who are not primary care residents, may not exceed 50% of the total number of entry positions in all such programs for all residents who are United States medical graduates.

The timeline in your legislation will not begin to show an improved production of primary care physicians until at the earliest 2006, and more likely, 2010 -- that is too long to wait. Considering that you envision the National Council convening in 1994, their recommendations about allocations of residency slots should be available in late 1994, or 1995 at the latest. This proposed revision would give residency programs time to adjust their programs and comfortably meet the new requirements.

Making this timeline more responsive to our primary care needs is critical. We should take steps in the next few years that make change inevitable. Postponing the guts of this process until years hence means we could face repeal efforts before we see real change. You know that even if interest in primary care practice changed so that starting <u>this year</u> fifty percent of graduating medical students chose this path, the "pipeline" of medical training is so long that we would not achieve the more desired 50:50 ratio of generalists to specialists until the year 2040, as Dr. Koop has repeatedly pointed out.

3. **Fully fund the scholarship and loan repayment programs of the National Health Service Corps by the year 2000 and pay for with the new 1.5% surcharge on premiums that is allotted to graduate medical education.**

Our legislation establishes a regular schedule that will increase funding for the National Health Service Corps that insures that there will be providers in all the health professional shortage areas by the year 2000. Payments are increased $226 million in FY94, $294 million in FY95, $381 million in FY96, $496 million in FY97, $644 million in FY98, $837 million in FY99, and 1,089 million by the year 2000.

A chronic shortage of physicians persists in both rural America and in our inner cities. Despite the hope that the training of more doctors would solve the problem of geographic maldistribution of physician services, primary care physician-to-population ratios in rural counties are still only about one-third those in urban areas. These areas are underserved because of they are geographically undesirable. There is no evidence that we will be able to attract sufficient numbers of providers to these areas even with the other payment and practice reforms that accompany national reform. This should be one of our priority areas.

4. **Establish criteria that the National Council on Graduate Medical Education will use to allocate residencies that will include:**

a) the need to assure that the distribution of positions in approved programs is not inequitable in relation to geographic distribution and that training institutions are qualified to offer such programs;

b) the need to assure the provision of primary care and other health care services to medically underserved communities; and

c) the retention rate of residents who train in an area which is generally underserved.

The lack of criteria which the National Council must consider is a serious deficiency in the President's proposal -- it is an invitation to maintain the status quo. Without these considerations, there are no assurances to either programs or Congress that the allocation process will be conducted fairly, and in a manner that is sensitive to the geographic differences. For example, without special criteria small, quality

programs could be at risk of losing out in the allocation process to the larger training centers. We do not want to create regional training centers that will further frustrate our ability to provide quality, trained residents in specialties and primary care alike, in every state of the union. For example, West Virginia has an excellent retention rate for the specialists that it trains. If it were to lose its ability to operate small, quality programs its access problems would be exacerbated.

We are equally concerned that allocations not reduce access to comprehensive services to underserved communities in general.

5. Establish a more equitable formula for your transition payments to programs in compliance which will lose residents available to provide care when their IME adjustments are revised as a reduction is allowable residency slots.

We suggest you seriously consider our transition mechanism which provides that during the transition period, a hospital's IME payment will be reduced to no less than 90% of the prior year's fiscal amount; for disproportionate share hospitals the payment should be reduced to no less than 95% of the prior year's amount.

Your transition payment may not adequately buffer the losses of services provided by residents today.

6. Insure that approved, non-hospital training sites will be directly reimbursed for the training that they provide.

The shift of health delivery to settings outside the hospital has created the need for ambulatory training to be an integral part of graduate medical education training. As more services are provided on an ambulatory basis, hospital stays shorten and only the most acutely ill patients are admitted in the inpatient environment offering an increasingly restricted range of educational experiences. Training in nonhospital settings gives residents the chance to acquire skills that span the continuum of care and train in the settings in which they will actually practice most. Moreover, it increases the probability that residents will select primary care as their field. Direct payment will help overcome the transitional barriers to providing training in these offsite settings, as will the transitional adjustment that we recommend. It will also encourage training of other health care professionals in more appropriate settings, such as advance practice nurses and physician assistants.

JOHN D. ROCKEFELLER IV
WEST VIRGINIA

United States Senate

WASHINGTON, DC 20510

FROM THE OFFICE OF SENATOR JAY ROCKEFELLER

FAX COVER SHEET

TO: Chris Jennings

OFFICE: The White House

FROM: Tamera Stanton

DATE: November 17, 1993 [7:00pm]

 # OF PAGES (INCLUDING COVER): Three (3)

Problems with transmission call (202) 224-6472

MESSAGE:

I thought you would want to see this.

JOHN D. ROCKEFELLER IV
WEST VIRGINIA

United States Senate

WASHINGTON, DC 20510

November 17, 1993

Dear Ira,

It was very good to talk to you on Sunday evening. Thank you for all of your hard work.

The purpose of this letter is to elaborate on another issue that deserves the Administration's serious attention. As you know, a significant change in policy on independent contractor status was made from the widely-circulated September 7 draft of the health care plan that appeared in the legislative language transmitted to Congress. In the bill language delivered by the President on October 27, current law is changed to have the effect of deleting a long-standing statutory prohibition on the Internal Revenue Service preventing them from independently issuing rules on redefining, for federal employment tax purposes, whether an individual is an independent contractor or an employee of a firm.

In a conversation on a different matter today, I raised this directly with Erskine Bowles of the SBA. He confirmed his concern, and effort to work with you on this.

I am not writing to argue the merits of this specific provision. Rather, I am raising the issue because the Small Business Legislative Council -- the small business trade association that stands out in their generally positive attitude and intent towards the President's health plan -- is extremely alarmed at this rather sudden policy departure.

This is an immensely significant and controversial issue for the Council and other small business interests, and the Council was very surprised and disappointed by this change. Since the leak of the September 7 draft, they had been verbally assured*, as you know, that the President's plan would not change current policy on how the IRS classifies employees and independent contractors.

It is my understanding that this issue has not yet been satisfactorily or definitively resolved. I would like to urge quick resolution of this issue, and offer my assistance. As you know, I raise this with you in this manner because I believe a constructive resolution is in the best interests of health reform.

* by you, Ira.
(Dan)

Thank you, Ira, for your help and attention to this matter. Mary Ella Payne on my staff can be contacted at 244-6472 for further information.

Sincerely,

John D. Rockefeller IV

The Honorable Ira Magaziner
Senior Advisor to the President
for Domestic Policy
Domestic Policy Council
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Ira, I think - know - this is important politically for health care legislation.

Jay