

**POLICY OPTIONS
TO ADDRESS MEDICAL WORKFORCE ISSUES**

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EXECUTIVE SUMMARY

Objective

The purpose of this paper is to present an analysis of current problems in the composition and distribution of the U.S. medical workforce -- in particular, physicians and nurses -- that are contributing to runaway health care costs and poor access to care, and to offer policy options that the Clinton Administration can consider in formulating specific plans to reduce health care costs and expand access to quality care for all Americans. In presenting this analysis, the authors of this paper also hope to enhance policy makers' understanding of medical workforce issues and underscore the importance of addressing these concerns as an urgent policy matter.

Situation Analysis

Unless immediate attention is paid to medical workforce issues, it will be difficult to make progress in reducing health care costs and expanding access to care. The concept of managed competition is based on an adequate supply of generalists; right now, there are not enough generalists to make the plan work fully, and there are too many specialists, which continues to drive up health care costs. Currently the United States has no national policy on the medical workforce.

In addition to access and cost goals, there is a strong desire to maintain the overall *quality* of health care in the United States -- an attribute of our health care system that has become the envy of many developed countries. Adequate attention to medical workforce issues will have a positive impact on quality in several ways. By increasing the supply of primary care physicians and non-physician providers, we can fill in access gaps and nip in the bud some of the illnesses and symptoms that currently go unattended. We can also expand access to preventive care.

In addition, there is concern that the current patient volume among specialists is falling below that needed to maintain a specialist's technical skills. Decreasing the supply of specialists would help provide a smaller circle of specialists with sufficient patient volume to keep up their skills. Despite the recent enthusiasm for market reform, there is great doubt that the market can correct the medical specialty excess in the short run.

This paper covers **eight critical issues** relating to the medical workforce:

- 1) Physician distribution according to specialty
- 2) The overall supply of physicians
- 3) The geographical distribution of physicians
- 4) Minority representation among physicians
- 5) The overall supply of nurses
- 6) The training of advanced practice nurses and physicians' assistants
- 7) The distribution of nurses by specialty
- 8) The overall lack of national data on the health professions.

It is important to emphasize the interconnectedness of these workforce issues. A rational national workforce policy must address simultaneously each of these components, and must adjust, for example, overall physician supply to reflect specialty distribution of physicians, and the availability of nurse practitioners, nurse midwives, and physicians' assistants.

This Executive Summary provides a brief description of each of the eight issues, the authors' recommendations for government action to address each issue, and the estimated cost to government to follow that particular recommendation. Background information and detailed options are presented in the body of the paper. Because of the paramount concern about the Federal budget deficit, the authors suggest that all recommendations that contain requests for new funding represent funds shifted from other existing Federal health care expenditures, especially direct Medicare payments for graduate medical education (GME), and possibly a portion of indirect GME payments, if these are continued under new health reform proposals.

Issue #1 -- Physician Distribution According to Specialty

There is a growing national recognition that medical specialty distribution is a problem. Unlike any other country, the United States has far more physician specialists (70 %) than generalists (30 %), and the trend is continuing. This imbalance has helped to drive up health care costs by encouraging a more expensive, technology-intensive style of medicine, which has resulted in unnecessary, costly diagnostic procedures and treatment, including surgeries. The present state of the health care system in this country significantly influences the behavior of the work force, including distribution by specialty and geography. For example, federal expenditures provide incentives for students to pursue specialty careers because of the impact of those expenditures on the medical education and graduate medical education environment. This influence is through the reimbursement for medical school faculty, as well as research funding for subspecialty faculty.

Policy Recommendation I: First-Line Approach

A public and private sector partnership that would stimulate the market for generalist physicians and encourage medical schools to promote more interest in becoming a generalist physician. This option includes a number of steps to improve both the practice of generalism and the production of generalists at the expense of specialists. However, we think it highly unlikely that such a strategy would work. It is a political question whether one should let the private sector attempt to do a course correction, knowing that it will fail, or move directly to Policy Option II. A more direct regulatory approach in the workforce would have a much greater chance of success, but would also stimulate a great deal of political opposition, especially from academic medicine. Many of the members of our group felt that the government should proceed directly with Policy Recommendation II, but others were concerned that there may not be sufficient political capital to proceed along this line if at the same time the campaign for fundamental health care financing reform is being waged.

Policy Recommendation II: Second-Line Approach

Additional government action. It is doubtful that there is sufficient enthusiasm in the private sector to reduce the number of specialists adequately. As a result, the first-line approach is likely to be insufficient alone to reduce the number of specialists. Supplementary government action may be needed. Government may want to set a deadline for meeting specialty distribution goals by means of the first-line approach

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(e.g., by 1997), and be prepared to implement further measures if that date is not met. For example, the government could create a national manpower authority, provide additional support for generalist residency positions, and actively decrease the supply of specialist residency positions.

Cost: This recommendation is budget-neutral in the short-term. Depending on the extent of government revenues devoted to specific measures instituted later, the plan could cost up to several hundred million dollars per year, at worst case. Longer-term savings should begin to emerge within five years both from the more cost-effective patterns of generalist care and the decreased technology costs of specialists.

Issue #2 -- Adequacy of Overall Physician Supply

In comparison with other developed countries, the overall physician supply in the United States is adequate, although there is a significant imbalance with regard to the number of specialist physicians. If the number of generalists can be increased and the number of specialists decreased adequately, then there may not be a need to adjust the overall number of physicians beyond the current level. However, projections of physician supply show that curtailing the number of residency positions is necessary to stabilize overall numbers at the current level.

Policy Recommendation

Stabilize current supply of physicians by limiting support for residency positions to 110 % of U.S. graduating medical students. Develop a financing strategy to promote the use of nurse practitioners and physicians' assistants to cover hospital work load if specialty residency slots are decreased.

No other action is called for at present. This strategy would reduce the current number of residents by about 11,000. Then, wait and see if actions taken to encourage more generalists and discourage specialists are effective. If they are, there is no need for downsizing the supply of physicians. If they fail, government may have to institute a policy that will decrease the graduating number of physicians, making up the general deficit with non-physician suppliers.

Cost: The costs of government intervention, if needed, would depend on the kinds of incentives used for downsizing beyond the limit of 110 % of graduating medical students. Savings would occur from the eliminated residency programs. However, additional costs would be required to pay for nonphysician substitutes for those missing residents. These costs would exceed the savings, and would have to come from professional practice fees or hospital revenues.

Issue #3 -- Geographic Distribution of Physicians

Despite an overall increase in the number of physicians since 1980, the number of Federally funded shortage areas -- mostly in inner cities and rural areas -- has increased at an alarming rate. In Harlem, NY, for example, there are no private pediatricians for a population of 250,000. The problem is not unique to the United States, and it is related to a host of complex social and economic factors that encourage emigration from rural areas and cause urban blight. The increased specialization of physicians also contributes to problems of geographic maldistribution. Historically, it has been family physicians, general internists, and general pediatricians who are likely to serve in rural and inner city areas, and their proportions are declining dramatically. And, although the National Health Service Corps has been highly successful in placing physicians in geographical

areas of interest through scholarships and loan forgiveness programs, many of these physicians do not stay in these areas beyond their service obligations.

Policy Recommendation

A pro-active governmental strategy. Government should adopt an active strategy to reduce geographic problems of access, which make it impossible to provide quality care for all Americans. This strategy should include physician incentives to practice in shortage areas, an effort to encourage medical schools to select and educate physicians from minority and underserved areas, and expansion of nurse practitioner, physician assistant, and nurse midwife supply.

Cost: The net cost of government actions detailed in the body of the paper (e.g., increasing loan forgiveness, expanding Title VII including AHEC, expanding the National Health Service Corps, and expanding the Community Migrant Health Centers Program) is estimated at \$250 million per year, with half going to education and half to patient care programs and loan forgiveness.

Issue #4 -- Underrepresented Minorities

Although a number of Federally funded programs to increase minority enrollment in medical schools have been implemented over the last two decades, the proportion of minority physicians (African-Americans, Native Americans and Hispanics) to population is low. Increasing the number of minority physicians has several advantages, in addition to the moral arguments. Since minority physicians tend to choose primary care specialties in greater proportion than their white counterparts, and because they tend to be more willing to locate their practices in low-income, underserved areas, increasing the number of minority physicians could have the additional benefit of boosting the supply of generalist physicians. Although some private sector organizations have efforts under way to increase minority participation in medicine, the government could help stimulate this effort.

Policy Recommendation

Government stimulation of the private sector, including expanded student financing and direct medical school support.

Cost: Costs for remedial programs and faculty development would be split between the public and private sectors. Remedial programs would cost the Federal government approximately \$1.25 million per year. Minority faculty development would cost government about \$1.5 million annually. To expand student financing would present a Federal bill of about \$135 million per year for 9,000 students, increasing to 12,000 students if the AAMC's "3,000 by 2000" campaign is successful. Total costs might be \$200 million per year.

Issue #5 -- The Overall Supply of Nurses

Nurses constitute an important, but underutilized, national resource with the potential to improve health care access, quality and cost-effectiveness. Thus, they can play a key role in facilitating the transition to managed care. The overall supply of nurses is adequate for the present and near-term. In fact, the U.S. has one of the highest nurse-to-patient ratios in the world. However, there is a shortage of advanced practice nurses with Master's degrees. This shortfall is addressed under Issue #6 -- Advanced Trained Nurses.

Policy Recommendation

Status quo with careful monitoring. The overall supply of nurses is adequate and seems to respond to market conditions, especially with respect to rising nurses salaries. We can leave overall nurse supply to the market as long as it is monitored carefully.

Cost: No cost to government.

Issue #6 -- Training of Advanced Practice Nurses

While the overall supply of nurses is adequate for the present and near-term, the mix of educational preparation is not consonant with current or future needs. The most important shortfall is at the Master's degree level. Nurse practitioners, physicians' assistants and nurse midwives have been the focus of hundreds of effectiveness studies for more than 20 years, with results indicating that these professionals can cost-effectively serve the needs of much of the ambulatory patient population. The shortage of advanced practice nurses is expected to worsen as a larger share of Americans receive health services in managed care arrangements, where advanced practice nurses have been employed in significant numbers.

Policy Recommendation

Increase Federal support of advanced practice nurse training.

Cost: Doubling the number of graduates per year would cost approximately \$70 million annually.

Issue #7 -- Distribution of Nurses By Specialty

The vast majority of the country's 2.1 million nurses are generalists who can play a key role in filling current gaps in primary care. For example, international comparisons suggest that at least 75 % of all prenatal care and delivery of babies could be safely provided by nurse midwives; yet less than 4 % of births in the United States are presently managed by nurses. Recently, the OTA concluded that significant financial, legal, and professional barriers prevent the effective utilization of the existing pool of advanced practice nurses and physicians' assistants. Some of these barriers have been imposed directly by Federal reimbursement policies, which have a far-reaching effect since other payers tend to follow the Federal lead.

Policy Recommendation

Lower barriers to advance practice nurses, physicians' assistants, and nurse midwives to encourage their practice in underserved areas and as generalists.

Cost: It is difficult to estimate the cost of this policy. To the extent that nurse specialist services substitute for physicians, there might be cost savings, especially if nurses charge lower fees and are less likely to use expensive technology. On the other hand, if, as is more probable, these services are additive in the net, then they will require additional revenues. The direction and amount of the cost will depend, to a great degree, on the type of market reform, including organization and financing, that emerges.

Issue #8 -- The Lack of National Data on the Health Professions

While the Federal government, particularly the National Center for Health Statistics, is the source for most data on health status, facilities, utilization and insurance status, it does not collect information on the health professions. Some of this information is provided by health professional associations, state licensure boards and ad hoc surveys, and the Department of Labor collects data on occupations, but data from these various sources are not provided in the detail necessary for policy analysis. To complicate things further, an historic dispute between the Federal government and the American Medical Association keeps the Federal government from collecting information on the health professions.

Policy Recommendation

A cooperative joint venture between the public and private sectors. If cooperative efforts fail to establish a quality data base, the Federal government could become more involved in requiring states, for example, to collect uniform health professions data. Quality control mechanisms, such as those for the vital statistics program, also could be put into place.

Cost: About \$7 million per year, derived from Public Health Service funds.

Policy Options to Address Medical Workforce Issues

Though the composition and distribution of the medical workforce should be the centerpiece of any nation's health policy, the United States is unique for having no such policy. Indeed, it has not even developed a national system to track the different health professions or to compare current and projected supply with estimates of need and demand.

Because of time constraints and policy urgency, this report will be limited to two health professions--medicine and nursing. Recent changes in the supply of dentists and the demand for dental services, however, suggest that this is also an area that should be monitored carefully.

PHYSICIANS

Many economists and other health policy analysts believe that physicians' decisions determine at least 75 % of health care expenditures. Accordingly, policies regarding physician supply must be a central component of any national health plan. This paper will address four aspects of physician supply: distribution according to specialty; adequacy of overall supply; geographical distribution; and minority representation.

I. Specialty Distribution

The Facts:

- Every other country in the world has at least 50 % of its physicians as generalists, many as high as 70 %.
- However, in the United States, the proportion of generalists (including family physicians, general internists, and family physicians) is only 29 %, and that number is declining.
- Even more striking are data from the last two national graduating classes of medical students (1991 and 1992), in which less than 15 % of the students said they intended to pursue generalist careers.
- Specialists practice a more expensive, technology-intensive style of medicine. It will be very difficult to bring medical costs under control until the current specialty mix is changed.
- The specialty imbalance has left many rural and inner city areas without enough primary care physicians to meet the needs of people living in these communities, forcing them -- in some cases -- to rely on hospital emergency rooms for primary care.
- A major limitation to the growth of capitated health plans, a central tenet of managed competition, is the lack of well-qualified generalist physicians, who play a critical role in managed health plans. The current projections for the growth of managed

care are incompatible with the current and projected supply of generalists, as are the plans to provide basic health care to all Americans.

- Should universal entitlement occur, increased pressures for more generalist services will be felt.
- During the past several years there has been growing national recognition that medical specialty distribution is a problem, but the issue did not emerge as a political concern until the past year when a number of groups advocated producing fewer specialists and more generalists (some of which have set a target of 50 % generalist physicians). While the following groups have advocated producing fewer specialists, no particular plan has been adopted:
 - Accreditation Committee on Graduate Medical Education
 - Alliance for Health Reform
 - American Academy of Family Physicians
 - American College of Physicians
 - American Medical Association
 - Association of Academic Health Centers
 - Association of American Medical Colleges
 - Association of Professors of Medicine
 - Council on Graduate Medical Education
 - Federal Bureau of Health Professions
 - National Council of State Legislatures
 - National Governors Association
 - Pew Health Professions Commissions
 - Robert Wood Johnson Foundation
 - The U.S. Physician Payment Review Commission

In addition, there is growing bipartisan support for changing medical specialty distribution, exemplified by the statements of Senators Rockefeller and Durenberger.

- The control of the graduate medical education, (GME) system that determines the numbers and distribution of residency positions lies entirely within a voluntary network that includes a number of agencies and committees, ultimately dominated by academic medicine. The dollars to finance that system come either directly (about \$6 billion) or indirectly from the public.
 1. National physician specialty mix is determined by decisions of individual teaching hospitals and medical schools. These institutions derive so much of their income from specialized care that specialty residents and fellows are an economical way to free up faculty to do research and private practice.
 2. The voluntary system of graduate medical education assures program quality but is proscribed from dictating numbers explicitly because of antitrust considerations.
 3. In the current environment, changing the medical specialty mix requires shrinking the number of available specialty resident and fellowship positions.

4. Fiscal incentives exert powerful influences on individual career choice decisions as well as on teaching hospitals' decisions about residency training physicians. Current fee-for-service payment levels, even after the Resource-Based Relative Value Scale (RBRVS) reforms, greatly favor the use of medical technologies, thereby creating large incentives to specialize, as well as a low-cost labor pool supporting highly profitable specialty care.
 5. Current Federal support for graduate medical education includes \$1.6 billion for direct medical education, \$3.6 billion for the indirect medical education adjustment, (which may be reduced or phased out if health care reform comes about), \$640 million for the Department of Veterans Affairs, \$280 million for the Department of Defense, and \$171 million for Title VII grants.
- Earlier Federal efforts to stimulate the production of generalist physicians did not receive the support of the academic medical establishment.
 - Although there is emerging consensus about the need to change medical specialty distribution, there is no consensus about how that change should occur. Many of the voluntary agencies favor voluntary solutions, but the success of such solutions is suspect.
 - There is a long time-lag between changes in residency output and changes in the composition of practicing physicians. For example, even if 50 % of all residents were generalists by 1995 (an unlikely occurrence), not until the year 2040 would 50 % of all physicians be generalists. Thus, strategies addressing the specialty imbalance must have both short-range and long-range components.
 - Congressional control of GME is conflicting because of committee jurisdictional boundaries. There is similar jurisdictional overlap within the executive branch.

Possible Strategic Options:

- A. The status quo. Under this option no action would be taken, although governmental commentary about the importance of voluntary action could occur.

Pro: This strategy might be favored by the more purist advocates of the market, who will claim that changing the market dynamics through increased use of organized health plans will stimulate interest in generalist careers. It would also be the choice of those who feel that government is not capable of organizing health policy efforts.

Con: The linkage between market competition and changing the mix of specialty distribution is highly theoretical and yet unproven. Even if the most optimistic projections of market competition come to pass, they will be grafted on to a vastly bloated capacity as measured by excess specialists and technologies. It will be very difficult to slow the rise in health expenditures without attention to the specialty mix.

- B. Moderate government activity: A public/private sector partnership. Under this option, few direct actions would be taken regarding physician distribution. However,

government could improve the practice of generalism as well as stimulate the production of more generalists and fewer specialist physicians.

1. Improve the practice of generalism.

- a. Readjust the Medicare RBRVS to favor generalist services and reduce incentives for technology use. For example, the portion of the medicare payments based on historical practice costs could be reformed, and the updates on new technologies could be shifted from the specialty-dominated RVS Update Committee of the AMA to a more neutral body or to HCFA itself (cost-neutral).
- b. The third-party cost-containment hassles that fall disproportionately on office-based generalists could be eased, either as a part of the new health care reform or in addition to reform measures.
- c. Use the bully pulpit to enhance the prestige of generalism as well as to encourage adoption of revised (technologically neutral) RBRVS by other payors.
- d. Provide accurate information about the enhanced opportunities for generalists under the new market conditions of managed competition.
- e. Expand National Health Service Corps opportunities and thereby create new positions for generalists and new opportunities for generalism.
- f. Develop and encourage programs to retrain specialists as generalists.

2. Stimulate production of more generalists and fewer specialists.

- a. Encourage medical specialty societies to reduce the number of specialists trained by increasing quality standards for specialty program accreditation. This would require easing the threat of antitrust action by the Federal Trade Commission.
- b. Markedly increase funding of training grants to assist medical schools to increase their emphasis on primary care education.
- c. Change Medicare funding of graduate medical education by increasing payment for training physicians in the generalist specialties as compared to specialty residencies and fellowships.
- d. Develop indirect payments through Medicare reimbursement for ambulatory sites separate from the teaching hospital to more adequately reimburse these sites for the cost of GME.
- e. Markedly expand and redesign the Area Health Education Programs (AHEC) to increase the support of medical education in primary care at the community level -- thus creating "medical schools without walls."

- f. Provide financial incentives to medical students in the form of reduced payment disparities for generalists (see 1a above) and increase debt forgiveness for those entering primary care practice.
- g. Increase funds available for generalist research (approximately \$45 million in the first year, with increases of about 10 percent annually to \$70 million a year). These funds could come from the NIH budget.

Pro: As with the previous option, this one minimizes governmental intrusion. Though it might offend market theory purists, it is unlikely that they would have strong objections. The physician payment changes might generate some immediate Medicare savings if technology use decreased as a result of payment reform.

Con: Regarding enhancing the practice environment, the physician specialty groups (surgeons, etc.) will oppose further changes in the RBRVS. On the other hand, the kind of changes in RBRVS that are politically feasible may not suffice to impact specialty choice. At the graduate medical education level, it is doubtful whether sufficient support exists within academic medicine to result in the kinds of voluntary changes needed to move to 50 % generalists. The teaching hospitals would certainly object to any attempts to use graduate medical education support funds for policy purposes.

C. A systematic governmental strategy. This option is not a direct contrast to the voluntary sector activities described in option B, but it adds specific governmental actions. The payment reforms described under Option B would occur. In addition, a national manpower authority would be created (The Council on Graduate Medical Education calls this a National Physician Workforce Commission, analogous to the Physician Payment Review and the Prospective Payment Commissions).

1. Include all options listed under B (a public/private partnership)
2. Create a national workforce authority that would:
 - a. Allocate residency funds in partnership with regional bodies, according to national and local needs, as well as mandate accountability of how GME funds are spent.
 - b. Monitor physician trends in order to adjust overall supply.
 - c. Decrease the number of specialty slots, either directly through regulation or indirectly through the payment system for residency training. Use Federal and other GME dollars to adjust specialty mix. (For example, the funding of residency positions for each institution or consortia of institutions could be limited to twice the number of primary care residents. Payments could even be revised retroactively based upon the graduate's activity in the fourth post-graduate year, thus providing an outcome approach to funding).
 - d. Sponsor programs that could retrain specialists as generalists, in order to accelerate the specialist/generalist redistribution. (This assumes increased demand for generalists' services resulting from new market forces and a

decrease in demand for specialists' services, providing an incentive for specialists to retrain). Stimulate the states to require continuing medical education, including generalist content, in licensure/relicensure.

- e. Work with the National Health Service Corps to monitor placements of generalist physicians and set the terms of loan forgiveness.
- f. Sponsor programs to expand the supply of nurse practitioners and physicians' assistants, both to help ease generalist physician shortage in the short run as well as to compensate for the decreased number of specialty residents and fellows.

3. Other governmental programs.

- a. Expand Title VII programs and support.
- b. Use the residency training positions supported by the Veterans Administration to help achieve the desired national medical specialty composition.

Pro: A comprehensive workforce strategy has the best chance of achieving the desired specialty mix. Because so many different elements would be involved, the results would not depend on a single step and the ability to fine-tune the strategy would be enhanced. Showing that the government understands the linkages between access, medical costs, and physician specialty distribution increases the chances of achieving a victory in the battle against rising medical expenditures. Furthermore, every other country in the developed world has a coherent strategy to create an appropriate physician specialty distribution.

Con: Designating a strong Federal role in physician supply is sure to activate the familiar indictments of heavy-handed government as an ineffective social instrument. In addition, lobbying by the numerous special interests, including the 24 medical specialties, the more than 60 subspecialties, and the teaching hospitals could result in legislation very different from what was intended. Finally, it is not clear whether the government, either Federal or state, can withstand special interest pressures in its oversight of the legislated programs.

Recommended Options:

The members of this work group were unanimous in recommending that, political circumstances aside, Option C: A Systematic Governmental Strategy, was by far the most effective. Some members of the working group, however, were concerned that this option would generate a tremendous amount of political opposition by very powerful interest groups, especially the teaching hospitals, one of which is located in virtually every congressional district. One attractive strategy might be to recommend Option B as a first-line strategy, linking support for the strategy with a specific time line. If the voluntary sector is not able to achieve residency redistribution by a fixed date (e.g., 1997) then the move to Option C might be more politically feasible. On the other hand, should health care

reform prove less difficult than is currently envisioned, or should the Clinton Administration wish to take on fundamental reform of specialty distribution at the outset, than it may wish to proceed directly to Option C.

The options are close to cost-neutral in the short term (This depends on how much additional revenues are devoted to Title VII, health services research, and the reimbursement of substitutes for the physician labor lost to vanished hospital residency positions.). A worst-case scenario might be several hundred million dollars per year, but it is likely that this would be substantially less. Longer-term savings flowing from less specialty care should begin to emerge within five years, and these should be easily understood by the CBO.

II. Overall Physician Supply

The Facts:

- It is extremely difficult to judge whether a nation has too many or too few physicians.
- Current physician supply is about 255 non-Federal practicing physicians per 100,000, an increase from 190 in 1980. Projected supply for year 2020 is about 290.
- Compared with the determinants of demand for physician services, it is relatively easy to calculate the determinants of physician supply. Additions to the physician pool come from the 15,500 allopathic and 1,600 osteopathic medical students who graduate each year. An additional 4,700 international medical graduates (IMGs), both U.S. and foreign, entered the country in 1991 for residency training. Subtractions include those who retire, those who enter non-clinical activities, and those who work less than full time.
- The 1980 report of the Graduate Medical Education National Advisory Committee (GMENAC) predicted that there would be a surplus of 150,000 physicians by the year 2000. More recent analyses, such as the Third Report of COGME, see no immediate surplus and recommend continuing current physician-to-population ratio. Reasons why the GMENAC report may have overstated the physician surplus include underestimating demand from new technologies, the HIV epidemic, and the aging of the population, as well as overestimating effective supply by insufficiently adjusting for the decreased work hours by younger physicians, especially women with families.
- In comparison with other developed countries, the overall physician supply in the United States is not out of line. By contrast, we have a much higher proportion of specialist physicians than other countries.
- Until about three years ago, there was concern about the declining number of applicants to medical schools. But there has been a 40 % increase in applicants to allopathic medical schools in the past four years. The number of applicants for September 1992 -- 37,410 -- was the highest since 1978.
- Since medical education is conducted under both private and state auspices, it is difficult for the Federal government to influence medical school enrollment directly, although it can have considerable indirect influence, such as when it offered financial

incentives to the schools to expand enrollment in the late 1960s and the 1970s. By changing the formulas whereby it reimburses hospitals for graduate medical education, however, the Federal government can influence the influx of international medical graduates. It can also accomplish the latter goal indirectly by limiting the number of residency positions it will pay for.

Possible Strategic Options:

- A. Stabilize current supply. Limit the funding for graduate medical education to the numbers of graduating U.S. medical students plus 10%. In addition, the authors suggest careful monitoring by an established Federal agency, such as the successor to COGME. A financing strategy needs to be developed to substitute nurse practitioners and physicians' assistants for the eliminated residency positions. When time to prune, start with IMGs. But, if not able to change physician specialty mix, then would reduce overall numbers of medical students (possibly through GME funding) and use nurse practitioners to provide diminished generalist capabilities.

Pro: This is an incremental strategy that allows for evaluation of effects of health care reform on demand for physicians' services. Its flexibility permits an integrated and dynamic work policy. The decrement in residency training positions (about 11,000 residents at any one time) should improve quality by eliminating the most marginal positions.

Con: Hospitals affected by the cutbacks -- inner-city hospitals and those in certain states (e.g., New Jersey and New York) would resist this change unless their situations were greatly improved by health care reform.

- B. Further reduction of numbers, either minor or major. Cut back on IMGs, and on U.S. medical students as a way to decrease specialists and, therefore, reduce costs. Create incentives to decrease medical student enrollment by downsizing classes at existing schools, plus closing marginal schools.

Pro: This is a reasonable strategy if no progress occurs on the specialty distribution issue. It would also help to solve the medical cost problem.

Con: This would be a politically unpopular move with academic medicine and with many politicians, whose constituents still think there are not enough doctors. In addition, this strategy is in direct conflict with general higher education policy, which leaves the choice of discipline to students in universities.

Recommended Options:

Policy options on total number of physicians are intimately linked to whether or not a change in specialty distribution can be effected. Recommend Option A. If no movement toward increasing the number of generalist physicians and decreasing the number of specialist physicians occurs, then move to Option B, a governmental policy to downsize the graduating numbers of physicians per year. Like Option C under "Specialty Distribution", this could be triggered within a finite period, such as 1997. The costs depend on the types of incentives used for the downsizing.

III. Geographic Distribution of Physicians

The Facts:

- Problems of geographic distribution of physicians in the United States persist and are increasing in both inner city and rural communities
- Rapidly increasing numbers of physicians have not solved the problem. Despite an overall increase in the physician-to-population ratio of 22% since 1980, the number of Federally funded designated shortage areas has increased to 2,189, a 14 % increase. Communities with populations under 10,000 have declining physician-to-population ratios and a five-year turnover rate of 25%. While great variations exist, the average rural community of less than 10,000 has only one half the ratio of primary physicians of major urban communities and almost no physicians in other specialties.
- Geographic distribution problems are not unique to the United States and are related to the complex social and economic forces that cause urban blight as well as emigration from rural areas.
- The increased specialization of American physicians also contributes to problems of geographic distribution. Only family physicians are distributed in rural and urban areas in appropriate proportion to the population. General internists and general pediatricians are most likely to serve in inner-city areas. But, interest in generalist careers has now dropped to approximately 15 % of medical graduates (*See earlier section on specialty distribution, beginning on page 1.*)
- Graduates of family practice residencies have been almost three times as likely as graduates in other specialties to practice in rural shortage areas.
- There are six times as many physicians per population in cities such as San Francisco and Boston as there are in rural areas such as Appalachia.
- The number of general surgeons in rural areas is declining precipitously. This loss has negative implications for availability of trauma services and for the viability of rural hospitals.
- The availability of obstetrical services has fallen dramatically in rural areas. Only 6% of obstetricians practice in rural areas, and in many states, 40 % of rural physicians have terminated obstetrical services. Most rural obstetrical services are now provided by family physicians. High malpractice premiums have been a major factor in the reduced availability of rural obstetrical services.
- Minority physicians have been twice as likely to serve in shortage areas as non-minority physicians.
- The National Health Service Corps has been highly successful in placing physicians in areas of greatest need through both scholarship and loan forgiveness programs. Unfortunately, retention of physicians beyond their service obligations at these sites

has been a problem. Physicians practicing in the private sector in comparable positions have been more likely to remain.

- Medicare payment for physicians' services, even under RBRVS, continues to be less for rural practice than for urban practice, because rural overhead costs are less.
- The Council on Graduate Medical Education recommends that a national goal should be established to eliminate all physician shortage areas and to reduce the discrepancy in rural to urban physician population ratios.

Possible Strategic Options:

- A. Status quo. Assume that the increasing physician supply, implementation of the Medicare Fee Schedule, continuation of the National Health Service Corps, and continuation of community/migrant health center programs will limit the problems stemming from geographic maldistribution. The market will then resolve remaining problems.

Pro: This plan offers minimal additional governmental intrusion and does not necessitate additional expenditures, which would increase the budget deficit.

Con: Despite tremendous increases in the number of physicians, there has been minimal diffusion of physicians to rural and urban shortage settings. Lack of a strategy to increase the number of primary physicians will exacerbate problems of access. Increasing problems of geographic access to health care contribute to rural and urban blight.

- B. Adopt an active strategy to reduce geographic problems of access through selection and education of physicians most likely to practice in underserved settings. This could be accomplished through modifications in graduate medical education to increase the proportion of primary physicians (see issue #1), and through a program to enhance the attractiveness of practicing in shortage areas for physicians, nurse practitioners, physicians' assistants, and nurse midwives (see issues #1 and #7). The following might be included:

1. Incentives to locate and remain in geographically underserved areas.

- a. Provision of *real* incentives for practice in shortage areas by increasing Medicare and Medicaid payments to 25 % above non-shortage area rates. Such payments will partially compensate for the increased amounts of unreimbursed care provided by these physicians for the medically indigent. If the non-shortage area fees to specialists are reduced proportionately, this strategy could be budget neutral.
- b. Incentives to practice in shortage areas through loan forgiveness programs. This option should be available for graduates to practice in shortage areas separate from National Health Service Corps sites.
- c. Expansion of community and migrant health center programs as future sites for placement of National Health Service Corps physicians.

2. Incentives for medical students and residents

- a. Expansion of the National Health Service Corps scholarship and loan programs to place physicians in shortage areas of greatest need.
 - b. Incentives to expand residency programs in the primary care specialties of family practice, general internal medicine, and general pediatrics. Disincentives to create residency and fellowship positions in other specialties. Emphasis must be placed upon family practice because of the unique ability of graduates of these programs to practice in underserved rural settings.
 - c. Incentives to encourage undergraduate medical education to develop programs in primary care and to develop training in community settings by developing "medical schools without walls". This could be accomplished by increasing predoctoral funding under Title VII and redirecting AHEC programs.
 - d. Incentives for medical schools to select students from minority and underserved settings.
 - e. Incentives for medical school graduates to enter a primary care specialty by providing low interest rate loans.
3. Expansion of physicians' assistants, nurse practitioners, and nurse midwife supply. (*See later section on nursing.*)

Costs: The net impact of increasing loan forgiveness, expansion of Title VII including AHEC, expansion of the National Health Services Corps, and expansion of the Community Migrant Health Centers Program might increase Federal expenditures by approximately \$250 million per year, with half going to education and half to patient care programs and loan forgiveness.

Pro: The plan takes a pro-active approach to combat problems of geographic access. It not only enhances access to care, but also contributes to the social and economic well-being of the community. Significant portions of the costs can be accomplished through expansion and redirection of Title VII training grant funds, through expansion and redirection of AHEC programs, through budget-neutral modifications in funding of GME, and through budget-neutral reallocation of Medicare physician reimbursement. Political support could come from Governors and from rural legislators.

Con: Modifications in the funding of GME would be opposed by medical schools and teaching hospitals, which utilize residents to provide subspecialty services. A budget-neutral approach to provide direct payment incentives to shortage-area physicians at the expense of other physicians would probably be opposed by physician groups.

Recommended Options:

Poor geographic distribution of physicians contributes to insufficient access to health care. Therefore, if government aims to expand access to quality care for all Americans, it is

imperative that it adopt an active strategy to alleviate geographic problems of access. Policy Option B above provides some sound suggestions for beginning that process.

IV. Underrepresented Minorities

The facts

- Since the early 70s efforts have waxed and waned to increase the proportion of minority physicians, African-Americans, Native Americans and Hispanics, to approach population parity. The Association of American Medical Colleges has again made this a priority with its 3,000 by 2000 program.
- Minority physicians tend to choose primary care specialties in greater proportion than their white counterparts. They also tend to be more willing to locate practice in low income areas with large minority populations, and to be more sensitive to the socio-cultural needs of minority populations.
- By and large minority students come from lower income households than majority students, have college debt when they enter medical school and have difficulty financing medical education.
- Until the mid 1960s, two black medical schools trained 75% of the black physicians in the United States. Today, four historically black medical schools account for about 16% of the graduates. The shift is the result of desegregation. However, only a small number of majority schools have high rates of minority enrollment (except for Asians).
- Currently, 5.5% of the graduates of medical schools are African-American and 5.5% are Hispanic (including Puerto Rico). 7.4% of the entering class is African-American and 6.2% is Hispanic. Attrition rates for both groups are higher.
- A major part of the problem, particularly for African-Americans, is the size of the applicant pool. College enrollment of African-Americans declined between 1976 and 1988. Furthermore, many minority students received elementary and secondary education in educationally disadvantaged environments.
- The four minority medical schools are in fragile financial and managerial positions. Their sources of financing are different than the majority schools. They derive much smaller proportions of their revenue from research and patient care funds and are more heavily dependent on tuition.
- Over the years, a number of small programs have been funded by the Federal government to increase minority enrollment and to assist minority medical schools and historically black colleges. These include:
 - Health Careers Opportunity Program (HCOP) (Summer and preparatory programs for minority students)
 - Research Centers in Minority Institutions (RCMI), Minority Biomedical Research Support (MBRS) and the Centers of Excellence program, including Hispanic

- Centers. These programs are designed to strengthen schools with large minority enrollments.
- Title III of the Higher Education Act for Support of Historically Black Institutions.
 - In addition, Howard receives a Federal appropriation and Meharry is receiving assistance in merging its hospital with Nashville General Hospital.

Possible Strategic Options:

- A. Status Quo. Under this option no additional action would be taken, although the government could stimulate voluntary action since the Association of American Medical Colleges (AAMC) is on record as committed to increasing minority enrollment.
- Pro:** With the expansion of the National Health Services Corps Scholarships, there is increased funding for minority students which will help with the student financing. AAMC is committed to expanding minority enrollment. A number of schools have been successful in expanding minority enrollment (University of Illinois, Wayne State, University of North Carolina, University of California, San Francisco). No new Federal funds are required.
- Con:** Very little has changed with the current programs in place. In fact, between 1990-92, African-American enrollment declined slightly. Most majority schools have not made minority enrollment a high priority and do not provide educational and social support services to these students. Active work on this issue is the morally right thing to do.
- B. Further Stimulate the Private Sector. A number of private philanthropic organizations have provided grants to increase minority participation in medicine. The Federal government could provide a small matching grant program for specific purposes, such as support for remedial programs for educationally deprived students, minority faculty development, and pipeline enhancement to encourage minority students to prepare for medical careers.
- Pro:** This would require a minimum of Federal investment and might substantially increase private sector activities.
- Con:** The option does not address student financing and the financial status of the minority schools. It would also cost as much as \$13 million per year from government funds.
- C. Expand Student Financing for Medical Education. As part of a national service program proposed by President-Elect Clinton, scholarships would be offered for service payback for all students, similar to the National Health Service Corps Scholarships.

Pro: Integrates scholarships/service for all disciplines and would substantially expand current scholarships, easing the economic barriers for minority students and easing a financial disincentive to enter primary care.

Con: Does not address the education deprivation issue, nor the status of the four minority schools. It requires substantial Federal front end financing at a time of economic recession and high deficit. \$135 million per year.

D. Increase Federal Support for Minority Schools and Schools that Accept and Graduate 10% or more African-American, Native American, and Hispanic Students. This would be a two-part program that would 1) provide a direct dollar subsidy to the four minority schools that enroll, and 2) provide a capitation payment per minority student for schools that graduate 10% of the class who are minority.

Pro: Targets a short-term effort to increase minority enrollment. Increases stability for the four minority schools. Provides funds to majority schools to provide education remediation and support services to minority students.

Con: The usual objections can be expected re: quotas and selectivity by racial/ethnic background. Does not address the student financing issue re: low-income students.

- Costs - \$9 million per year.

E. As Part of a National Education Strategy.

1. Establish after-school tutorial programs
2. Establish Magnet Health Professions preparatory schools in inner cities similar to the school operated by Drew in Los Angeles.

Pro: In the long term, unless the applicant pool is expanded, little progress will be made in increasing minority enrollment. This option addresses the generic problem of inner city educational problems. It is also consistent with education reform and public school choice priorities for the new administration.

Con: In the short term, little progress would be made. Results would not be visible for 10-15 years. This requires a very large dollar investment, possibly up to one hundred million dollars annually.

Cost: The net impact of options B, C, and D is an estimated one hundred and fifty million dollars annually. The tutorial strategy under option E would cost about \$1,000 per student, if volunteer tutors are used. Thus, at 20,000 students the minimal annually cost would be \$20 million, excluding administrative expenses. For the magnet schools, if 10 schools participated, with 1,000 students per school, we estimate about \$3,000 cost per student per year, or \$30 million.

Recommended Options:

We recommend options B, C, D, and E. If fiscal constraints limit the ability to start with this full program, we suggest an immediate start of options B, C, and D, with a phase in of option E.

NURSES

Policy options concerning physicians and nurses are intertwined and must be seen as part of a dynamic health professional workforce policy. Nurses constitute an important, but underutilized, national resource with potential to improve health care access, quality and cost effectiveness.

In looking at ways in which nurses can be more effectively integrated into the medical workforce to help achieve the goals of national health care reform - improving access to quality health care at an affordable cost - the following were considered: the overall supply of nurses, the training of advanced practice nurses and physicians' assistants, and the distribution of nurses by specialty.

V. -- The Overall Supply of Nurses

The Facts:

- The national supply of nurses is adequate at present and for the near term. There are more than 2.1 million licensed registered nurses in the United States, which has one of the highest nurse-to-population ratios in the world (one nurse for every 145 Americans). Approximately 80% of nurses are employed, and the remainder are not seeking employment.
- There are 1,484 RN programs of which 501 are baccalaureate, 838 associate degree, and 145 diploma programs.
- Total RN enrollment as of 1990 was 221,000, of which 53% were associate degree students, 33% baccalaureate students, and 14% diploma students.
- 97% of nurses are female.

Possible Strategic Options:

- A. Status quo. Since overall supply of nurses is not a problem, government does not need to take action at this time. However, nurse supply should continue to be monitored to assure an ongoing favorable nurse-to-patient ratio.

Cost: None for status quo

We recommend this option.

VI. -- The Training of Advanced Practice Nurses and Physicians' Assistants

The Facts:

- 22,000 nurses are enrolled in Master's programs, a large proportion of whom are part-time students with job.
- about 3,000 of these are in nurse practitioner programs.
- about 2,000 students are enrolled in physicians' assistants programs.
- Although the overall supply of nurses is adequate, the mix of educational preparation is not consonant with current or future needs. The most important shortfall is at the Master's degree level of preparation for advanced practice, where the demand far exceeds supply at present. A 1990 OTA report estimated the availability of four to seven jobs for every advanced practice nurse graduate.
- Nurse practitioners, physicians' assistants, and nurse midwives have been the specific focus of hundreds of effectiveness studies for more than 20 years. The Office of Technology, Assessment in 1988 conducted a comprehensive review of these studies concluding "within their areas of competence, NPs, physicians' assistants, and CNMs provide care whose quality is equivalent to that provided by physicians".
- The shortage of advanced practice nurses is expected to worsen as a larger share of Americans receive health services in managed care arrangements. The demand for clinical nurse specialists will also grow substantially if they are used to substitute for medical residents in hospitals, as discussed later in this document.
- The Federal government has been instrumental in the development of advanced practice nurses through direct student educational subsidies and grants to schools of nursing to develop strong educational programs.
- Federal investment in nurse practitioner and nurse midwifery programs has declined during the past decade, as has National Health Service Corps scholarship support for nurse practitioners and nurse midwives.
- Advanced nurse practitioner training is among the most expensive of nursing education programs because of the intensive clinical nature of the training, thus it is highly unlikely that nursing schools can expand or even maintain current programs without subsidy.
- An example of the potential of advanced practice nurses to meet national health care needs is certified registered nurse anesthetists. They currently provide 65 % of the 26 million anesthetics administered in this country and are the sole anesthesia providers in 85 % of rural areas.

Possible Strategic Options

A. Status quo - Let market forces direct Advanced Nursing supply.

Pro: Relies on market. No new funds needed.

Con: Need to increase supply to meet new access demands resulting from health reform.

B. Stimulate the field through increased Federal training support

1. Increase Federal grant support to maintain and expand strong advanced practice nurse training programs, and support the training of faculty for nurse practitioner programs.
2. Increase Federal student subsidies for nurses in certificate and graduate programs preparing nurse practitioners, nurse midwives, and physicians' assistants.

Pro:

1. Advanced practice nurses and physicians' assistants can be trained much more rapidly than primary care physicians. The family practice physician requires four years of college, four years of medical school, and a three year residency; advanced practice nurses require four years of college and one-to-two years of graduate education. Even under the most optimistic assumptions, (i.e., if medical schools immediately turned their attention to increasing the production of primary care physicians and enough prospective physicians could be recruited to primary care training programs), it would take until the year 2040 to reach a physician specialty distribution with 50 percent of physicians in primary care, because the medical education pipeline is so long. In contrast, an increase in educational capacity for advanced practice nurses and physicians' assistants would have an almost immediate effect on primary care availability.
2. Advanced practice nurses and physicians' assistants can be trained at a fraction of the cost of primary care physicians.
3. An increase in nurse practitioners, nurse midwives, and generalist physician assistants will enhance national primary care capacity.

Con:

1. Increasing Federal subsidies of nursing education without decreasing other Federal health professional education expenditures will not be budget neutral in the short term.
2. Increasing the supply of advanced practice nurses could exacerbate a national physician surplus and increase overall health expenditures, unless steps were taken simultaneously to limit physician supply, especially specialists.
3. Increasing Federal subsidies to graduate nursing education would meet with opposition from some interest groups. The AMA is opposed to the training and practice of nurse practitioners because of turf concerns. Other physician groups, however, have formally supported the concept of advanced practice nurses, including the American College of Obstetricians and Gynecologists and the American College of Physicians.

Cost: Doubling the annual number of graduates of nurse practitioner, physician assistant, nurse midwife programs would cost about \$70 million per year. As mentioned in the executive summary, we recommend that these funds come from existing Medicare graduate medical education funds.

Recommended Options:

We recommend the adoption of the Option D, but only in the context of an integrated approach to the medical work force.

VII. -- Nurse Specialty Distribution and Substitution for Medical Residents

The Facts:

- All nurses are educated as generalists in their basic educational programs; specialization takes place at the graduate level. Thus, the specialty distribution of nurses is the mirror image of that of physicians, i.e., the vast majority of the 2.1 million nurses are generalists.
- Two-thirds of nurses work in hospitals because that is where most of the nursing jobs are. Hospitals have experienced cyclical shortage of nurses since World War II; these shortages appear to be the result of fluctuations in demand for hospital services and nurses' relative wage rates rather than a nurse supply deficit.
- Advanced nurses include approximately 63,000 RN's who have received nurse practitioner training through certification or master's programs, of whom about 23,000 are in practices carrying the title nurse practitioner. In addition, there are currently about 4,500 practicing nurse midwives in the United States.
- Nurse practitioners are almost exclusively in primary care or ambulatory-based practices. Nurse-midwives are primary care providers managing 3.4% of all births in the U.S. and providing primary care and family planning services to women. A 1988 national survey of nurse practitioners found that 88% were in primary care, and that they practiced in a wide variety of settings, including health departments, hospital-based outpatient departments, community-based clinics, prepaid group practice, and schools; only 7% were self-employed. Clinical nurse specialists are more likely to be employed in specialty practices in acute, often tertiary hospitals.
- Physician assistants (PAs) -- numbering 25,000 presently -- are mid-level practitioners who work under the supervision of physicians, unlike nurses who are licensed to perform a wide variety of functions independently.
- International comparisons suggest that at least 75 percent of all prenatal care and delivery of babies could be safely provided by nurse midwives. Less than 4 percent of births in the U.S. are presently managed by nurses.
- Shortages of primary care providers will limit growth of capitated and managed care options that are central to reform of the U.S. health care system, and will impede efforts to expand access to poor inner city and rural Americans.

- The OTA concluded that significant financial, legal, and professional barriers prevent the effective utilization of the existing pool of advanced practice nurses and PAs. Some of these barriers have been directly imposed by Federal reimbursement policy which has far-reaching effects since other payers tend to follow the Federal lead.
- Nursing homes have experienced difficulty recruiting sufficient numbers of nurses; this is primarily due to poor working conditions and noncompetitive salaries rather than a lack of interest among nurses in caring for the elderly.

Possible Strategic Options:

A. Status quo

Pro: same as for Issue #6

Con: same as for Issue #6

B. Stimulate the field by removing barriers to practice

Eliminate barriers within the control of the Federal government that prevent duly licensed NPs, CNMs, and PAs from providing primary care within the scope of their legal practice as defined by the states. The following changes in Federal reimbursement policies should be considered:

1. Change present Medicare and Medicaid reimbursement policy that prohibits reimbursement to CNMs for Medicare-covered primary care services including routine gynecological care.
2. Change present Medicare and Medicaid reimbursement policy requiring on-site physician supervision of advanced practice nurses; this is a legal scope of practice issue that is more appropriately decided by states' licensing and credentialing bodies.
3. Eliminate present Medicare restriction requiring nurse practitioners who provide care to nursing home residents to be reimbursed through an employing organization.
4. Where fee-for-service arrangements exist, grant advanced practice nurses eligibility for direct reimbursement for covered services under Medicare and Medicaid.
5. Use nurse practitioners and physicians' assistants to substitute for specialty residents whose positions are eliminated under the options described in I and II.

Pro:

1. The shortage of primary care providers could be reduced by utilizing the present cadre of advanced nurse practitioners to the limits of their legal scope of practice.

2. Present restrictions on NP reimbursement, including the requirement for on-site physician supervision, adversely affect the deployment of NPs to physician shortage areas.
3. Some have argued that present restrictions on NP reimbursement increase the cost of medical care.
4. Using physician residency positions as a source of Federally subsidized low-wage medical coverage in hospitals is extremely costly since each additional physician graduate adds hundreds of thousands of dollars a year to national health expenditures. The use of fully trained advanced practice nurses and PAs, as permanent staff, to provide medical coverage would be a major cost-savings to Medicare and other payers.

Con:

1. Extending direct reimbursement to advanced practice nurses might increase overall expenditures, because nurses are inclined to provide more management and evaluation services than physicians, and would extend access to care to population subgroups currently receiving few services.
2. The replacement costs to hospitals of substituting advanced practice nurses and PAs for hospital-based residents may be higher because the salaries of permanent, fully trained nurse practitioners, physicians' assistants, and nurse midwives are higher and the work week shorter than for resident physicians, who temporarily forgo earnings and endure longer hours with the expectation of much higher earnings following completion of residency training. Hospitals will be opposed, therefore, to paying increased salaries unless third-party payment policies offset this increased cost to the hospital.
3. The AMA is likely to oppose any additional use of nonphysician providers. The AAMC, however, has testified before the PPRC in favor of using advanced practice nurses in lieu of residents to meet hospital service needs.
4. Other provider groups will be stimulated to request increased Medicare funding.

Cost: Cost estimates are so dependent on the issue of the net volume of increased services under these reforms, as well as whether services would be additive or substitutive, that we are unable to derive a figure with any confidence.

Recommended Options:

The committee is unanimous in recommending many of the strategies listed under Option B. Some division about the degree of independent practice by nurse practitioners and nurse midwives exists among the committee. (Physicians' assistants are not able to practice independently). The nursing members of the committee as well as some of their external colleagues were the strongest advocates of independent practice.

Issue #8 -- Health Professions Data

The Facts

While the Federal government, particularly the National Center for Health Statistics, is the source of most data on health status, facilities, utilization, insurance, and status, it is not the source of health professions information. These latter data are derived from health professional associations, state licensure boards and ad hoc surveys. The Department of Labor does collect data on all occupations but not in the direct detail needed for policy analysis. The reason that the Federal government does not directly collect information on health professions is due to a historic dispute between the Federal government and the AMA. Through negotiations with professional associations, the government has access to some of the data. The Federal government, from time to time, provides support to various associations for data collection and occasionally conducts special surveys. The problems with the current situation are:

- Lack of national data on physicians and nurses that include: numbers in current practice by type of practice, physician specialty certification (specialty is self declared), mobility patterns, retirement/attrition.
- The Federal government has no control over the quality and timeliness of the data collected.
- In nursing, major problems exist with duplicate counts, where nurses are licensed in more than one state, and with their actual active status.

Possible Strategic Options:

- A. The Status Quo. Continue to rely on the private sector and state licensure for the production of health professions data.

Pro: Avoids a major political battle with the professional associations which could result in a breakdown in access to data currently collected.

Con: Will continue to impede program and policy planning to address issues such as the actual provision of primary care services. Will also continue to raise issues of the quality and timeliness of information. The Federal government can't access the raw data.

- B. Enter Into a Cooperative Joint Venture Between the Public/Private Sector. Under this option the Federal government, with the private sector, would establish data elements, definitions and quality standards for uniform national collection of data on the professions. The Federal government would share in the cost of collection and would have access to the raw data.

Pro: This would avoid the political problem of the Federal government assuming full responsibility for data collection. It could improve the quality and usefulness of the data for policy analysis and program planning.

Con: The AMA in particular might object to a Federal role in defining the data to be collected. The AMA also is highly sensitive to privacy issues regarding

physicians, particularly in the areas of physician economics and practice patterns. The states might also see this as an incursion on state licensure and data collection activities.

- Costs about \$7 million per year, from Public Health Services funds.

- C. Restart Joint Federal State Cooperative Statistics Activity. In the 1970s, the Federal government (NCHS) funded the Cooperative Health Statistics System (CHSS). One of the components of this system was health manpower data. There was a minimum data set developed by the Federal government. This was a voluntary program. A number of states developed health manpower data. In 1980-81, funding for the program ended. The Federal government, as a condition of Medicaid/Block grants, could require and subsidize the states to collect uniform selected health professions data.

Pro: Would insure that the Federal government had easy access to data, collected under Federal guidelines. Quality control mechanisms would be in place similar to those for the vital statistics system. In addition, there would be ready access by the states of state and county data for program planning. The data collection could easily be a routine part of state licensure and relicensure.

Con: Political opposition could be expected from the professional associations. In addition, states have uneven capability for producing accurate and timely data except for vital statistics. Finally, the Federal government would have to develop a process to eliminate cross state duplication results from professionals licensed in more than one state.

Recommended Option:

We suggest starting with Option B and moving to Option C if cooperation with the private sector is not possible.

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January 12, 1993

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Divider Title: _____

**Health Reform Technical Work Group on
Long-Term Care**

**A Report Prepared for
the Presidential Transition Office--Health Policy Group**

January 19, 1993

LONG TERM CARE AND PERSONAL ASSISTANCE SERVICES

From Putting People First: "Expand Medicare for elderly and disabled Americans to include more long term care; place special emphasis on home- and community-based care; and make funding flexible so that those who need care can decide what serves them best."

Several million Americans with physical and mental impairments need services that go beyond our acute medical care system. These needs for long term care and personal assistance services reflect a combination of medical and supportive services to allow individuals to retain at least some independence and a higher quality of life. In some cases, services are necessary for individuals' survival.

Needs for long term care or personal assistance services run the gamut from institutional nursing home care for an extremely frail and/or cognitively or physically impaired population to mechanical aids for persons with disabilities who can then function well within the mainstream of society. The needs vary substantially and the desires of specific groups such as older Americans and younger persons with disabilities also suggest that one model may not fit all situations.

We have relied on a combination of a flawed welfare approach and the personal savings and incomes of disabled individuals and their families to finance such services. Private insurance has been slow to develop and will likely only ever cover a minority of Americans. Increasingly, Americans have signaled their desire for a more reasonable public policy to deal with these needs. But the demands on such a system will be great, potentially resulting in substantial new federal costs. Breaking up these needs into manageable pieces poses a difficult challenge.

OVERARCHING ISSUES

Three basic sets of choices set the stage for how to deal with long term care and personal assistance services: 1) will we rely mainly on the public sector or the private sector, and if we expand the public sector, what type of program will we choose, 2) what will the structure of benefits look like and 3) will we cover all persons with disabilities and if so in the same programs? These will then influence choices of specific implementation issues.

The overall approach. The most basic decision is whether to rely on a public or private program. We already pay for a considerable amount of long term care through the public sector, so the issue essentially is how far we want to go in expanding it.

Choosing a universal approach requires substantial public funds and deemphasizes the role of the private sector. This is consistent with an approach that would expand Medicare. This "entitlement" view of long term care would build on a social insurance model that establishes eligibility on the basis of an "earned right," with nearly everyone covered. A more targeted approach limits coverage to those with low incomes and assets. This would build on the Medicaid model. Benefits are consequently available to a smaller group of the disabled population--but those most in need. This approach is more compatible with

encouraging or even subsidizing a role for private insurance. A third alternative would be to rely on discretionary spending programs, such as the Social Services Block Grant, rather than an open-ended program like Medicaid or Medicare. Benefits would not have to be means-tested, but would not involve an entitlement.

A mixed strategy is also possible. For example, some benefits could be added through Medicare and others expanded under Medicaid. This is similar to the approach taken in the Congressional Leadership bill of 1992.

The type of program chosen may also strongly affect the role of the states in any long term care system. If the approach is to expand Medicare, it may be more difficult to allow states flexibility in designing programs. Since states have been very creative in this area and services often need to vary depending upon local situations, this might be less desirable. On the other hand, a strong commitment to a uniform program is a goal that many advocates of long term care have sought and moving away from Medicare as the base would be objectionable to many of them.

The structure of public benefits. Another very basic choice is whether a full range of possible benefits will be part of any expansion, or whether only some types of services will be expanded. There is strong agreement that home care should be a major part of any rebalancing of long term care benefits. While people want these home and community-based benefits, the truly catastrophic costs for families come from nursing home expenses. But even within that commitment, many variations are possible. For example, should such benefits be provided in a highly structured environment with case managers and other controls, or should they be offered with flexibility at the discretion of the recipient (e.g. implicitly cashing out the benefits for those who are able and willing to manage their own services)?

The populations covered. Persons with disabilities are actually a set of very diverse subpopulations, many with very different needs. It is not just a question of whether we will cover the elderly and nonelderly, but also whether the mentally ill and the developmentally disabled should be in the same types of programs as the wheelchair dependent, for example. If we cannot offer the full range of services needed by all groups (e.g. educational programs for the mentally retarded and developmentally disabled), do we want instead to have a series of separate programs? Do we want to cover only a few services for everyone? These are among the most difficult choices that will have to be made.

All of these broad choices will be strongly influenced by the availability of public support. If the amount of resources available are heavily constrained, limitations on who or what is covered will need to be seriously addressed. Further, this will influence the rate of the phase in of any program: should services offered or eligibility be gradually expanded? If so, how can that be accomplished in a manner agreeable to all involved.

These major choices need to be made before settling on the many critical program design issues. This memo first addresses a set of possible alternative approaches and then briefly introduces a number of the other decisions that will later need to be made.

ALTERNATIVE APPROACHES

A broad range of options could be considered, but we pose three basic directions. Within each of these three directions, a number of variations are possible, implying different levels of spending on long term care at the federal level.

The first approach would make a downpayment on long term care that would commit few public resources. This first option could either be viewed as a short run strategy to allow further time to decide whether to later follow the basic path outlined by one of the other two approaches, or it could simply be an interim strategy to delay the costs of implementing a chosen direction. Alone, it is unlikely to satisfy the many groups clamoring for expansions of long term care except in the short run.

The other two basic approaches represent the choices outlined above of moving in the direction of a universal entitlement, or of a more targeted approach combined with private insurance expansions. These two options represent a very clear choice, and each has advantages and disadvantages. If a choice of one direction or the other is made from the start, option 1 could be skipped or modified somewhat to be fully compatible with the chosen direction.

The following discussion highlights the issues and options within each of these broad strategies.

Making a Downpayment on Long Term Care

A number of important improvements can be made to the existing federal efforts on long term care and personal assistance services at little or no cost. These should be included in more expansive options as well. These changes include:

Private long term care insurance reform including minimum federal regulatory standards. Currently, private insurance has many problems including deceptive sales practices, poor basic quality of coverage, and inappropriate pricing policies that both put purchasers at risk and give many others pause in buying insurance because of the lack of standards. Reforms should include: standards for sales practices to give consumers protections such as waiting periods, requirements for standardized definitions, and limits on various bait and switch tactics. Quality of coverage requirements should be inflation protection, minimum years of coverage, nonforfeiture of benefits clauses. These would raise the costs of insurance, but assure its value to those who purchase it. Other practices should also be regulated to insure that purchasers may upgrade their policies when such improvements are offered and renewability insured. These and other recommendations are discussed further in the enclosed supplemental papers, one by Joshua Wiener and one by Stanley Wallack.

Allowing home and community based services to be a Medicaid option rather than requiring a waiver and eliminating cost-neutrality requirement. This should not be very costly because many states are unlikely to move rapidly to expand their home

care programs. This also means, however, that it would not go far in expanding home care and solving that problem. It does relieve states of the burdens of seeking waivers and demonstrating that costs can be saved.

Implementing and enforcing nursing home quality regulations (OBRA 87) that have been held up by OMB. There is strong consensus in the disability community that these regulations are useful; they simply have never been implemented.

Improving coordination of long term care, housing and related programs of the federal government to ensure that we make the most effective use of existing funds. Since control over these programs is centered in separate agencies, coordination is a problem. A task force would likely be required; the goal would be to use resources more efficiently. For example, simple modifications of subsidized housing could help substantially persons with mobility problems and ease the need for human assistance.

Educating at risk population of needs for long term care, both to encourage private insurance but also to inform people of what is not now covered. This is important whether the goal is to justify expanding public or private coverage; many elderly and disabled persons believe that Medicare will cover their long term care needs and they are disappointed to learn that it does not.

Making sure that care of a disabled relative is part of any family leave legislation.

Expanding research on crucial areas such as Alzheimers, rehabilitation, arthritis, nutrition for the elderly. Some of this involves sophisticated medical research, but equally important is practical research on prevention of falls and the importance of nutrition, for example.

Political Analysis

Advantages: These options could yield some improvements in long term care while recognizing that efforts to reform other parts of the health care system take first priority. If combined with serious promises to revisit the issue later, perhaps with a task force charged with developing a blueprint for reform, consumer interest groups such as AARP, the Alzheimers Foundation, and younger disabilities groups might be willing to wait for a year or two. These groups will need reassurance that this is not the only reform contemplated. A task force or the promise of later legislation might also be part of the package. The insurance reform, in particular, could yield important benefits for consumers. While members of Congress will publicly decry this approach, privately most will not push for substantially more.

Disadvantages: There are many who would like to see a more aggressive approach on the issue of long term care immediately. They will be skeptical of an approach that does not put

any new money into the system and will argue that this is breaking a campaign pledge. If the important interest groups representing the elderly and persons with disabilities are not satisfied, they may hold health care reform hostage. Insurance reform may come with the political cost of clarifying the tax rules, which could raise the costs of this option. These tax costs have not been given a lot of scrutiny.

Targeted Options

A targeted approach to long term care reform could include expansion of both Medicare and Medicaid. Other special needs groups might be helped with discretionary programs such as through the Social Services Block Grant. A package combining some of the following could meet the most critical needs for the disabled at a phased-in cost of about \$15 to \$20 billion annually.

Medicaid Expansions

Medicaid could be substantially improved to meet needs for long term care and personal assistance services. This approach would also maintain considerable state involvement where much of the creative work on providing long term care services has gone on. The focus would be on those most in need. Possible changes include:

Mandating coverage of home and community based care as part of regular benefits;

Increasing personal needs allowance for nursing home residents;

Making spousal protection requirements more generous, increasing them to twice the poverty level;

Easing the asset limits for eligibility for single persons, raising them from their current low levels to perhaps \$10,000;

Raising federal spending share for the program so that states are only required to maintain their current level of effort.

These benefits would largely help those with low and moderate incomes. To help ensure more protection for those with more income and assets, there could be efforts to further encourage purchase of private insurance. One approach would be to clarify the tax treatment of long term care insurance. The full costs of this tax change are unknown.

Political Analysis

Advantages: Changing Medicaid is perhaps the least costly way to seriously address the problem of long term care. It is a targeted approach and the "new" Medicaid program that emerges would be much improved over the system. One of the popular features would be an easing of the assets requirement, the most popular part of the Medicare Catastrophic Act of 1988. It retains an important role for states who have developed many creative programs. Improvements in Medicaid could also be phased in slowly, beginning with improvements in home care and some expansion of eligibility, for example. Since eligibility is restricted, its expansion can be more carefully controlled over time than social insurance options. This approach would leave an important role for private insurance for those who can afford it.

Disadvantages: Even after spending substantial sums on long term care under this option, problems will remain. Again, the specific disadvantages depend upon which general approach is chosen. There is still a welfare-based approach and no amount of tinkering will satisfy many groups who are firmly committed to social insurance. This includes all the big interest groups pressing for long term care expansion. It also is counter to the campaign pledge of expanding Medicare. Even if the name changes and all the major disadvantages of Medicaid are addressed over time, it will still be identified with a very unpopular program.

Improvements in Medicare

This general approach would not be targeted by income, but to keep such an expansion moderate in its costs, the types of benefits offered would need to be restricted. Expansion of long-term care services under Medicare can be made by changing the rules governing the existing Medicare skilled nursing facility (SNF) and home health benefits and by creating new home and community-based services under Medicare. Medicare finances only 2-3 percent of total nursing home expenditures and its home health benefit is also quite limited. Only skilled care is covered and other restrictions mean that home health care is provided for only a limited period of time. With the exception of hospice services, Medicare does not currently provide "long-term care" services such as personal care for the disabled or respite care for family or friends who provide the bulk of such services for the disabled. Modest Medicare options include:

Setting the copayment amount for Medicare SNF services at 20% of the cost of care, and extending the maximum number of days of coverage from 100 to 150 days.

Eliminating the "intermittent" rule for home care, allowing home health services to be provided consecutively as long as needed; a copayment of 20% could be instituted to help control the costs of this expansion. To keep costs low this still must be a skilled benefit.

For people who meet the skilled requirement, expanding services covered under the Medicare home health benefit to include personal care, in addition to skilled nursing or rehabilitation services.

Adding respite care to alleviate the burden of informal caregivers.

Substantially expanding hospice services.

Political Analysis

Advantages: Relying on Medicare alternatives also has a number of advantages. These changes, while limited, would constitute serious improvements. All of the benefits would likely expand substantially because current restrictions on these services have left an important gap in the care that Medicare beneficiaries need, although these are skilled benefits and not long term supportive services. Expansions of respite and hospice care do meet some of these traditional long term care needs. For example, a major reason why disabled persons originally residing in the community have to enter nursing homes is that their informal caregivers "burn out;" assistance for the caregivers of the disabled may enable them to provide care longer.

Disadvantages: Because Medicare is strongly viewed as an insurance program for medical services provided by hospitals and doctors, options to improve access to the SNF and home health benefits may not be seen as serious expansions in "long-term care." Moreover, debate over the Medicare Catastrophic Coverage Act provided a new perception that Medicare does not cover nursing home care. Finally, the political pressure to repeal the Catastrophic Coverage Act may make Congress shy about revisiting SNF and HHA provisions in that Act.

Other Changes

Additional resources could be devoted to improving the quality and availability of private insurance. In addition, limited experimentation with innovations in the long term care area could take place on a number of different fronts. Each separate piece could be limited in scope and added to some of the Medicare and Medicaid changes discussed above. Specific examples include:

Making private long term care insurance deductible, it would be subsidized and hence more affordable to those who buy the insurance.

Tax law changes to encourage development, including offering a tax-favored status to qualifying plans. Payments for such insurance could be made at least partially tax deductible.

Expanding coverage of personal assistance services to severely disabled individuals as a separate discretionary program.

Changing the Disability Insurance program to provide personal assistance and mechanical aids to persons who meet the disability criteria, but who remain in the workplace. This could help to prevent those individuals from withdrawing from work and eventually needing DI cash benefits.

Expanding Supplemental Security Income payments to help support board and care homes as part of the long term care continuum.

Compensating caregivers. This could take the form of respite care benefits offered to those who provide care or tax credits for such persons. Most such proposals anticipate relatively modest subsidies.

Political Analysis

Advantages: These options could yield some important improvements in long term care while recognizing that efforts to reform other parts of the health care system take first priority. In some ways this might satisfy the younger disability groups more since it would emphasize a number of innovative programs they favor; but these various programs would have to be substantially expanded before anyone would be very pleased.

Disadvantages: There are many who would like to see a more aggressive approach on the issue of long term care immediately. Expansions of this sort might be seen as stalling actions and not serious attempts to address the problem. Each specific group among the disabled will scrutinize such a package to make sure they receive a "fair share." And even these small efforts may be expensive. Moreover, by spending considerable sums on these nontraditional programs, advocacy groups for comprehensive home and institutional care might simply demand that as a full addition to these programs over time. Two major groups who will not be helped by expanded insurance are persons with disabilities under the age of 65 for whom insurance is not a good option and persons with moderate incomes for whom even substantial subsidies will not result in purchase of insurance. These are two extremely important groups who will be very unhappy at the prospect of devoting scarce resources to subsidies for higher income persons to purchase insurance at the expense of other expansions in the system.

Universal Coverage Option

Any option that includes universal coverage of disabled persons for all or part of needed services will, by necessity, be quite expensive. This approach would require substantial financing. The Democratic Leadership approach is a combination of social insurance and

needs-based approach. Preliminary estimates by CBO indicated a one year cost of about \$45 billion once fully phased in. Its main components include:

Universal coverage of home care

6 months up-front coverage for nursing homes for everyone

Income-related benefits thereafter, but more generous than those now offered by Medicaid. Spousal protections would be better and asset requirements would be substantially eased.

The approach floated by Congressional Leadership offers limited social insurance for home care and short nursing home stays and a floor of asset protection. Any option that provides comprehensive long term care for all ages will, by necessity, be quite expensive.

Political Analysis

Advantages: Many of the groups interested in improving long term care coverage--both in the aging and disability communities--favor this type of approach and believe that the campaign promise was for social insurance. A social insurance approach is likely to be popular with the American public as well. Further, by stressing home care, this option would lead to changes in the system that most analysts and observers of long term care feel is important. By limiting the coverage for persons in nursing homes, it also meets the objections of those who argue that full nursing home coverage merely protects the assets going to the heirs. But no one loses their life savings. Individuals who are likely to be discharged back to the community are likely to stay less than 6 months in the nursing home--and they would be fully protected by this program. At least in theory, many Americans express a willingness to pay taxes to help finance such an option.

Disadvantages: This is a very expensive option and critics fear these numbers would rapidly rise. Nonetheless, many of the advocates of social insurance will criticize it as too little since it has some income-tested aspects. They will be satisfied only with full coverage of nursing homes and home and community based care for everyone. (A full social insurance approach would cost closer to \$60 billion in 2000 when fully phased in.) On the other side will be critics of offering yet another generous benefit that helps mostly older Americans who already receive a disproportionate share of federal government spending. Members of Congress are very reluctant to support such an expensive bill, even if they publicly pay lip service to it.

OPTIONS - LONG TERM CARE REVENUE ESTIMATES

If a moderate or high cost approach is chosen, new financing would be necessary. The type of financing that makes the most sense is likely to be related to how the benefit is

structured. A social insurance approach will particularly help those with higher incomes and assets among the disabled, so progressive financing is particularly important. If benefits are more strongly targeted to those with low and moderate incomes, other less progressive types of financing are reasonable. But financing options that limit Medicare benefits or tax Social Security, for example, are most compatible with social insurance options.

	94	95	96	97
Add an income related premium to Medicare for persons with incomes over \$100,000	1.2	1.2	2.5	4.5
Tax the value of both portions of Medicare for persons above an income threshold	4.7	5.6	6.7	8.0
Increase the fraction of Social Security benefits included in Adjusted Gross Income and subjected to taxation	5.6	6.2	6.9	7.7
Eliminate \$130,000 wage cap for Medicare hospital fund payroll tax*	3	6	7	7

*This option is also put forward as part of the health care reform financing options.

Note: Revenue options that would affect only Medicare beneficiaries are most appropriate for the options that would expand Medicare and not for Medicaid or other changes.

There are strong justifications for at least partially financing long term care by reducing Social Security or Medicare benefits programs to the elderly and disabled. For example, higher premiums under Medicare, taxing the value of Medicare benefits or more of Social Security are likely ways to expand long term care coverage, while holding the line on overall benefits to the elderly and disabled. Since older Americans in particular are likely to be windfall gainers from a major expansion in long term care offerings, using some financing mechanism that taps that group explicitly is likely to be important. Lifting the earnings limit on either the Social Security or Medicare tax base is another source of financing with an obvious link to the benefits. It could be used in conjunction with taxes that require the elderly to contribute since most of the revenues from this source will come from workers under the age of 65.

	94	95	96	97
5% Value Added Tax with food, housing and medical care excluded	47	70	73	77
Borrow from Social Security trust fund	5	10	15	17

A major social insurance program would need a major funding source: a payroll tax increase, a major income tax increase or a whole new source such as a value added tax. Alternatively, it would be possible to borrow from the Social Security trust fund to pay for this option at least in the early years. The amount shown here is enough to pay for the moderate option. In no year would this lower the trust funds to a level that experts feel would put it at a financial disadvantage (i.e. below 100 percent of one year's payout).

PROGRAM DESIGN ISSUES

Once a general approach is chosen, a number of critical design issues will remain. A number of these are taken up in more detail in the appended material, but a few of them are briefly discussed below.

Coordination with other areas

Increasingly we are beginning to understand how difficult it is to separate needs for long term care services from other needs such as housing. Without good coordination, a long term care program will likely be much more expensive because it will lead to inefficient choices. For example, if homes are not adapted for use by the frail or disabled, or good lower level support services are not available, individuals will resort to more formal services at higher costs. Nursing home use and formal home care will be more often used, for example. This is also a major issue for the younger disabled who may be anxious to work or continue working, but who face barriers that lead them to the disability programs that require they be out of the labor force.

See the attached memo from Robyn Stone on housing coordination issues and the memos by Korbin Liu on acute and long term care and coordinating types of long term care services.

Cost containment

There are a number of ways to control long term care expenditures. These include, cost sharing, case management, strict eligibility requirements, requiring providers to bear the risk, rate controls, and strict limits on the frequency of home visits or length of nursing home stays. All of these have their advantages and disadvantages and there is little consensus on which approach is best. There is only agreement that we need to move aggressively in this area. States may be able to play a very important role in cost containment--indeed that is a strong rationale for keeping them involved.

See the enclosed paper by Joshua Wiener.

Flexibility of benefits

One element that may conflict somewhat with cost containment, but that is critical for many younger disability groups, is the need for program flexibility. Many persons with disabilities wish to be actively involved in managing their own care. This is particularly critical in the area of personal assistance. For example, this might mean deciding what types of services will be used and being in charge of hiring personnel. Such an approach is quite different than traditional models of strict case management, often developed for dealing with older disabled persons who are not willing or able to oversee their own care. State flexibility is also an important issue.

See the enclosed paper by Trish Reilly.

Determining eligibility

The traditional measures of ADLs and IADLs appear to remain the most promising means for establishing eligibility standards. But no strategy should rely only on one set of those measures since different groups within the disabled population have different requirements and circumstances. Persons with cognitive impairments need particular attention and perhaps further research for establishing appropriate criteria.

See the paper by Korbin Liu on eligibility.

Marilyn Moon
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202-857-8691

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Divider Title: _____

**Health Reform Technical Work Group on
Health Care Delivery**

**A Report Prepared for
the Presidential Transition Office--Health Policy Group**

January 19, 1993

January 15, 1993

To: Stuart Altman
From: Thomas Chapman and Kathryn Mershon
Re: Report of the Task Group on Health Care Delivery

Please find attached, a report of the work conducted by the Task Group on Health Care Delivery.

All members of the Task Group were pleased and honored to participate in the efforts of the Transition Team to prepare a comprehensive health care proposal.

There is a willingness among participants to continue to be of assistance to President-elect Clinton and his staff as they continue in this endeavor to bring health care reform to the citizens of United States.

Report of the Task Group on Health Care Delivery

After hearing presentations by chairs of the five policy task groups which identified issues, options and questions in the development of a comprehensive health care reform proposal, the health care delivery task group divided itself into five subgroups to discuss the information presented. Each participant brought to the discussion a unique perspective reflective of the participant's experience as a provider in the current delivery system.

While each subgroup shared its major issues with the entire group, there was no attempt to reach consensus. Unless otherwise indicated, each comment can be attributed to a subgroup of about 10 providers. To the extent possible, comments have been taken verbatim from subgroup reports. They have been reorganized by topic for clarity.

I. TIMING, PRIORITIES AND SCOPE

A. Time Constraints

Given the magnitude of any comprehensive reform proposal, the feasibility of producing a well thought out plan in the first 100 days of the new administration was questioned. It was suggested that there may be a way to create a framework for the plan, with details provided for high priority issues initially and with a time table established for the remainder. At the same time, there was general optimism and excitement that the commitment to reform will, in fact, make change in the system a reality in this administration.

B. Universal Coverage

There is a moral imperative to obtain universal coverage of all Americans as soon as possible. Even though elements of market restructuring and cost containment may require years to implement, coverage for all should not be delayed. This may require an initial increase in federal outlays for health care, but the symbolic -- and thus political -- value of bringing everyone into the insurance pool is crucial. Whenever this step is taken, there will be new costs. The opportunity of a "honeymoon" period between the new Administration and Congress is the time to absorb these costs. Moreover, there is evidence from Lewin et al. that these new costs will be less than is often assumed. It is also likely that bringing the uninsured into a rational system will lead to cost savings for the system as a whole (ending cost-shifting, encouraging appropriate sites for care, more prevention, etc.) and long-term savings to the federal budget. One member of the committee summed up the issues this way: "Efforts to contain costs will be a permanent part of health policy. Three generations hence, our grandchildren will still be designing strategies to this end. But they shouldn't still be burdened with the moral problem of millions of Americans without health care coverage."

C. Medicare

It was not clear to participants why Medicare would be excluded from the new HIPC/AHP system. It was felt that this would encourage discontinuity in physician-patient relationships, that Medicare has high cost increases in need of control, and that managed care could provide more diverse plans for the elderly.

Now is the time to act on this tremendously important part of federal health care spending. All the stakeholders -- providers, consumers, payers, etc. -- understand that sacrifices will be required if the system is to be reformed. It would be a mistake to begin the dialogue on shared sacrifice by exempting Medicare enrollees. There was some sentiment that means testing of Medicare eligibility should be instituted immediately to cut costs and to end the morally suspicious practice of providing public subsidies to the wealthy while many needy go without. An option to leave Medicare for the managed competition plan should be created at the outset. This will give AHPs an incentive to develop managed care innovations to attract the elderly. Medicare should be incorporated as quickly as politically possible to insure a system of equal coverage.

II. COVERAGE/BENEFITS/FINANCING

Participants viewed the core benefits package differently. Some saw it as "minimal" coverage and others saw it as "basic" coverage. The following comments reflect those differences in perspective.

A. Minimal Coverage

- * The National Medical Board should decide the specifics of the minimum health benefits package with states given little flexibility. If left entirely to the states, migration of sick people to states with good coverage could be problematic. The coverage should encompass only medically necessary proceeds, including a basic plan to treat tooth decay in children.

- * To meet the problem of treatment of patients who have exceeded the care provided in a minimum package, each plan should dedicate a small percent of the capitation fee to an uncompensated risk pool. The provider would continue to provide care and the cost would be absorbed by the risk fund.

B. Basic Coverage

- * The basic package of benefits provided under the new system should be comprehensive enough so that the great majority of Americans -- 80 % to 90 % -- rely on it exclusively for their health care coverage. There must be options to buy supplemental insurance outside the basic package. Americans will insist on this freedom and it creates a useful consumer check on the basic package. But purchase of extra health insurance should not have public subsidy and should be heavily taxed. Some trigger mechanism should be developed to fold new benefits into the basic package when private insurance purchases of that coverage reach a certain threshold. For example, if 40 % of the population buys insurance for bone marrow transplant, this benefit should be brought into the basic package. Most importantly, the basic package should not become a minimal package used only by the poor. If so, it will inevitably lose public support and become a welfare program. Programs for the poor become poor programs. While the very wealthy may be able to buy out of any public package, the best defense of the poor lies in linking their interests to that of the middle class who have the political ability to maintain a comprehensive and high quality package of benefits.

- * Home and community based services should be included in a basic benefit package.

C. Resource Management

- * The experience of one HMO physician and manager suggests that detailed specification of covered benefits as a means of controlling expenditures leads to micromanagement of medical care and frustration for both providers and patients. Therefore, the benefit package should be broad and comprehensive, leaving AHPs responsible for managing within their budget constraints.
- * "Medical necessity" as a criterion runs the risk of under-utilization, but allows providers and managers in AHPs to manage resources flexibly.
- * Modest copayment at the point of service would reduce over-utilization of health care.
- * Core benefits should be the product of clinical decision-making based on individual patient needs, rather than a specific list of "covered" services.

III. MARKET STRUCTURE/COST CONTAINMENT

A. Structure and Characteristics of HIPC's and Ah.

* There was confusion about the roles and functions of HIPC's and AHPsA. One question was whether the HIPC would function as both a regulatory body as well as a participant in the market to purchase health insurance services for small businesses and individuals. Two options suggested are:

- The HIPC could serve as the sole "clearing house" of insurance for everyone -- large and small business, individuals, uninsured, etc. -- in a region or state, certifying several AHPs for the individuals to choose among. If the HIPC served all it could then be both a regulatory and clearing house without a conflict. This arrangement would make community rating easier to implement and reduce the need for complex risk adjustments of businesses who want in or out of the HIPC system.
 - The functions of the HIPC could be divided into: 1. a regulatory body which would issue rules and enforce them; and 2) the HIPC purpose which would be a "benefits office type of clearing house" for small business, individuals, etc.
- * Hospitals, doctors and HMOs are able to "game" (respond to the opportunities afforded) any conceivable system. In addition, even well-meaning competing AHPs will not necessarily respond to unique features impacting health care in a market. Therefore, HIPCs will need to be more "active" than "passive" managers of the competition. Rather than duplicating state and local public health departments or recreating HSAs, HIPCs will need information from and work in coordination with the public health infrastructure.

* Employers as HIPCs are perhaps necessary politically, but the track record is spotty. For every CALPERS, there are ten sleepy or misguided corporate attempts to manage health benefits. Size of the firm is no proxy for quality. HIPCs should be "certified" in some way as to their capacity and breadth of function so that most employers would not wish to bother.

* There should be some flexibility for the cut-off at which point businesses have to participate in the HIPC structure depending upon local factors, such as prevailing business size. The cut-off should be high (around 1,000 employees) so a large proportion of the population (85 % was mentioned frequently) would be purchasing through the HIPC.

* Some participants pointed out, however, that prevailing business size is a real issue in states like South Dakota where 97% of businesses employ fewer than 50 people. Consequently, there was a suggestion that firms with fewer than 100 employees should participate in a HIPC.

* Models for AH structure are likely to be varied because diversity of needs is great. Responsibility for total patient care should promote greater organizational cooperation between types of providers in the development of new AH models. Specific options suggested were: physician-controlled HMOs; hospital centered organizations (structures that could be particularly workable in underserved inner city areas); individual physicians practicing under capitated indemnity structure; "professional management" organizations which would allow physicians to focus their efforts on delivery of medical care.

* Ah would receive capitation payment for total patient care.

* Ah managed care should mean the coordination of patient care by medical professionals.

* Ah must be sufficiently large to incorporate risk sharing.

* Legislation for AHPs needs to include: (a) start-up financing (perhaps low interest loans); (b) anti-trust protection; (c) risk adjustment through reinsurance mechanism; and (d) assistance for formation of health networks.

* Ah will require technical capacity to manage and coordinate services delivery.

* There will have to be careful reinsurance or bonding mechanisms. Some provisions will also be needed to protect those who lose their primary care provider when their AH fails.

* To "manage" competition, HIPCs will need uniform data from AHPs but will also need to "snoop around" in a way that good corporate health benefits officers can. Again, this implies a more activist approach.

B. Accountability

* There was some concern about who the AHPs would be accountable to and on the basis of what. If we view them more as a business, then accountability is to "shareholders" and the basis is profits. If we view them more as dispensing a social good that all people are entitled to, then they serve critical political functions and the major accountability is to their patients and participating health care providers. There was concern that "input" of the patients and providers not just be viewed as the opportunity to select and change AHPs from year to year, but a more substantive input on the range of benefits to be provided, what hospitals to use, etc. The patients might be viewed as more "cooperative members" and less as "consumers" and this might require some added structure in the AHPs for ensuring such participation and input, possibly along the lines of discussion groups used by Group Health of Puget Sound and Oregon Health Decisions.

* The state regulatory body should regulate advertising by the AHPs. At a minimum this should include monitoring for truth in advertising but also might be to limit total proportion of expenditures that can be spent on non-health care items such as advertising and sales

C. Diversity of HIPCs and AHPs

* Every effort should be made to assure that AHPs represent the communities they serve geographically and demographically. A scenario to be avoided is the development of multiple AHPs competing for healthy and compliant suburban enrollees and one AHPs bidding for the inner city poor with their multiple health and social problems. Several strategies to achieve this end were explored. Risk-adjusted capitation may erase these differences. Each AHPs could be required to be available to all throughout the HIPC region. Or AHPs could be required to enroll a certain percentage of lower SES or rural households in the HIPC region.

* There should be maximal diversity among the AHPs and HIPCs with the regulatory board ensuring provision of minimal services and fair contribution to caring for high risk patients. The idea that different AHPs would provide different packages of benefits was endorsed. In this sense it was not clear that the major competition would be based on price -- as envisioned by the initial advocates of managed competition -- but might focus on range of benefits and quality, much different notions and a business market flavor. Thus having flexibility under regulatory rules was supported. So was the idea that in some states the HIPC would serve all businesses and individuals, much like a single payer, while in other states or regions they might serve only businesses with less than 100 employees was endorsed.

* There was the view that there should be incentives and seed money for public hospitals, community health centers, and other organizations to develop AHPs in the inner city and for the poor. It was also felt that it is not necessarily wrong for one or two AHPs to serve the poor as long as this was based on a suitable range of AHPs choices for the poor and not avoidance by AHPs who serve the richer suburbs of the inner city and poor. Ensuring a suitable range of choice would be a function of the regulatory body. If a suitable range of choices among AHPs was not offered the poor, then it was felt the regulatory body should require all AHPs in a region to open facilities in the inner city and take a fixed percentage of the poor.

* Academic medical centers may wish to set up their own Ah, but rather than participating in the competitive market structure, they should focus on their mission of education, research and development and providing tertiary care.

* Centers that organize Ah should link with community hospitals for lower levels of care.

* AHPs strategy success will be judged by how well structure deals with urban inner city and rural service delivery needs. Could be addressed through satellite clinics, "designated" AHPs and other specially qualified and financially supported structures.

D. Providers

* AHPs should have broad discretion in organizing and choosing the make-up of its providers. In a price-competitive market, team approach and reliance on use of nurse practitioners and physicians assistants would be cost efficient strategies. Legislation should remove barriers and disincentives to team model of medical practice and, more specifically, prohibit states from creating legal or regulatory barriers to use of nurse practitioners and physician assistants.

Changes in the AHPs, especially annual price changes, could encourage frequent changes in physician-patient assignment. Many of the physicians who work with patients from managed care groups experience frequent changes in patient panels. For instance, in Minnesota with numerous managed care arrangements, the average time of a patient with one physician is 18 months. It was felt that a high priority should be to encourage long-term physician patient relationships. One desirable way to achieve this is for there to be multi-year contracts where patients select an AHPs only once every three years or so rather than annual open enrollment. Obviously, the opportunity to change the AHPs with a change in family circumstances would be important. Such multi-year contracts would add predictability to AHPs for multi-year planning. It might also encourage greater preventive care since the AHPs might receive the benefits of expenditures for preventive care interventions.

IV. QUALITY/MALPRACTICE/TECHNOLOGY

A. Malpractice

- * Malpractice reform is needed both on its merit and as a political trade-off to providers. A bold stroke would be to eliminate individual provider malpractice risk, completely substituting organizational liability of AHPs.
- * There should be a separate insurance system developed to cover awards for maloccurrences.
- * Practice guidelines would greatly assist the MDs in their attempts to practice less defensive medicine. An arbitration board could be formed to dismiss frivolous cases prior to court action. Several physicians felt that MDs would accept a lower income level if they could just stop practicing defensive medicine.

B. Quality Measures

- * Providers are primarily interested in autonomy, and decreased administrative and malpractice hassles. AHPs need to be designed to support these goals. If they try to manage by micromanaging health care, physicians and patients will revolt.
- * Outcome measures are useful but not currently robust enough to adequately measure quality-- HIPCs will need to monitor; there will continue to be a "I know it when I see it" art to this.
- * Practice Guidelines are themselves a "technology." There should probably be national guidelines for preventive care, but AHPs should have flexibility to develop local guidelines to promote innovation; Health Standards Boards should recommend/sponsor health services research to expand knowledge of effective clinical practice. As in industry, a portion of delivery system dollars should be spent on effectiveness research.

C. Technology

- * The market will not adequately ensure that technology is managed appropriately; HIPCs or some other entity will need to manage; antitrust laws need revision to allow joint purchase and other collective action.

IV. HEALTH PROFESSIONS

There was a general consensus among all task group members that efforts to increase the numbers of primary care physicians and to decrease the numbers of medical specialists was an obvious requirement of a reformed health care system.

There was also general agreement that new emphasis should be placed on the number and scope of responsibilities of nurse practitioners.

A. Workforce Policy, Goals and Incentives

- * The development of a national workforce policy is needed because the market is not correcting itself in the near term.
- * A goal of 50% primary care physicians should be established.
- * No federal payments should be made to teaching hospitals which do not have approved primary care residency programs.
- * Several participants had little faith that the system for training physicians would change without incentives to meet the goals stated above. Consequently, waiting until 1997 to institute legislative requirements presented to the group by Steve Schroeder seemed to postpone the inevitable. On the other hand, some felt the need to eliminate the antitrust barriers to private physician supply planning and supported the five year deadline prior to imposing government control over numbers of funded specialty residency slots.
- * AHPs will require an increase in the supply of primary care professionals. Specialist physicians in over-doctored areas will face the brunt of the move to AHPs - a potent force; AHPs would likely "freeze out" specialists, leading to court challenges.
- * Graduate Medical Education financing should be expanded beyond Medicare to all payers; a "tax on HIPC's" could be considered.
- * Support federal grants for Nurse Practitioner/Physician Assistant training, general practice faculty members.
- * Graduate medical education costs should be identified so that they can be appropriately defined and adjusted for in institutional costs and so their distribution can be more policy-directed. Centers should be responsible for the designation and distribution of residency training positions.
- * There should be federal funding set asides for graduate medical education, National Health Service Corps, research and development, AHPs start-up funding, and other public policy driven needs. Distribution of set aside funds should be controlled by regional and/or state input.

- * Consideration should be given to including mandatory service provisions and payback of educational expenses during service, as well as adding an international component.
- * Scholarship support for those choosing primary care professional tracks is needed.
- * Payments to public hospitals outside the regular reimbursement system would allow them to attract more primary care professionals.
- * Use of a multi-site medical school model so that medical students can follow patients through the entire course of treatment should be considered.
- * The number and the scope of the responsibilities given to nurse practitioners, midwives, and physician assistants should be greatly enhanced. The cost savings and the improved patient quality of life from the added attention to primary and preventive care would easily exceed the investment in this human resource. The National Health Service Corps could be the vehicle for quickly training and placing all types of primary health care providers.

B. The Real World

- * A short, medium, and long-term strategy is needed to increase reimbursements (or incomes in general) for GPs. This could be accomplished by:
 - Guaranteeing a GP an acceptable salary. Ultimately, the greatest savings for the country's health care budget will come if patients see GPs before their problems get out of hand.
 - Changing reimbursement schedule.
 - Modifying medical school curriculums and funding. With medical school funding relying on faculty practice fees and research based on sub-specialties, the students are indoctrinated early on that the route to prestige and importance is in the world of sub-specialties.
- * Better utilize the currently existing Area Health Education Centers (AHEC). The AHEC in Arkansas works extremely well, placing satisfied GPs in underserved communities. The Duluth, Minnesota experiment has also proven successful in convincing MDs that the life of a GP is rewarding.
- * There is a need to address the cultural and administrative environment facing primary care providers, especially family practice physicians in rural areas. In addition to enhanced reimbursement, these professionals need more respect and freedom from overbearing and demoralizing administrative burdens. Health care reform must simplify the professional lives of primary health care providers if sufficient numbers are to be attracted into these fields. This applies to nurse practitioners as well as physicians.

VI. LONG TERM CARE

In general there was concern about long term care and its treatment in any health care reform plan.

A. Plan Development

- * There is such a unique set of needs here extending beyond the medical model that LTC may need a plan all its own. In other words, the managed competition framework developed for acute care may be inappropriate in this area.

- * Long term care should be divided into two groups for analysis: 1) post-acute care and (2) long term nursing home care. The former should definitely be viewed as part of the health care reform plan and that AHPs should be responsible for nursing home or rehabilitation hospital stays after acute hospitalizations. It was also felt that separating the nursing home care from Medicare would lead to "cost-shifting" games of dumping. Thus there was some sentiment for trying to include long term care into the overall plan. There was also sentiment for giving states great flexibility in providing long term care especially if it is left out of the major health reform plan. One member of the group encouraged looking at having middle income people with resources of their own, e.g., houses with equity, to pay for nursing home care.

- * "Second generation" managed competition should fold in long-term care insurance, managed by HIPCs.

B. Interface with System

- * Medical education should include clinical experiences in long term care sites. Physicians providing primarily geriatric care should be generalists, but all medical students should be exposed to geriatric care.

- * Care needs to be coordinated across the "interface" between the acute care and the long term care systems. One part of this coordination could include the assumption by nursing homes of additional skilled care responsibilities.

- * Develop a major adult daycare strategy, using existing agencies, such as the Area Agencies on Aging as adult day care sites. Services could include primary and preventive health care, therapy services, nutrition, medical education training, social services and social programs, respite programs for working women.

C. Research

- * There is need to develop a research component for long term care to begin to identify the medical conditions and needs of the population that requires nursing home care. This research needs to become part of the competitive funding available to academic medical centers.

VII. TRANSITION AND OTHER ISSUES

A. Transition to a Reformed System

- * Transition team and new administration need to think through the transition details in more depth -- the "getting from here to there" logistical, political and administrative issues need as much attention as the conceptual and technical. Recommend the administration convene groups blending analysts/political strategists/providers to work out the transition details.
- * Cost will continue to increase over the next 3 - 5 years until the final plan is implemented. To ensure credibility among businesses, to limit the base expenditures at which the new plan is implemented, and to ensure that the proper structure for AHPs would begin being created, especially in forcing physicians and hospitals to joining together to share financial risk, some set of actions was thought necessary. Suggestions for this transition included: wage and price controls, Medicare incentives for managed care, and expansion of enterprise liability for the formation of managed care plans.
- * Very few markets currently have the capacity to support and develop 8 - 10 AHPs. The implementation of managed competition will require extensive technical assistance and support of currently unsophisticated providers to at least "get to the starting line." If inefficient providers lose out under managed competition, at least they got to compete in the first place.
- * Urban hospitals, academic health centers, CHCs may compete poorly in the transition to managed competition - they should receive technical assistance, modest federal grants, and special attention by HIPCs in the early stages.

B. Pharmaceuticals

- * Legislation should ensure that approval process require relative not absolute efficacy and that new and more expensive drugs whose primary purpose is to take the place of older, less costly drugs, not be approved.
- * Legislation of pharmaceutical industry is needed, particularly related to identifying actual costs of development and equitable return on those costs.
- * HIPC's or AHPs instituting large group purchase through formularies can bring purchasing leverage into the prescription drug marketplace.

C. Communication to Consumers and Providers

- * Managed competition/HIPC/AHPs are confusing concepts. Early development of a communication strategy for providers, consumers, and the media is recommended.

- * Consumers want a simple system that allows them to see their physician of choice at reasonable cost. Planning for communications systems needs to begin now.
- * Political impact of managed competition on powerful delivery system interest groups needs to be addressed. Specialists and academic health centers are two that need to be brought in early.
- * A national dialogue should begin to set patient (consumer/voter) expectations at a proper level. Physicians want practice guidelines, which will alleviate malpractice fears and be an integral aspect of cost containment, however the patients might view the results as rationing.
- * Basing treatment on the results of outcomes research would alleviate the need for the use of the politically incorrect word, rationing. However, rationing is a current reality and MDs, in particular, need guidance and support in denying treatment to patients with very little or no chance of surviving. Without a national dialogue on the issue of "rationing," any health care reform plan will fail. Consumers/voters must understand the very real implications of the marriage between universal access and cost containment without the MD being viewed as the "cop."
- * In current HMO systems, a tremendous amount of patient education is being conducted. President Clinton and his health care staff should hit all the media sources to start a national dialogue on the role of personal responsibility and cost containment on the treatment choices for the ill. Specialty groups should perform the necessary outcomes research in their own field to have control of the direction of the type of medicine they can continue to practice.

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8

Divider Title: _____

MEMORANDUM

FROM: Bruce Fried

RE: Transition Health Policy Group Outreach Effort
Positions of Various Groups

DATE: January 24, 1993

During the Transition, the Health Policy Team aggressively reached out to virtually every sector interested in reform of the nation's health care system. Meetings were held with the following organizations, either individually or in groups. The meetings had several purposes:

1. Informing groups about the structure and personnel of the Transition and the Health Policy Team.
2. Informing groups about the President-elect's position on health care reform, basically a reiteration of the Campaign position.
3. Obtaining the views of the groups and making specific requests for their advice and recommendation on various policy issues. In all cases, groups which expressed a concern about a particular issue were requested to provide their position and any alternative policy recommendation, in writing, to the Transition Team. Policy recommendations submitted by groups were forwarded to the group within the Health Policy Team for their consideration.

Files containing notes on these meetings with additional materials are being transferred to appropriate offices within the Administration. Summary of interest group positions follow.

Chris Jennings has prepared a similar memorandum covering meetings he had with pharmaceutical interests, small employer groups, states, Congress, aging advocacy organizations and long term care groups.

LABOR

AFL-CIO

Service Employees International Union

AFSCME

United Auto Workers

National Education Association

International Ladies Garment Workers Union

Retail, Wholesale, and Department Store Union

Building Trades Department, AFL-CIO

Communications Workers of America

Teamsters

American Federation of Teachers

United Mine Workers of America

Policy position: Labors position is fairly straightforward. In order to secure labor support, the Clinton health plan must have a means of achieving a real, enforceable budget, must have a mechanism for achieving universal access, and must assure a high-standard for quality care. Union presidents advised that they are willing to go to their members for additional taxes, but advised that they will aggressively oppose the taxation of health care benefits.

Many unions have special concerns. For instance, the UAW and the Steelworkers are concerned about the problems of retiree health coverage both from the perspective of their retired members and from that of their employers who are being required to post unfunded health care obligations as liabilities.

DISABILITY GROUPS

The Arc

Epilepsy Foundation of America

United Cerebral Palsy Association

American Speech-Language-Hearing Association

American Psychological Association

National Association of Developmental Disabilities Councils

American Congress of Rehabilitation Medicine

AIDS Action Council

Policy Positions: The primary concern of disability groups in the design and details of the core benefit package. As they put it, health care reform should be "non-discriminatory," should have comprehensive benefits, provided in an appropriate manner, with financing and other burdens being equitable.

The focus on managed care is a particular concern, the fear being that in a managed care environment, the special needs of people with disabilities could be lost or ignored.

These groups are particularly concerned about and opposed to an Oregon style approach to resource allocation.

HEALTH CARE ADVOCATES

National Senior Citizens Law Center

National Health Law Program

Families USA

Health Care for America

National Leadership Coalition for Health Care Reform

Healthcare Leadership Council

Policy Positions: The two law groups have specialized expertise in the health care needs for low-income Americans, particularly with how the current system operates in the real world.

The National Leadership Coalition and Health Care for America are both coalitions committed to comprehensive health care reform. NLC is better established with business, labor, provider and consumer participation (including Families USA). Its position is close to that articulated during the Campaign. HCA is a vestige of the Kennedy health care effort. While not as well positioned as NLC, it has a large number of important groups among its members. HCA's position will allow it to be supportive of the President's efforts.

Families USA is an effective advocacy group with sophisticated grass roots and communications abilities. It will support the President's position with particular attention to the coverage issues.

The Healthcare Leadership Council is a coalition of large insurers, pharmaceutical companies and for-profit hospitals. The organization opposes global budgeting and supports a tax cap on benefits in excess of the core benefit package. They would use revenues from the tax cap to expand access. They are strongly in support of managed competition as articulated by the Jackson Hole Group.

SINGLE-PAYOR ADVOCATES

American Public Health Association
Church Women United
Citizen Action
Consumers Union
Graphic Artists Union
International Brotherhood of Teamsters
National Association of Social Workers
National Council of Senior Citizens
National Farmers Union
National Hispanic Council on Aging
Neighbor to Neighbor
NETWORK: A National Catholic Social Justice Lobby
Oil, Chemical, and Atomic Worker Union
Physicians for a National Health Program
Public Citizen
United Cerebral Palsy Associations
United Church of Christ, Office of Church in Society
United Electrical Workers

Policy Positions: The single-payor advocates basically wish that the President would support their position. Since he does not, they would like for their to be sufficient flexibility in the enacted reforms so that the states can adopt a single-payor system. Most of these groups recognize that they share the President's objectives and will set aside their ideology to support the President so long as those objectives are not abandoned.

RELIGIOUS

Interreligious Health Care Access Campaign
National Council of Churches
United Church of Christ
United Methodist Church
Evangelical Lutheran Church in America
Church Women United
US Catholic Conference

Policy Position: These groups are very committed to universal access. While other issues (financing, quality, etc.) are important, universality is primary. The USCC is also fundamentally committed to progressive reform, but is also opposed to inclusion of abortion services in the core benefit package. The groups are not generally focused on the specifics of the President's position, though many in the IHCAC are single-payor advocates. The church groups have not been particularly effective as health care advocates, but might be helpful as the debate becomes more real.

CHILDREN'S HEALTH ADVOCATES

Children's Defense Fund
Child Welfare League
Association of Maternal and Child Health Programs
National Association of Children's Hospitals and Related Institutions
National Commission to Prevent Infant Mortality
March of Dimes Birth Defects Foundation
Association for Care of Children's Health
The Alan Guttmacher Institute
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American Nurses Association
American Public Health Association
American Speech-Language-Hearing Association
Association for Retarded Citizens
American Association of University Affiliated Programs
Health and Medicine Council of Washington
National Association of Community Health Centers
National Center for Clinical Infant Programs
National Council of Community Hospitals
U. S. Catholic Conference -- Department of Social Development
Virginia Perinatal Association
Women's Legal Defense Fund

Policy Position: These groups are primarily concerned with the inclusion on child specific health benefits (pre- and neo-natal care, well baby care, immunizations, etc.) in the benefit package. Other issues include universal coverage, access to medical care, and the problems in the Medicaid program.

MINORITIES

NAACP
National Urban League
National Council of La Raza
National Hispanic Advisory Committee on Health
National Congress of American Indians
Cherokee Nation
National Indian Health Board

Policy Positions: All groups were primarily concerned with universal coverage, with other important issues being quality and cost containment. None of the groups were particularly focused on the President's plan, except that the Indian groups were concerned about the implications for the Indian Health Service and meeting the needs of very poor and very rural populations. Hispanic groups are concerned that a managed care model that does not address

the needs of a population that often shies away from contact with official offices will still not have access to care.

ALCOHOL AND DRUG ABUSE

National Association of Alcoholism and Drug Abuse Counselors
Coalition for the Prevention of Alcohol Problems
American Academy of Family Physicians
National Coalition to Prevent Impaired Driving
Center for Science in the Public Interest

Policy Position: These groups were focused on inclusion of alcohol treatment in the benefit package, and supportive of a major increase in taxes on alcoholic beverages dedicated to health care improvements.

EMPLOYERS -- LARGE

National Association of Manufacturers
 including Alcoa
Washington Business Group on Health
National Retail Federation (both large and small employers)
IBM
General Motors
Acme Steel
Bethlehem Steel
Inland Steel
LTV
National Steel
Wheeling-Pittsburgh Steel
American Iron and Steel Institute
Erisa Industry Committee
Pepsico
Association of Private Pension and Welfare Plans
Johnson & Johnson

Policy Positions: Large employers are not monolithic in their position. The mature industries (auto, steel, etc.) are supportive of health care reforms which effectively control costs, assure universal coverage, incentive quality care. Others are opposed to the imposition of budgeting strategies. This opposition is essentially ideological, though real problems are presented in how an effective budgeting approach could be developed and implemented.

Most large employers are supportive of the managed competition strategies articulated by the President -- insurance reform, pooling for small purchasers, increased use of managed

care delivery systems. Many support a tax cap on benefits, but would protect the tax advantage for the employer, making excess benefits taxable as income for employees.

The vast majority of large employers self-insure and will want to protect their ability to self-insure in a reformed health care system. Several groups have been asked to make policy recommendations on how self-insurance could be maintained without damaging the President's plan. As of this date none have been received.

INSURERS

Health Insurance Association of America

Policy Position: After regularly opposing any kind of comprehensive reform, HIAA now has staked out what can be considered a negotiating position. On access HIAA would require employers to offer, but not pay for, a plan, and offer payroll deduction so that employees can purchase the coverage. A gradual phase in of a mandate might be acceptable. On cost containment, HIAA's position is that providers must use uniform rate setting methods with all payors. On HIPCs, HIAA likes existing association type schemes. Believes HIPCs should be tried but should compete against other pooling arrangements. Want federal preemption of state anti-managed care laws. Support a tax cap. Opposed to budgeting.

Large Insurers:

Aetna
Prudential
Cigna
Travelers
Metropolitan Life Insurance Company

Policy positions: These very large companies generally support managed competition strategies, favor expanded managed care (all are deeply into managed care), favor HIPCs (but should be exclusive), favor a tax cap, oppose global budgeting, and support insurance reform (ban on preexisting condition exclusions, community rating but with geographic and age bands, single claims forms). They favor tort reform. They are concerned about the impact of a mandate on small employers and that subsidies could lead to rate suppression. All these companies are members of the Health Leadership Council and HEAL, coalitions which support "pure" managed competition. Travelers preferred to keep controls on the public sector and let managed competition be tested in the private sector. Travelers is also a leader in electronic data and will soon have terminals at every provider in CT. Health Policy Alternatives have been retained by these companies to see if a budgeting mechanism can be found to work with managed competition.

Mid Range Insurers:

Massachusetts Mutual
New York Life
Mutual of Omaha
General American Life
Phoenix Home Life

Policy Position: These companies are all members of HIAA and generally support its position. Many are in the small group and individual market and are concerned about losing that business. New York Life made a very effective presentation that managed competition is essentially a change in the market with a focus on employees/consumers. Their entire marketing is targeted to employers/purchasers. NYLife argues that the Clinton plan should not take employers out of this picture in making coverage purchase decisions. It argues that insurers be allowed to operate outside HIPC's but be subject to all the same rate and access regulations. NY Life argues (like some of the larger insurers) that association coverage should be permitted under a new plan. Mutual of Omaha supports an employer mandate. MoO prefers an all-payor system to budgeting given the complexity of budgeting. MoO has a position similar to NY Life, supporting allowing insurers to play outside a HIPC but with the same regulations so that it can sell to individuals. MoO raised concerns about the solvency of insurers if small insurers drop out and the number of covered lives is expanded.

BlueCross BlueShield Association

Policy Position: BC/BS has a more progressive position than their commercial counterparts. They support 1) insurance reform (rating/preexisting condition bans), increased managed care, administrative simplification, 2) moving the market to community care networks with obligations that the percentage of people in AHPs increase each year. Also would require employers to continually increase %age employees in AHP each year in order to keep their deduction. 3) cost containment -- may support targets with triggered caps: see IOWA plan

Dental Insurers

Delta Dental Plans

Policy Position: Two concerns: 1) tax cap may have unintended consequences. In CA only 21% of teachers elected to take dental coverage with after tax dollars; 2) if dental is part of core benefit package it should be priced realistically (\$9-10/ month/person)

Supplemental Insurers

American Family Life Assurance Company (AFLAC)

Policy Position: AFLAC expects to do well in a reformed system since it focuses coverage on benefits not normally covered by a primary insurance plan. Would be well positioned to be a supplemental insurer for benefits not covered by the core benefit package.

Miscellaneous

Independent Insurance Agents of America

Policy Position: Concerned about their future in HIPCs. Point to federal flood and crop insurance programs as ones where independent agents play a role. No position on tax caps. Asked for input on forms and administrative simplification.

Self Insurance Institute

Policy Position: This group is focused on retaining the ability of employers to self-insure. Size of HIPCs are a big concern. This group prefers smaller. Also not opposed to mandatory coverage. They were asked to provide recommendations on how self-funding could be meshed with managed competition. Nothing has been received as of this date.

PHYSICIANS

American Medical Association

Policy Position: The AMA's position is set out in Health Access America. It calls for an essential benefits package for all, universal pay-or-play coverage, competitive market based strategies to control costs while protecting the right to choose providers, ban on preexisting condition exclusions, and tort reform. Also favor community rating, taxation of benefits above a "benchmark", small group reforms, and administrative simplification. AMA opposes global budgeting.

American College of Physicians

Policy Position: ACP's positions are very close to the President's. ACP supports a global budget, pay-or-play universal coverage, ban on preexisting condition exclusions, community rating, outcomes research and practice guidelines, control of technology.

American Academy of Family Physicians

Policy Position: Very similar to ACP.

American Academy of Pediatrics

Policy Position: Urge that coverage be phased in by covering children and pregnant women first. Also, benefits package should be child sensitive, recognizing that children are not "little adults." AAP supports a one tier system. Also recommends that HCFA develop an RBRVS for children (was in tax bill, needs no legislative authorization.)

American Society for Internal Medicine

Policy Position: ASIM supports a tax cap. Also believes access should not take a back seat to cost containment, and supports an employer mandate. Opposes global budgets, but prefers flexible goals if necessary. Strongly supports increased focus on primary care.

National Medical Association

Policy Position: Supports a single-payor system

Society on General Internal Medicine

Policy Position: A single-payor group, mostly academic, very progressive. Support mandates and budgeting.

Physicians Who Care

Policy Position: Supports maintenance of fee-for-service medicine. Opposes managed care reimbursed on capitated basis.

American Academy of Ophthalmology

American College of Obstetricians and Gynecologists

American College of Preventive Medicine

American College of Surgeons

American Psychiatric Association

College of American Pathologists

Society of Thoracic Surgeons

NON-PHYSICIAN PROFESSIONALS

American Nurses Association

American Chiropractic Association

American Dental Association

American Psychological Association

American Optometric Association

American Podiatric Medical Association

American Association of Nurse Anesthetists

American Physical Therapy Association

American Academy of Physician Assistants

American Association for Marriage and Family Therapy

American Occupational Therapy Association

American Speech-Language-Hearing Association

American College of Nurse Midwives

Association of Minority Health Professions

Employee Assistance Professionals Association

Policy Positions: These groups have a variety of positions on different issues. They share a concern that non-physician health care professionals be assured of appropriate roles in a new health care system. Concerns run not only to issues of licensure and reimbursement but also to coverage of their services (i.e., chiropractic care, mental health services) in the core benefit package. Some groups such as the ANA have detailed positions or principles on various system design issues. Most are concerned about their members ability to provide care in the new system.

HOSPITALS

American Hospital Association

Policy Position: AHA has a well developed reform proposal entitled: A Healthier America through Community Care Networks. This plan is similar in many ways to the President's position on managed competition. It calls for coverage of a core benefit package in a pay-or-play system. Its networks are similar to the delivery reform/managed care approach. AHA is concerned that managed competition will drive hospitals to be lowest-priced vendor and threaten the mission orientation. Might support budgeting if "bottom up", based on capitated payment system. Strongly urge anti-trust reforms to permit easier collaboration/coordination by hospitals.

Catholic Health Association

Policy Position: Has a very progressive plan, very similar to the President's except has favored a single-payor approach. Now moving to more of a managed competition strategy but with a mandate for employer coverage, budget caps, delivery reform though capitated payments. Interesting in that plan starts with an articulation of values and builds delivery and financing from their.

Federation of American Health Systems (for-profit hospitals)

Policy Position: Very supportive of Conservative Democratic Forum plan. Supports a tax cap. Absolutely opposed to rigid budgeting. Opposed to mandate due to alliance with small employers through HEAL. Major player in HEAL and Health Leadership Council.

American Healthcare Systems Institute

Policy Position: Supports elimination of medical underwriting. Wants a tax cap. Wants medicaid expansion to cover the uninsured. Wants tort reform. Wants equivalent funding for training of primary care and specialty doctors. Wants practice guidelines. Oppose global budgets. Supports CDF managed competition plan.

St. Joseph's Hospital (on Ethics)

Policy Position: These religious based hospitals and systems are mission oriented, and generally are supportive of the President's direction on health care reform.

Columbia Hospital Corporation

Policy Position: This for-profit system has a position similar to FAHS's.

American Association of Osteopathic Hospitals

Policy Position: Concerned about survival of these often small hospitals in a managed competition setting where AHPs are likely to contract with traditional MD oriented institutions.

Methodist Health Systems
American Protestant Health Association
Riverside Methodist Hospitals
Lutheran General Health Systems
Miami Baptist Hospital
InterHealth
National Association of Children's Hospitals and Related Institutions
Voluntary Hospitals of America

MANAGED CARE PROVIDERS

Group Health Association of American
American Managed Care and Review Association
American Association of Preferred Provider Organizations
Kaiser Permanente
FHP, Inc.
United Healthcare
US Health Care
Healthcare Compare
Foundation Health

Policy Position: GHAA supports managed competition. It is concerned that tying tax deductibility to the lowest AHP premium may encourage "low-balling." HIPCs should be exclusive for small employers, should be non-profit and not allowed to self-insure. The term "managed care" should be defined by statute, with an HMO component (they prefer the Medicare definition per Title 18, section 1876.) They recommend the basic benefit package under the federal HMO act for the President's benefit package.

AMCRA generally supports the CDF approach to managed competition.

Kaiser supports managed competition and made several points on HIPCs: They would have HIPCs cover small and mid-sized employers, individuals and part-time employees, Medicaid beneficiaries. HIPCs should be exclusive. There should be one per market. HIPC should cover 200,000 to 500,000 lives.

REHABILITATION

National Association of Rehabilitation Facilities
National Rehabilitation Coalition

Policy Position: These groups are focused almost exclusively on having rehabilitation services included in the core benefit package.

LONG TERM CARE

Home Care Coalition

Health Industry Distributors Association

American Federation of Home Health Agencies

American Association for Respiratory Care

The Oley Foundation

Policy Position: This coalition of providers and consumers supports increased delivery of health care in the home. Wants benefits and delivery system to permit and encourage greater use of home care in the health care system.

LABORATORIES

MetPath

Policy Position: Concerned that doctors are padding laboratory charges. Would like for laboratories to be able to direct bill patients.

OTHERS PROVIDERS

Ad Hoc Hispanic Health Care Providers and Policy Experts

COSSMHO-- Coalition of Hispanic Health and Human Services Provider

Wellness Councils of America

MISCELLANEOUS

American Heart Association

Policy Position: No position on health care reform beyond general principles which would permit support for the President's plan. Major focus on the need for increased medical research.

SUPPLIERS

Health Industry Manufacturers Association

Policy Position: Most concerned with FDA and its failure to make decisions regarding new technologies. Also concerned with global budgets.

National Association of Medical Equipment Suppliers

National Association for Infusion Therapy

Policy Position: Both these groups are concerned that the core benefits package include coverage for their services.

ADMINISTRATION/ELECTRONIC DATA PROCESSING/FINANCING

American Health Information Management Association
Health Care Financial Management Association
Joint Commission for the Accreditation of Healthcare Organizations
GMIS , Inc.

Policy Position: Each of these groups has specialized expertise in various aspects of health care financing, financial and health data processing, quality assurance, and overall administration. Each can offer valuable information in their areas of focus.

RESEARCH/ACADEMIA

Association of Independent Research Institutes
Association of American Medical Colleges
American Federation for Clinical Research
Association of Minority Health Professions Schools
Association of Academic Health Centers
Association of Schools of Allied Health Professions
Federation of American Societies for Experimental Biology
Howard University
National Coalition for Cancer Research
Cystic Fibrosis
Arthritis Foundation
American Society of Tropical Medicine and Hygiene
AIDS Action Council
Merck
Alliance for Aging
Johns Hopkins University
American Society of Microbiology
Hereditary Disease Foundation

Policy Position: General concern about research funding, role and leadership of NIH, and similar research oriented issues.

RURAL INTERESTS

National Rural Health Association
National Association of Rural Electric Cooperatives
Communicating for Agriculture

Policy Position: These groups are especially concerned about reform of the delivery system. Their concerns focus on the lack of managed care in rural communities and the resulting inability for managed competition to function successfully; the urgent need for health care professionals and institutions in many small communities; the need for increased funding for

the National Health Service Corps and community health centers. Additionally, CoA is supportive of risk pools as a means of assuring affordable care for agricultural families, given the high cost of coverage for these high-risk workers.

M E M O R A N D U M

TO: Clinton Administration Health Team
FR: Chris Jennings and Steve Edelstein, Health Transition Staff
RE: Meetings/Outreach Report

DATE: January 24, 1993

During the last two months, the Health Policy Transition Team reached out to as many individuals and groups as possible who are interested in contributing to or affecting President Clinton's health care reform initiative. The outreach effort that I chaired was aimed at the various and multiple interests of the Members of Congress, the Governors and non-executive branch state and local governments, aging/long term care/prescription drug coverage advocates, small businesses, and pharmaceutical interests. Bruce Fried met with virtually every other interest group that does not fall under these categories. His report is being forwarded under separate cover.

Meetings were held with numerous individuals and/or organizations, either individually or in groups. The meetings had several purposes:

1. Informing individuals and/or groups about the structure and personnel of the Transition and the Health Policy Team.
2. Informing them about the President-elect's position on health care reform, basically a reiteration of the Campaign position.
3. Obtaining the views of the participants & making specific requests for their advice and recommendation on various policy issues. In all cases, those who expressed a concern about a particular issue were requested to provide their position and any alternative policy recommendation, in writing, to the Transition Team. Policy recommendations submitted by groups were forwarded to the group within the Health Policy Team for their consideration.
4. Focusing participants on high priorities, rather than laundry lists. Discussing the need for everyone to make contributions/sacrifices for health care reform to get enacted. In that regard, asking them to be part of the solution and not part of the problem. (Almost without exception, this message was heard and well received).

Files containing any pertinent notes on these meetings, or containing written materials submitted by the individuals or groups, are being transferred to appropriate offices within the Administration. A listing of the individuals and/or groups we met with, along with a brief summary of their general health care position, can be found on the following pages.

CONGRESSIONAL OUTREACH:

1. Congressional Leadership

Senate

George Mitchell, Senate Majority Leader

Bob Dole, Senate Minority Leader (through staff)

Senator Moynihan, Finance Committee Chairman

Senator Bob Packwood, Finance Ranking Republican Member (through staff)

Senator Kennedy, Labor and Human Resources Chairman

Senator Nancy Kassebaum, Labor Ranking Republican (through staff)

Senator Jay Rockefeller, Finance Medicare Subcommittee Chairman

Senator Dave Durenberger, Finance Medicare Subc. Ranking Republican

Senator John Chafee, Finance Medicaid Subc. Ranking Republican (through staff)

Senator David Pryor, Aging Committee Chairman and Secretary of the Senate

House

Speaker Foley (through staff)

Minority Leader Michels (through staff)

Richard Gephardt, House Majority Leader (through staff)

Newt Gingrich, Republican Whip (through staff)

Congressman Dan Rostenkowski, Ways and Means Chairman

Congressman Bill Archer, Ways and Means Ranking Republican (through staff)

Congressman John Dingell, Energy and Commerce Chairman

Congressman Norman Lent, E&C Ranking Republican (through staff)

Congressman Pat Ford, Labor and Education Chairman (through staff)

Congressman Pete Stark, Ways and Means Health Subcommittee Chairman

Congressman Henry Waxman, Energy and Commerce Health Subc. Chairman

Congressman Pat Williams, Labor and Education Subcommittee Chairman
(through staff)

Policy Positions: First, as it relates to the Democratic Leadership, there was a very encouraging willingness and desire to work in concert with the new Administration to develop a health reform proposal. As a sign of this cooperation, with the exception of one representative (Pete Stark), all agreed to hold off on introducing initiatives that could potentially signal that the Democrats were heading in conflicting directions.

The Democrats mentioned above, most particularly the two Majority Leaders, felt that the only way an inevitably controversial and complex health care reform bill could make it through the Congress would be for all or most of the Democratic Leadership

to get behind a relatively detailed and unambiguous health care proposal pushed by the new President. A process by which this could be achieved was established by the Transition Team. An agreement to have regular and substantive meetings was reached and, at the conclusion of the Transition, many of these meetings were deferred until the major health care players of the new Administration were in place.

Although there are widely varying opinions on how to proceed with health care reform, the likelihood of success in achieving a sufficient amount of support in the Congress for a Clinton health reform plan seems good as long as careful and consistent consultation takes place among the members and particularly the leadership. In preparation for the Committee Chairman's meeting with the then President-elect, a brief memo on their current reform positions was drafted and is attached for your review. In addition, a detailed summary of the Senate Finance Committee members background in the health care area, which was produced for Secretary Shalala for her confirmation hearing is also attached for your use.

2. Outreach to Rest of the Congress:

Senator Max Baucus (Dem. - Montana)
Senator Jeff Bingaman, (Dem. - New Mexico)
Senator David Boren, (Dem. - Oklahoma) through staff
Senator John Breaux (Dem. - Louisiana) through staff
Senator Tom Daschle (Dem. - South Dakota)
Senator Bob Kerrey (Dem. - Nebraska)
Senator Howard Metzenbaum, (Dem.- Ohio)
Senator Donald Reigle (Dem. - Michigan) through staff
Senator Paul Wellstone, (Dem. - Minnesota)
Senator Harris Wofford (Dem. - Pennsylvania)

Congressman Mike Andrews (Dem. - Texas)
Congressman Xavier Becera (Dem. - California)
Congresswoman Cardiss Collins (Dem. - Illinois)
Congressman John Conyers (Dem. - Michigan)
Congressman Jim Cooper (Dem. - Tennessee)
Congressman Kika de la Garza (Dem. - Texas)
Congressman Harry Johnston (Dem. - Florida)
Congressman Jim McDermott (Dem. - Washington)
Congressman Robert Menendez (Dem. - New Jersey)
Congressman Solomon Ortiz (Dem. - Texas)
Congressman Bill Orton (Dem. - Utah)
Congressman Bill Richardson (Dem. - New Mexico)
Delegate Carlos Romero-Barcelo (Dem. - Puerto Rico)

Congresswoman Lucille Roybal-Allard (Dem. - California)
Congresswoman Louise Slaughter (Dem. - New York)
Congressman Charles Stenholm (Dem. - Texas) through staff
Congressman Louis Stokes (Dem. - Ohio)
Congressman Mike Synar (Dem. - Oklahoma)
Congresswoman Nydia Velasquez (Dem. - New York)
Congressman Ron Wyden (Dem. - Oregon)

Congressional Black Caucus
Congressional Hispanic Caucus
Senate Rural Health Caucus

Policy Positions: Obviously there is and there will continue to be a wide range of opinions relating to national health reform amongst this group. Almost without exception, however, these particular members are committed to achieving the goals of cost containment and universal access. In attempt to reach out to all members of Congress, regardless of their past or current positions, the Transition Team sent a memorandum to every member soliciting suggestions and the names of key staff contacts.. This communication was extremely well received, particularly among the Republicans.

STATE AND LOCAL INTERESTS:

1. Governors

National Governors' Association

Governor Lawton Chiles (Dem. - Florida)
Governor Howard Dean (Dem. - Vermont)
Governor Jim Florio (Dem. - New Jersey)
Governor Roy Roemer (Dem. - Colorado)
Governor John Waihee (Dem. - Hawaii)
Governor David Walters (Dem. - Oklahoma)

Policy Positions: Governors have a great interest in working collaboratively with President Clinton in the development of a health care reform proposal. Their priorities are that any proposal contain significant state flexibility in terms of state administration, cost containment, and personnel and technology distribution. Those states who have comprehensive state-wide reform proposals in place consistently argued that efforts aimed at passing a national reform initiative should not hinder the development of state plans. The transition team, in consultation with the NGA, incorporated the governors and their representatives into the policy work groups that were established. Lastly, although not related to comprehensive reforms, almost all Governors would also like to see immediate Medicaid financial and administrative relief provided to the states.

2. Other State and Local Officials

Association of Attorneys General
American Public Welfare Association
City Managers Association
National Association of Counties
National Association of State Treasurers
National Association of Towns and Townships
National Caucus of Black State Legislators
National Conference of State Legislatures
National League of Cities
U.S. Conference of Mayors

State Senator Robert Connor (Rep. - Delaware)
State Representative Art Hamilton (Dem. - Arizona)
State Representative Tom Mason (Dem. - Oregon)
State Representative Karen McCarthy (Dem. - Missouri)
State Senator Cindy Resnick (Dem. - Arizona)
State Representative David Richardson (Dem. - Pennsylvania)

Policy Positions: Policy positions extremely similar to the Governors. However, they strongly believe that they have an important and unique perspective, separate and apart from the Governors that should be incorporated into the policy development process.

AGING/LONG TERM CARE/PRESCRIPTION DRUG ADVOCATES:

1. Consumer Groups

Alzheimer's Association
American Association of Retired Persons
Consumers Union
Families USA
National Association of Area Agencies on Aging
National Committee to Preserve Social Security and Medicare
National Council of Senior Citizens
National Council on the Aging

In addition, met in group settings with:

The Leadership Council of Aging Organizations (32 national aging organizations)
The Long Term Care Campaign (representing 137 cooperating Organizations)
Save Our Security (representing over 100 organizations)
Generations United (representing numerous aging and children's advocates)

Policy Positions: Almost without exception, all of these visible and potentially powerful interest groups are assuming that there will be a prescription drug benefit for both the under and the over 65 population. (They repeatedly cite Clinton campaign pledges to make this happen). They also are relatively confident, based on campaign rhetoric, that strong drug cost containment be applied to these benefits so that beneficiaries and taxpayers are not saddled with overwhelming premium costs. They are so certain that the drug benefit coverage and cost containment campaign pledges will be met that they did not even spend much time lobbying for them.

The primary two-pronged theme emerging from these meetings is that long term care cannot be forgotten, so don't assume that a drug benefit will suffice. Once again, they cite campaign pledges to meet the long term care need. The room for compromise in these groups' positions with regard to long term care is that it can be phased in over a period of time. In fact, it appears that most would be satisfied with a home health benefit, which includes personal care assistance services for the disabled, that sets up a process as to how to deal with the institutional (nursing home) long term care shortcomings in the current system.

2. Provider Groups

National Association for Home Care
American Health Care Association (Nursing Homes)
American Association of Homes for the Aging
National Institute on Adult Daycare

Policy Positions: The long-term care provider groups generally support health care reform. None are strongly wedded to a particular approach. Instead, they are looking to win points from their accommodating position on health care reform which they can parlay into the inclusion of some kind of long-term care program as part of the health care reform effort. Most would accept a less than comprehensive long-term care benefit if it contained some coverage for the services provided by their membership. The only significant exception to the above, is that home care providers are now strongly advocating the inclusion of home care services within any minimum benefit package for the under 65 population.

SMALL BUSINESS INTERESTS:

National Association of Life Underwriters (Insurance Agents)
National Federation of Independent Businesses
National Small Business Legislative Council
National Small Business United
U.S. Chamber of Commerce

Policy Positions: A sizable segment of the small business community will oppose any reform plan that includes a mandate. They view it as an unwarranted intrusion by government on the operation of their business. But the response of the majority of small businesses will hinge very strongly on the timing of the phase-in schedule, particularly the relation of the mandate to implementation of cost controls. Small businesses will complain most bitterly if the mandate precedes any significant effort to reign in private market insurance costs. They may offer grudging support for the plan if cost controls are in place prior to the mandate.

In a significant recent development, the National Small Business Legislative Council has signaled their willingness to consider a mandate if the cost issue is adequately addressed and small businesses are not unduly burdened (i.e. they receive sufficient subsidies). However, Small Businesses United, previously considered the more liberal small business group has not indicated any change of their position in opposition to a mandate, instead favoring a broad surtax on income to finance expanded access to health care. the most visible and influential small business advocacy group is without question the National Federation of Independent Business. Although our meetings with them have been non-confrontational and constructive, it is highly unlikely they will see it in their interest to support any health care plan that includes an employer mandate.

The National Association of Life Underwriters is particularly concerned with the role of independent insurance agents after the reform plan goes into effect. They fear that with health insurance purchasing cooperatives, the role of independent insurance agents will be obsolete and most will be forced out of business. They have suggested the purchasing cooperatives be permitted to contract out with agents to sell the approved policies.

PHARMACEUTICAL INTERESTS:

1. Drug Manufacturers

Merck
Johnson and Johnson
Pfizer
Schering Plough
SmithKlineBeecham
Syntex
Eli Lilly
Searle
Marion Merrel Dow

Policy Positions: The industry has initiated conversations about a voluntary drug price agreement in which drug manufacturers would keep their price increases to at or below the general inflation rate. It is their desire to use this proposal as a substitute for much more intrusive and unappealing government cost containment intervention. They also have come out in support of the concept of managed competition as another market-based and acceptable approach to containing costs. Merck and a few other companies acknowledge that their remain outstanding issues on their voluntary price constraint proposal including a lack of an enforcement mechanism, an assurance that all companies would enter such an agreement, and the a concern that the price constraints would not be extended to all purchasers, particularly non-managed care purchasers. The industries infatuation with the voluntary agreement and managed competition does little or nothing to address and contain the prices of new drugs. This is particularly the case with new drug products that have no therapeutic alternatives and for which there can be no competition.

2. Generics

Generic Pharmaceutical Industry Association
National Association of Pharmaceutical Manufacturers
National Pharmaceutical Alliance

Policy Positions: These associations, representing numerous generic companies, do not want to be singled out as the bad guys of the pharmaceutical industry. They argue persuasively the they are not contributing to drug price inflation. Their primary request is to insure that they be treated differently than the name brand manufacturers and, in fact, protected to insure that they continue to provide a cost-effective alternative to name brands. They obviously do not have major concerns about limitations on new drug prices.

3. Biotech Interests

Industrial Biotechnology Association
Roche Pharmaceuticals
T Cell Sciences, Inc.
Novo Nordisk
Genetech, Inc.
Synergen, Inc.

Policy Positions: The biotech industry has one primary concern related to drug prices: the regulation of prices of new drug products. They feel that any such regulation will not only constrict but may eliminate them as an industry because they live or die on their ability to produce new products over the next several years.

4. Pharmacists

American Pharmaceutical Association
American Society of Consultant Pharmacists
National Association of Chain Drug Stores
National Association of Retail Druggists

Policy Positions: These organizations represent a relatively diverse and comprehensive cross section of the nation's pharmacists. They have yet to agree on a unified position but in general all agree that a minimum benefit package should cover pharmacist services. They argue that such services are cost effective because they assure appropriate compliance and help guard against expensive adverse drug reactions. They also appear to be moving toward a position that at least on a temporary basis assures that all pharmacists who provide covered services are protected from being excluded by insurers attempting to contract with selected individual pharmacists.

5. Purchasers

Group Health Association of America
American Society of Hospital Pharmacists

Policy Positions: These groups, like other hospital or HMO based purchasers requested that any health reform protect their ability to continue to negotiate using managed competition methods, such as the use of drug formularies. They therefore oppose the use of a provision like the Medicaid "best price" law to contain the cost of any other purchaser such as Medicare (they fear that a requirement to provide the best price to the Medicare program will harm their ability to negotiate freely with drug manufacturers). Lastly, one cannot have a discussion about purchasers without mentioning consumers, please refer to aging/long term care/prescription drug advocates section above.

MENTAL HEALTH INTERESTS:

American Academy of Pediatrics; American Psychiatric Association
American Psychological Association
Child Welfare League of America
Mental Health Law Project
Mental Health Policy Resource Center
National Alliance for the Mentally Ill
National Association of Community Health Centers
National Association Psychiatric Treatment Centers for Children
National Association Social Workers
National Council of Community Mental Health Centers
National Mental Health Association

Policy Positions: The mental health groups (the Mental Health Liaison Group--a coalition of 25 plus groups, including the American Psychiatric and Psychology Associations, National Alliance for the Mentally Ill, National Mental Health Association--supports nondiscrimination between mental health and other health benefits for patients and are focused on eliminating what they feel are the artificial limits, e.g., 20 visits, etc, on counseling type services. Note that the National Alliance for the Mentally Ill believes that the health reform plan must focus first on the most needy and severely ill.

Groups insist on the importance of coordinating national reform with existing federal, state and local community health systems. To build capacity in communities to meet mental illness needs, they recommend: expanding mental health block and PATH grants, using community mental health block grants to enhance state integrated comprehensive service plans for individuals, improving community services with demo programs, and developing processes to assure coordination of CMHS services development and support.

M E M O R A N D U M

TO: President-Elect Clinton
FR: Judy Feder, Chris Jennings
RE: Congressional Visit and Health Care

December 6, 1992

This week, during your discussions with Members of Congress, and particularly during your conversations with Committee Chairmen, a number of the Members may wish to discuss their preferences and concerns about health care reform. In addition, many Members will likely want to hear you give hints on what direction you are headed.

To date, we have been extremely encouraged by the willingness of the House and the Senate leadership to follow your lead on health care. Not surprisingly, however, based on the conversations we have had with numerous Members and their staffs, the Congress continues to have widely varying views on this issue.

The attached gives you brief descriptions of leading Members' positions on reform. Three points to keep in mind as you meet with them:

- (1) When you talk about the importance of cost containment, emphasize private as well as public cost containment. On your last visit, some Members thought you were focusing solely on federal costs.
- (2) While seeking input and support from all Members, avoid the impression you are anointing any single Member as speaking on your behalf. The message is that you are developing your own health reform plan with everyone's input.
- (3) The Congressional Leadership staff have indicated a willingness and a desire to pressure Members to hold off individual bills, as long as we are effectively pursuing a collaborative process to move your health care reform plan. We have agreed to begin that process in mid to late December.

THE HOUSE

- * **Congressman Gephardt:** Personally stated that you must make this your issue and your process. They want to provide you input, but believe you must lead process. Also, believes this must happen this year. Last year, he advocated a health care proposal with enforceable global budgets; he used his savings to begin to expand access and strongly believes that you cannot afford (politically) to use the savings for anything else other than reinvestment in health care.
- * **Congressman Rostenkowski:** Has stated that he will NOT introduce any legislation before you unveil your plan. As you know from your conversations with him, however, he believes that a reform plan should be one of your highest priorities, but thinks it cannot pass without your active and personal involvement. Last Congress, he introduced an employer-based, global budget, universal access plan. He had to incorporate additional revenues to pay for the legislation. It died like all other health care bills. (No bill will make it to the floor without first making it through Rostenkowski's Ways and Means Committee.)
- * **Congressman Dingell:** The Energy and Commerce Chairman has introduced a single-payer health care plan every year since he came into the House in the late 1950s. This year will be no exception, although his staff has indicated that he will be more than willing to be flexible. His Committee is the second most influential health care Committee in the House.
- * **Congressmen Ford (Education and Labor) and Moakley (Rules):** These two will be the most influential of the "other" Chairmen. Ford, because employer-based benefit issues come under his jurisdiction; Moakley, because no bill will go to the floor without a rule from his Committee. (Moakley has been a single-payer advocate). Ford, in particular, sometimes feels like a stepchild in the health care legislating process. Recognize their role.
- * **Congressman Montgomery:** As the influential Chairman of the Veterans Committee, he cannot be overlooked. His staff has expressed nervousness that this Committee and its interests will be ignored. Best to make sure that this perception is eliminated.
- * **Congressmen Stark and Waxman:** Although not full Committee Chairmen, these are the two "nuts and bolts" health care subcommittee chairmen. Stark teamed up with Gephardt last year, while Waxman went back to his single-payer roots. The two must be consulted during every step of your legislative development process.
- * **Congressmen Andrews, Cooper and Stenholm:** Are the leading proponents of the Conservative Democratic Forum(CDF)/managed competition element of the party. Important to assure them that their views will be taken very seriously. However, other Members are concerned that they perceive themselves to be your spokesmen. Avoid leaving this impression.

THE SENATE

- * **Senator Mitchell:** Is leading an effort by the Democratic Policy Committee to develop some degree of consensus among the Senate Democrats on health care. Although the prospects for a successful outcome of this process remain unclear, initial reviews have been positive and it would be good to commend Sen. Mitchell on his efforts.

- * **Senators Bentsen and Moynihan:** It is highly unlikely that any bill will have a chance on the Senate floor without first being favorably reported out of the Finance Committee. Senator Bentsen has not taken a position on comprehensive health care reform; he has cited the fact that there is no consensus on the issue among the Committee's Members as the reason for this position. His (likely?) departure may make it easier to get a bill marked up out of Committee, but may also make it more difficult to get it passed by the full Senate. (This is because his name on a bill will give cover to, and influence, key southern Democrats).

Like Bentsen, **Senator Moynihan** has not taken a position on national health reform. Based on his history, however, one might suspect that it would be easier to "sign him on" than it would be for Bentsen. Unfortunately, however, although Moynihan's intellect is well-respected, he does not have the same degree of credibility with Members south of the Mason-Dixon line. His most recent health care work has been associated with an unsuccessful effort to provide Medicaid managed care waivers to states.

If you see Senator Moynihan and he raises the Medicaid managed care waiver issue, we believe it is best to maintain the position you have taken with the Governors: You are exploring quick action to provide states immediate financial/administrative relief (adjusting the Bush regs; facilitating administration of the waiver process), and will fold in the broader Medicaid waiver issues (such as the managed care waiver) into the comprehensive reform legislative development process.

- * **Senator Kennedy:** As Chairman of the Labor Committee, Kennedy heads the second most influential health committee. Formerly an advocate of single payer, he has -- for the past 5 years -- advocated employer-based plans because he believes that the smaller revenues necessary to finance it make it more politically feasible. He is working closely with Senator Mitchell and his DPC workgroup. Advisable to recognize his historical and current work in this area, however.

- * **Senators Breaux and Boren:** These are the official "CDF" representatives in the Senate. Both seem to be willing to follow your lead, as long as there is a significant role for managed competition. Advisable to thank them for their assistance.

- * **Senators Daschle, Kerrey, Wofford and Bingaman:** These members, like Garamendi in California, would like to find a way to -- at least as much as possible -- break the employment link to the provision of health care. None of them are Chairmen, but all will be influential and should be recognized for their leadership.

- * **Senator Rockefeller:** An employer-based advocate who has been and will be very visible. It is advisable -- if you see him -- to privately acknowledge his hard work on the campaign and what an important player he will be in the health care debate. Not a good idea to publicly designate him, or any one Member of Congress, as your "special health care envoy."

HEALTH CARE - CONFIRMATION BRIEFING

SENATE FINANCE COMMITTEE

GENERAL OVERVIEW AND COMMITTEE MEMBER SUMMARIES

General Overview

- * With its jurisdiction over taxes, Medicare, Medicaid, and Social Security, the Finance Committee is the central clearinghouse for all major comprehensive health care reform proposals and other health initiatives. To have a real chance of getting reform legislation passed on the Senate floor, the bill must first be favorably reported out of Committee. As a result, a strong and productive working relationship with these 20 extremely influential Senators is absolutely essential.
- * During the last 12 years, the Members -- particularly the Democratic Members -- have grown extremely frustrated with the administration of Medicare and Medicaid by HCFA. They are optimistic about the likelihood for change, but would appreciate hearing how you share their concerns and how committed you are to working to see that the health care bureaucracy is organized to be as responsive as possible to the Congress, the states, consumers, and providers.
- * Every Member of this Committee has a number of health care provisions which were included in H.R. 11, the tax bill that the Congress passed, but the President vetoed last year. Most of the questions will be related to the rural health provisions of this bill, in particular, the provision dealing with extending the Medicare dependent hospital status out for a few more years. This issue is important to at least 8 members (Dole, Boren, Daschle, Durenberger, Grassley, Pryor, Breaux, and Rockefeller). Many of these and other Members will want to the know Administration's position on moving on all health provisions of the Senate passed bill EARLY in the 103rd Congress.
- * In terms of detailed and broad knowledge of health care policy, the Republican Members tend to outshine their Democratic counterparts. Senators' Packwood, Dole, Chafee, Durenberger, and Hatch are particularly impressive in this regard. With the exception of Senators' Mitchell, Rockefeller, and Daschle, the Democrats tend to avoid spending too much time on complex and controversial health care issues (leaving them to their staffs) and instead focus on individual pieces of the health care pie.

- * Based on preliminary discussions, it appears highly unlikely that you will receive anything but a gracious welcome from the Democratic Members of the Finance Committee. Most of them will want to focus on broad issues. For the most part, they simply desire to begin to get to know you and develop the basis for a strong relationship. The only way to alienate this Committee is to not actively listen to, or to trivialize, their concerns and questions.

- * The Republican greeting may not be as welcoming, but it may also not be as bad as some fear. Some within the party are apparently trying to dig up "dirt" and encourage some Members to use it. At this point, however, it is far from clear whether anyone on the Committee has any desire to use it. Rather, it is probably much more likely that they will attempt to maneuver you into saying something controversial about difficult policy issues. Although there are many questions that may emerge during your confirmation hearing (they are outlined in an attached document), the following are 10 thematic, difficult questions that you may well hear repeated throughout your confirmation hearing:
 1. **Rationing and Taxes.** How can the Clinton health care reform plan be implemented without rationing and/or raising taxes? Will he pledge not to raise taxes?
 2. **Abortion and Other Benefit Issues.** Will abortion services be covered in a national, mandated benefit package? Do we really need any more incentives for abortion? Will it cover RU486?
 3. **Tax Cap.** Is a tax cap on benefits a tax increase or a cost containment mechanism?
 4. **Oregon Waiver.** Since the President has indicated his support for the Oregon waiver plan, when can we expect to see it approved by HCFA? Will he approve immediate relief for financially-strapped states?
 5. **Medicare Cuts/Deficit Reduction.** In light of the growing deficit and how much health care costs contribute to it, should not savings from any reductions on Medicare growth be directed to help reduce this drain on our economy?
 6. **Small Business.** If the President-elect cares about jobs as much as he says he does, how can he even contemplate an employer mandate on the most delicate and essential element of our recovering economy?
 7. **Rural Health.** How can the President's managed competition plan work in rural areas? What is he going to do to ensure access to affordable and cost-effective providers in medically underserved rural areas of the nation?
 8. **Long-Term Care.** How will the President fulfill and pay for his campaign promise to provide long-term care?

9. **Marijuana Legalization.** Do you share the perspective of the likely future Surgeon General that marijuana should be legalized for medical use?
10. **Public Financing of condoms, AIDS and Pregnancy Counseling.** Do you mean to suggest that taxpayers should be forced to pay for condom distribution and pregnancy/abortion counseling in all of our children's schools?

COMMITTEE MEMBERS SUMMARY

The following provides a health care background summary for each Senate Finance Committee Member. Each name is listed in order of seniority and by party affiliation. After each summary, there is an italicized "headline" listing of all the health care provisions of the tax bill (H.R. 11) that were either sponsored or supported by the Finance Committee Member. If the Member sponsored his own bill (and, therefore, there is a greater chance that he will ask a question on the subject), the bill number is bracketed. If the Member did not introduce the legislation, but has a particular interest in the provision, there is an asterisk before it. (In the event you wish to familiarize yourself with the various provisions of the tax bill, two summaries of this bill -- one short and one much longer and more detailed -- are attached for your review at the end of this document.)

Please note that practically every Member of the Finance Committee is supportive of the expansion of the self-employed tax deduction for health care from 25 percent to 100 percent. It is not listed in the following summary because it is considered a tax issue, although most Members associate it with incremental health reform. Some of these Members may raise the question of the status of the tax deduction increase. The best answer is to say that the President-elect is very supportive and would like to include it within the context of overall health care reform.

Senator Lloyd Bentsen. Although the former Chairman will not be in attendance, this will be just the second hearing that he is not presiding and it would be wise to acknowledge his absence and his leadership on the Finance Committee. You may even want to say something funny, like how pleasant and accommodating Senator Bentsen said the Finance Committee Members were to him. (They lived in fear of him).

Democrats

Senator (Chairman) Daniel Patrick Moynihan

The new Chairman is not a detail person when it comes to the health care debate. He is much more likely, if he asks anything at all on health care, to ask extremely broad questions on the issue. In previous hearings, he has wondered and complained out loud how no one has really been able to tell him where all these health care costs come from. He may ask you for your opinion.

Other than the above, there is an extremely limited number of health care-specific questions that Senator Moynihan may ask: He may ask questions about where you see Clinton (and yourself) coming down on the issue of the homeless and the mentally ill within the overall health care reform question. He is also interested in adequate coverage of substance and chemical abuse treatment. In addition, he appears to be somewhat sympathetic to the financial and administrative burdens that states face. This interest was incorporated into a relatively controversial (CDF opposed it) state managed care waiver bill that did not make it through the Congress last year. Although it is very doubtful, he may ask for your position on this, particularly as it relates to your former CDF position.

The only health care provider interests that appear to have some significant sway with the Senator on the health care issue are his powerful and influential in-state hospitals. Having said this, it is unlikely that any issues will be raised regarding the hospitals.

An important issue has come to our attention very recently. HCFA is disputing the State of New York's Medicaid plan amendments which would require a one-time retroactive payment of approximately \$200 million to New York for indigent state psychiatric problems. Senator Moynihan will likely raise this problem during your private meeting with him or (less likely) at the confirmation hearing. We are now looking into this issue to determine if these dollars are counted in the current budget baseline. If not, New York and New Jersey's combined retroactive payments may require over \$650 million in federal spending for Medicaid. No policy decision or recommendation has been made.

Although true about ANY Member, Senator Moynihan is -- above everything else -- unpredictable. Be prepared for anything. Lastly, it is clear that he intends to be very supportive of you and it appears highly unlikely that you will have any problems whatsoever with the senior Democrat from New York.

Moynihan sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- *repeal of reduced payments under Medicare for new physicians (Sec. 112);*
- *review and revision of geographic practice cost index (Sec. 114);*
- *extending Medicare coverage for oral cancer drugs (Sec. 128).*

MEDICAID:

- * - *waiver of the 25/75 rule (Sec. 252);*
- * - *rolling one month eligibility (Sec. 253);*
- * - *enhance match for quality review (Sec. 254);*
- * - *increase in Medicaid waiver period from 3 to 5 years (Sec. 251);*
(these 4 provisions represented a controversial compromise -- that the
Conservative Democratic Forum and Waxman still opposed -- on Moynihan's
managed care legislation [S.3191])
- *Institutions for Mental Disease (IMD) exclusion (Sec. 231);*
- *freedom of choice (Sec. 251);*
- *optional foster care (Sec. 271);*
- *substance abuse (Sec. 232);*
- *change in conditions for audits and disallowances of payment (Sec. 283).*

Senator Max Baucus

In the last several years, Senator Baucus has not been a major health care player. Although, like most of the others, he considers himself to be one. Probably his best known health care achievement was an amendment named after him (the Baucus Amendments), which reformed the plagued Medicare supplementary insurance (Medigap) market in the early 1980s. He also has sponsored -- like most other Members of this Committee -- many rural health care initiatives. Since Montana has many truly "frontier" health care facilities, these initiatives were (and are) very important to his constituents and he is justly quite proud of them.

Senator Baucus was a member of the famous Pepper Commission. Most notably, however, he voted against the final access recommendations (they won by just an 8-7 vote), primarily because of his concern about the proposal's impact on small business. Baucus considers himself to be one of small businesses best friends and this is, of course, particularly relevant to any proposal that utilizes any employer requirement to help finance health care. As a result of this concern, and because the Canadian system is quite popular in Montana, he is a single-payer advocate. In fact, he is a member of a 5-Member working group (Daschle, Kerrey, Bingaman, and Wofford) that is looking at alternatives to employer-based models.

Senator Baucus is likely to focus his comments on the need for real cost containment, sensitivity to legitimate small business concerns, and the advisability of a special consideration for rural concerns. Although he, too, can be unpredictable, it is doubtful that he will either stray too far from these issues or give you anything but a relatively welcome greeting.

Baucus sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- *separate payment for interpretation of EKGs (Sec. 111);*
- *repeal of reduced payments under Medicare for new physicians (Sec. 112).*

Senator Bill Bradley

Senator Bradley is known more for his work on tax policy than for his work on health care financing. The press loves Bradley, but the Members are not as impressed with his approach or style to the political process. Having said this, as a Rhodes Scholar, he has a kinship with the President-elect and feels generally comfortable with descriptions of himself as being a "New Democrat." He has indicated an interest in introducing health care reform legislation similar to what the President-elect has been advocating. The one exception to his general support of the Clinton health care approach may well be with regard to prescription drugs. As a Senator representing the state which is the capital of the pharmaceutical industry, Bradley is a fierce advocate for the industry and their concerns. With Senator Hatch, he led the fight against Senator Pryor's effort to influence the industry to contain price increases to inflation by linking their pricing behavior to eligibility for tax credits. (The Pryor proposal was endorsed by Clinton in the campaign). In recent weeks, he has discussed with Bill Clinton the industry's willingness to moderate their prices to inflation. Although the President-elect has indicated that this is an encouraging sign, there are still a number of outstanding questions related to enforcement of the pledge and whether or not the pledge would really keep prices to inflation for individuals who do not have drug coverage.

As a member of the Infant Mortality Commission, Senator Bradley is proud of his work to ensure that the Medicaid program was expanded to eventually cover pregnant women and kids. He also is a strong advocate for preventative care services. He has sponsored several bills on tobacco, including revised warning labels and tobacco as a drug to be included in the Drug Free Schools program. Lastly, although he incurred the wrath of some aging groups with his opposition to prescription drug price constraint, he has been a long-time supporter of home and community-based long term care services, particularly with regard to respite care services.

He can be expected to be very supportive of your appointment. It appears doubtful that he will spend any time on questions with regard to the pharmaceutical industry. It is more likely that he will focus on children's health issues, as well as (possibly) the respite care issue.

An important issue has come to our attention very recently. HCFA is disputing the State of New Jersey's Medicaid plan amendments which would require a one-time retroactive payment of approximately \$450 million to New Jersey for indigent state psychiatric problems. Senator Bradley will likely raise this problem during your private meeting or (less likely) at the confirmation hearing. We are now looking into this issue to determine if these dollars are counted in the current budget baseline. If not, New Jersey and New York's combined retroactive payments may require over \$650 million in federal spending for Medicaid. No policy decision or recommendation has been made.

Bradley sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- *delay change in paying for anesthesia services from actual to average time spent (Sec. 113);*
- *extending Medicare coverage for oral cancer drugs (Sec. 128).*

Senator David Boren

Although not generally associated as a health care reform leader, Senator David Boren is the lead sponsor of the Senate companion (S. 3299) to the House Conservative Democratic Forum's managed competition bill. In recent months, however, he has become more sensitive to the inability of the Conservative Democratic Forum's approach to adequately address the access or cost containment challenge. Like virtually every member of the Committee, he considers himself to be a strong supporter of rural health and small business issues. Like Bradley, though, he has been traditionally been more focused on tax policy than health care.

He may talk briefly about his health care proposal, but his unease with the issue is more likely to ensure his health care oriented questions are not too detailed or difficult to answer. The exceptions to this rule may be his desire to indicate the importance of assuring significant state flexibility within the context of any health reform proposal (his Governor is pushing a major initiative in Oklahoma now and wants some significant assistance/relief from the Federal Government) and to discuss how desirable it would be to provide some immediate relief for rural hospitals (as was included in the Congressionally-passed, but Presidentially vetoed, H.R. 11).

Boren sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- * - continuing special payment for Medicare dependent rural hospitals (Sec. 102);
- * - reauthorizing rural health transition grants (Sec. 103);
- extending Medicare coverage for oral cancer drugs (Sec. 128).

MEDICAID:

- * - change in conditions for audits and disallowances of payment (Sec. 283).

Senator George Mitchell.

Few Majority Leaders in the Senate's history have been as interested and as committed to passing comprehensive health care reforms. Unfortunately, to date, he has yet to be very successful in achieving consensus even within the Democratic party as to what to do. This is not due to any lack of effort on his part, however.

Mitchell is the sponsor of two Senate Democratic leadership comprehensive reform bills dealing, respectively, with access (S. 1227, Health America) and long-term care (S. 2571, the Long Term Care Family Security Act). In addition, he has initiated what appears to be a promising effort by the Democratic Policy Committee (within the Senate) to attempt to develop consensus on the health care issue within the Democratic party.

Senator Mitchell believes that the single payer approach is not politically feasible. However, at this point, his primary concern and commitment is to push through anything that will pass the Congress. He has repeatedly indicated his intention to work closely with the new President to help assure that a bill can make it to the White House before the end of the 103rd Congress.

Senator Mitchell's long-standing interest in health care comes from his tenure as Chairman of the Finance Subcommittee on Health. (This Subcommittee was subsequently divided up into two Subcommittees -- now chaired by Senators Rockefeller and Riegle). Mitchell's most notable work off the Subcommittee: groundbreaking nursing home reforms, the establishment of the Agency for Health Care Policy Research (AHCPR) (the agency charged with doing medical outcomes research and developing practice guidelines), and a significant amount of work on the ill-fated catastrophic health care law.

The Majority Leader can be expected to be very supportive of you. Since his time is almost always limited, his questions are likely to be brief. He may choose not to ask questions and use his time for a welcoming statement and a discussion of the importance of ensuring that cost containment is reinvested into the overall health care reform initiative -- rather than short-term deficit reduction. In other words, he strongly believes that only way to achieve savings and support for reform is to ensure that any savings be reinvested for health.

Mitchell sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- *repeal of reduced payments under Medicare for new physicians (Sec. 112);*
- *separate payment for interpretation of EKGs (Sec. 111);*
- *review and revision of geographic practice cost index (Sec. 114);*
- *standards for durable medical equipment (Sec. 121);*
- *extending Medicare coverage for oral cancer drugs (Sec. 128).*

MEDICAID:

- * - *extension of maternal and child health demonstration project (Extremely important to Maine -- see long summary of Medicare tax bill);*
- *IMD exclusion (Sec. 231);*
- *freedom of choice (Sec. 251);*
- *optional foster care (Sec. 271) .*

Senator David Pryor

Senator David Pryor is part of the Senate leadership (Secretary of the Democratic Conference) and is probably Bill Clinton's closest friend in the Senate. As the Chairman of the Senate Special Committee on Aging, he is well liked and trusted by the powerful aging advocacy community. In addition, he is one of the few Democrats that the small business community genuinely trusts. Further, his role as a former Governor and his advocacy of state-based approaches to comprehensive reforms has gained him a great deal of good will with the Governors. Although an unassuming Member and one who does not get overly involved in detailed policy discussions, he has also emerged as one of the most influential and best liked Members of the Senate. All of these roles ensure that he will be a particularly key player on the health care front. As a result, a good relationship with him is extremely important.

In terms of health care priorities, drug cost containment is the first, second, and third highest priority for Senator Pryor. The concept of linking drug cost containment to tax credits (embodied in Pryor's Prescription Drug Cost Containment Act -- S. 2000) was endorsed by President-elect Clinton. In addition to his drug cost containment interests, he also has a notable legislative achievement record in rural health (relief for hospitals and incentives for primary care doctors in medically underserved areas), state-based reform (his NGA-endorsed Leahy/Pryor bill), and long-term care (his proposal for Federal standards for private long-term care insurance policies).

Further, like most other Members, he has a gut level distaste for HCFA and the way it has traditionally run its programs. Some think that Senator Pryor's frustration with the agency may have contributed to the Clinton comment that he would like to get rid of HCFA. Finally, although not health specific, for over a decade, Pryor has made it his mission to end the over-utilization of private consultants to do Government work, seeing it as an unacceptable conflict of interest. He might be impressed if you acknowledged his work in this area.

Senator Pryor's questions will almost inevitably be related to prescription drug costs. This is his baby and the best advice is to NOT cross him on this issue and make a point of commending him for his long-standing work on this issue. If he goes into any other area, it will probably be questions related to the need for state flexibility and for responsiveness to small business concerns. He is a big advocate for expanding the self-employed tax credit to 100 percent which Clinton endorsed. You will find him, however, to be the classic southern gentleman and, as long as you are generally responsive to his concerns, he will be very supportive of your work.

Pryor sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- delay change in paying for anesthesia services from actual to average time spent (Sec. 113);

** - continuing special payment for Medicare dependent rural hospitals [S. 2400] (Sec 102);*

- extending Medicare coverage for oral cancer drugs (Sec. 128);

- standards for durable medical equipment [S.3270] (Sec. 121);

- physician payment limits [S. 2698] (Sec. 115).

MEDICAID:

- change in conditions for audits and disallowances of payment (Sec. 283).

Senator Donald Riegle.

As you noted from your meeting with Senator Riegle, he will be extremely supportive of your appointment. He is extremely pleased with your support of children's issues and your commitment to do whatever you can to ensure an adequate budget for your massive mandate.

Senator Riegle considers himself to be a major player in the health care debate. He is Chairman of the Finance Subcommittee on Medicaid and was a lead sponsor of the Mitchell, Rockefeller, Kennedy "play or pay" health care reform proposal. He has always felt he did not get adequate credit for his work on the bill. Although he sponsored this bill, he appears to be extremely willing to sign on to virtually any approach that achieves universal coverage and cost containment.

Senator Riegle is very interested in many health issues, including: child immunization programs, rural health care, Medicare prescription drug coverage, retiree health liability concerns, long-term care, and a host of others. Some within and outside of the Congress view his broad-based interest in these and other, non-health care issues to also be one of his greatest weaknesses. That is, he tends to focus on so many things that he does not acquire enough expertise or credibility to push on any one issue.

The questions posed by Senator Riegle are likely to be softballs. His staff says it will be a love feast. Senator Riegle's questioning time is frequently used for statements that illustrate his concern and knowledge about an issue. Frequently, they end up with a "do you agree" type question. Although he may talk about virtually anything, Senator Riegle is most likely to focus on his strong belief that cost containment savings be used to help reform the health care system -- NOT for deficit reduction.

Riegle sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- *separate payment for interpretation of EKGs (Sec. 111);*
- *repeal of reduced payments under Medicare for new physicians (Sec. 112);*
- *delay change in paying for anesthesia services from actual to average time spent (Sec. 113);*
- *physician payment limits (Sec.115) ;*
- *extending Medicare coverage for oral cancer drugs (Sec. 128);*
- *Medigap duplication.*

MEDICAID:

- * - *extension of maternal and child health demonstration project (see long summary of Medicare tax bill);*
- * - *change in conditions for audits and disallowances of payment (Sec. 283).*

Senator John "Jay" Rockefeller.

Senator Rockefeller views himself as being Bill Clinton's number one health care advocate. He certainly has reason to lay claim to this title. He was a tireless campaigner and defender of the Clinton health care plan. He also was a National Co-Chair of the Clinton campaign. He should be praised and thanked for his past, current, and likely future efforts on behalf of the President-elect.

Rockefeller is the current Chairman of the Finance Subcommittee on Medicare and Long Term Care. He also has chaired the Pepper Commission and the National Commission on Children. In addition, he is the founder and Chairman of the Alliance for Health Reform, a nonpartisan organization dedicated to advance health care reform through education of public opinion leaders -- elected officials, congressional staff, business leaders, and the media. Lastly, beginning this year, he will be the new Chairman of the Senate Veterans Committee.

Rockefeller's health care legislative work is quite impressive. He joined Senator Mitchell in drafting and introducing HealthAmerica and the Long Term Care Family Security Act. In addition he introduced the recommendations of the National Commission on Children in the form of two bills: the Family Income Security Act and the Family Investment Act. The latter bill would fully fund HeadStart, WIC, and Childhood immunization. Although these bills have not been enacted, he has successfully enacted the following bills (that are particularly important to him): (1) the Retired Coal Miners Health bill, which salvaged financially troubled private retiree health program for coal miners and was enacted last year; (2) a bill to ensure that the VA program gets more reasonable prescription drug prices, also enacted last year; (3) a bill to provide additional funding to Medicaid home and community-based waiver programs, which was enacted in 1990; (4) a groundbreaking reform on Medicare physician reimbursement, which reorients reimbursement towards primary care and away from specialists, which was enacted in 1990; and (5) the Rural Health Clinic Act, which promotes expansion of clinics in rural areas and which was enacted in 1989.

Senator Rockefeller's health care priority is very simple: He desperately wants to see a comprehensive reform package enacted during the Clinton Presidency. Although he thinks the long-term outcome of such an achievement is politically attractive, he is primarily pushing this reform because he is sincerely committed to the need for reform. In this vein, he is not overly committed to any one particular approach. He, therefore, can be counted on to support virtually anything Clinton proposes, as long as it achieves universal access and cost containment.

Because he wants to help Clinton in any way he can, Rockefeller's questions are likely to be aimed at making you look good. He may ask you about whether you believe the Congress should move quickly to pass the health care provisions of H.R. 11. He has a number of provisions in the bill of interest to him, but the most important one seems to be related to one that expands coverage of Medicare for oral cancer drugs.

Very recently it has become apparent that Rockefeller will ask you about HCFA's new regulations affecting and narrowing states' ability to fund their financially-strapped Medicaid

programs through provider taxes/donations and disproportionate share payments (reimbursement for hospitals disproportionately serving the uninsured and poor). He will ask what, if anything, the new Administration is going to do about it (West Virginia is running afoul of this regulation; this could mean millions of dollars in recoupment from the state and Rockefeller is extremely concerned). The answer to his question is that Clinton is very sympathetic and wants to find a way to help out, as long as it does not cost too much money. (We are working on options that we need to discuss with you in the very near future.)

Rockefeller sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- reauthorizing rural health transition grants (Sec. 102);
- separate payment for interpretation of EKGs [S. 1810] (Sec. 111);
- repeal of reduced payments under Medicare for new physician [S. 1810] (Sec. 112);
- review and revision of geographic practice cost index (Sec. 114);
- delay change in paying for anesthesia services from actual to average time spent (Sec. 113);
- * - extending Medicare coverage for oral cancer drugs [S. 1996] (Sec. 128);
- physician payment limits (Sec. 115);
- * - psychologists may treat Medicare patients without physician supervision.

MEDICAID:

- substance abuse (Sec. 232);
- * - change in conditions for audits and disallowances of payment (Sec. 283).

Senator Tom Daschle.

Senator Daschle is the Co-Chair of the Democratic Policy Committee. (He Co-Chairs it with Majority Leader Mitchell). He is one of the more well informed Democratic Members on health care issues and rarely can resist sharing his knowledge at any appropriate forum.

Senator Daschle is most well known on and off the Finance Committee for his Medigap (private supplementary insurance to Medicare) reform initiative, which was enacted into law in 1990. The new law has worked to clean-up a private insurance market plagued with major abuses (by establishing new regulations governing the marketing, sale and content of Medigap policies) . His other enacted legislative achievements include: (1) establishing the "EACH" (Essential Access Community Hospitals) program that converts failing rural hospitals into low-intensity, short-stay facilities eligible for Medicare payments and (2) a provision providing direct Medicare reimbursement for nurse practitioners who provide services to Medicare patients in rural areas. Obviously, he like almost every other Member of the Committee considers himself to be one of the Senate's foremost legislators on rural health care.

Daschle is much more comfortable with a single-payer type approach to health care, primarily because he believes it is a much easier political sell to his small business folks and the rest of his constituents. In fact, he joined Senator Harris Wofford in introducing legislation (S.2513) to achieve this end.

The Daschle/Wofford bill would be administered by states and would provide an acute and long term care benefits package to all Americans, which would be designed by an independent Federal Health Board -- modeled after the Federal Reserve. Although he much prefers a single entry point for raising revenues to pay for health care, he does not believe it needs to flow through the Federal Government in the form of new taxes.

While he and his staff are participating in Senator Mitchell's DPC working group, Daschle is also leading a separate working group (the one with Senator Baucus, mentioned above) that is developing alternative approaches to health reform. Daschle is the penultimate team player, however. As part of the Senate leadership, he can be counted on to push his agenda as far as it can go, but he will also do everything he can to assure that we pass comprehensive reform and the President-elect's plan. He will probably use his time to welcome you and ask you some relatively easy questions about the need for restructuring the health care system from one that is overly specialist-based, to one that has a much greater emphasis on primary care.

Daschle sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- * - continuing special payment for Medicare dependent rural hospitals (Sec. 102);
- separate payment for interpretation of EKGs (Sec. 111);
- extending Medicare coverage for oral cancer drugs (Sec. 128).

MEDICAID:

- *IMD exclusion (Sec. 231);*
- *freedom of choice (251);*
- *optional foster care (271).*

Senator John Breaux.

Senator Breaux is the newest addition to the Finance Committee, although with Chairman Bentsen's departure, there will be one more. He is one of those "up and coming" New Democrats for whom many see a bright future. He also is someone who feels (and is) very close to Bill Clinton. He will not hesitate to pick up the phone and call him, and Clinton will take the call.

Previous to this year, Senator Breaux was not overly active in health care issues. 1992 changed all that when he introduced the Conservative Democratic Forum's managed competition bill with Senator Boren. He is very concerned, however, about the bill's limitations with regard to assuring adequate access to health care in rural areas. He is also concerned about whether this approach will actually achieve broad-based costs savings. Having said this, he remains uncomfortable with alternative approaches to date and he will want to make sure that the Conservative Democratic Forum's model is utilized as much as possible during the upcoming debate.

Senator Breaux is yet another of the Committee members who care deeply about small businesses and rural health care. In addition to the CDF bill, Senator Breaux introduced with Senator Daschle H.R. 3280, a bill to set up an infrastructure trust fund to help rebuild and rehabilitate public hospitals. His interest in this issue stems from the poor condition of the Charity Hospital system in Louisiana.

Senator Breaux's main questions on health care are likely to center around H.R. 11, and how to improve access to health care in rural areas. Because of his interest in access to health services in rural areas, he also may inquire into new rules limiting self-referrals by Medicare providers. He will be interested in the possibility of an exception for sole providers of unique services who have no record of abusing the system. He is also likely to be interested in the new Medicaid disproportionate share regulations, and the negative financial impact they will have on the states. In addition, he may seek support for the AIDS Clinical Trial Units, a competitive NIH grant which received insufficient funding for the current fiscal year. This caused a cutback in programs run by the Tulane University Hospital and Charity Hospital of New Orleans.

Breaux sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- continuing special payment for Medicare dependent rural hospitals (Sec. 102);
- separate payment for interpretation of EKGs (Sec. 111);
- repeal of reduced payments under Medicare for new physicians (Sec. 112);
- * - psychologists may treat Medicare patients without physician supervision.

MEDICAID:

- change in conditions for audits and disallowances of payment (Sec. 283).

REPUBLICANS

Senator Bob Packwood.

Senator Packwood is an advocate of an employer-based universal coverage plan. He is the only Republican on the Finance Committee that has publicly supported an employer mandate. As a result, he may feel in a somewhat uncomfortable position with many in the Senate leadership--who are likely to vehemently oppose an employer mandate. Packwood attacked his opponent's (AuCoin) single-payer approach last year as a multi-billion dollar tax increase that would result in a government run system. In Oregon, at least, Packwood won the debate.

The primary criticism of Packwood's plan is that it didn't go far enough on the cost containment side. Some of the aging advocacy groups also criticized it for its lack of comprehensive long-term care coverage.

Any Member from Oregon must, almost de facto, defend and strongly support the now famous Oregon Medicaid waiver proposal. Packwood is no exception and he can be expected to push you on this issue, particularly keeping in mind your past association with one of the most visible critics of the plan -- CDF.

Beyond the above-mentioned work, Senator Packwood has had a notable health care career. He has sponsored quite a bit of legislation dealing with rural health and long-term care (LTC). Specifically, he introduced a relatively extensive public/private LTC bill in the 101st Congress. However, because it costed-out as a rather expensive initiative and because the aging advocates were not enthralled with it, he decided to stick to Federal standards and tax clarifications for private LTC insurance policies. In addition, working with Pryor, he introduced legislation that could provide tax credits for primary care personnel to serve medically underserved rural areas.

Questions from Packwood could range from the status of H.R. 11, to the Clinton Administration's position on the Oregon waiver to questions that illustrate his pro-choice support (and perhaps deflect some criticism away from him). The latter line of questioning, though, could well backfire and we believe he is too smart of a politician to take that chance.

Packwood sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- *separate payment for interpretation of EKGs (Sec. 121);*
- *repeal of reduced payments under Medicare for new physicians (Sec. 112).*
- *delay change in paying for anesthesia services from actual to average time spent (Sec. 113).*

Senator Bob Dole.

The Minority Leader is, without question, the most influential Senator among Republicans. As an ally, he can be absolutely invaluable. As an enemy, he can be vicious and effective. Currently, it appears he is trying to decide whether health care reform should be a partisan or a bipartisan issue. He has members who are strongly pushing him on both sides of the question -- with the majority probably urging him and the Republican Party to stake out this issue as an effective contrast with those "pro-government, pro-regulation, pro-employer-mandate and pro-taxing Democrats."

The betting from here is that he and his staff will opt to appear to be willing to work with the Democrats, but will eventually choose to turn on the new Administration on the reform issue. While this could be terrible for comprehensive reform, it could also mean that he will want to appear to be helpful in other health care areas. These could include: the usual, modest Medicare/Medicaid changes, a greater openness to traditionally too-hot-to-touch public health issues, and a willingness to refrain from making a stink over any -- except the most controversial -- of the upcoming political appointments at HHS.

If ugly questions do arise during the confirmation hearing, however, you should know that they came to fruition with at least the tacit approval, if not the outright endorsement of, Senator Dole. Questions from Dole will likely be varied, but one thing appears certain: He is greatly interested in and concerned about the extension of the Medicare dependent reimbursement designation for his rural hospitals. He was successful in getting this provision in H.R. 11 last year and is likely to want to see it revived soon. His desire to do so could make it possible for a revival of the bill -- as long as he pushes to ensure that there are no other major and/or controversial Republican amendments to last year's bill. (This would not be the time for a Christmas tree initiative that could embarrass the new President.)

Lastly, his chief of staff is a major player in health care. Sheila Burke, a nurse, is one of the strongest, most knowledgeable and most intimidating staffers on the Hill. She also has many close relationships with the Department. Like Dole, it is important to cultivate a friendship and to avoid, at all costs, a negative and potentially damaging relationship.

Dole sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- * - continuing special payment for Medicare dependent rural hospitals (S. 3117) (Sec. 102);
- separate payment for interpretation of EKGs (Sec. 111);
- delay change in paying for anesthesia services from actual to average time spent (Sec. 113).

Senator William (Bill) Roth.

Until the last couple of Congresses, Senator Roth was not known for his involvement in health care. As Ranking Member of the Government Affairs Committee, he has had extensive involvement and interest in the Committee's Permanent Subcommittee on Investigation's inquiry into the multi-billion dollar issue of health care fraud and abuse.

Roth and his subcommittee staff found many instances of health care providers billing and receiving fraudulent Medicare payments under the Medicare as Secondary Payer (MSP) law. This law prohibits Medicare from serving as the primary payer when the beneficiary is employed and has private health insurance (He found that providers would be paid on the full amount by both the insurance company and Medicare, which should only pay the balance). He believes that there could be much better administration of the MSP program, which would hopefully ensure that this type of fraud does not continue.

More recently, Roth has actively advocated that the Federal Employee Health Benefit Program, which the Government Affairs Committee oversees, be extended to the working uninsured and small businesses. (This is similar to, and builds on, a proposal that has been championed by the Heritage Foundation.) Under this proposal, the self-employed and working uninsured would have access to the FEHB plans that were utilizing managed competition as a cost containment/quality assurance mechanism. In so doing, these individuals would have access to the same rates that the insurers charge the federal government and their employees for the benefits.

Senator Roth is likely to ask you about the above two issues as well as his on-going interest in support of prostate and breast cancer prevention. He is generally not a tough questioner and you should not have too many problems with him.

Senator John Danforth.

Senator Danforth is to cost containment what Bob Packwood is to mandates. He is the most likely to state that strong federal/state caps on spending must be imposed to effectively contain health care costs. He states his strong views on this issue repeatedly, despite admonitions from his staff and other Republicans that such statements are not consistent with the Republican Party line.

Although willing to support the need for strong government cost regulation, he also believes that to do so would require explicit rationing. (And, yes, he is a big fan of the Oregon waiver). What is more, unlike most Democrats, he desires to publicly proclaim that rationing is necessary and something we must own up to. (In taking his position on health care cost containment, he makes both Democrats and Republicans, as well as his staff, very nervous).

If Senator Danforth should pursue his usual line of questioning, he may well open the discussion with such items as how much we spend in the last year/month of life and how much we are spending on our elderly versus our children, etc. He then may attempt to push you on answering difficult and incredibly controversial ethical issues. In response, you may wish to consider praising him for his sponsorship of legislation in the 1990 reconciliation bill that directs hospitals to inform Medicare patients of their advanced directives/living will options. Then, it would be probably best to acknowledge concern, commit to working with him on these and other difficult questions, and then move on.

Senator Danforth is one of the most respected and influential Members of the Senate. There is no question that Clarence Thomas could not have made it through his confirmation process without Danforth as his strong and unyielding advocate. He is one of Bill Clinton's best opportunities for a Republican ally during the upcoming health reform debate. It is, therefore, extremely important that the Clinton Administration cultivate and strengthen our relationship with him.

Danforth sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- *separate payment for interpretation of EKGs (Sec. 111).*

Senator John Chafee.

Senator Chafee is the Chair of the Republican Task Force on Health Care. He likes to point out that the bill his group introduced in the last Congress had the most cosponsors of any major comprehensive health reform bill; one assumes he will not be shy now about citing this fact again. He may well also continue to exhibit the monumental chip on his shoulder about last year's health care debate with the Democrats. It is his strong belief that, if not for Presidential and partisan politics, there was enough consensus between his and many Democrats bills to move forward on many high priority health reform proposals.

If Chafee takes this course of discussion, he will discuss common ground issues: self-employed tax deduction increase to 100 percent, insurance market reform, expansion of community health centers and other health care delivery systems, and state experimentation -- to name a few. He may charge that the Democrats sacrificed these and many other important health care improvements because they wanted the issue more than the legislation.

On the Committee, Senator Chafee is primarily known for his long-standing interest in providing alternative care settings -- through the Medicaid program -- to persons who are disabled. He and his staff are literally heroes with many in this field, particularly those who advocate non-institutional care approaches. He is also well known for his strong advocacy of, and relationship with, community health care centers. In addition, he -- like a number of the Finance Committee membership -- are growing weary of funding programs for the elderly when there are so many needs in the non-elderly population.

Lastly, and most recently, he has criticized the Medicaid drug rebate law (a 1990 statute that requires that the Medicaid program have the benefit of the same low cost deals that the private sector receives), and not so indirectly, David Pryor, for the perceived problem of the law providing incentives for cost-shifting to the private sector. This is a controversial and complex issue that involves more than just policy, but the best advice from here is to lay low on this matter and state that you are aware of the issue and look forward to working with both Senator Chafee and Senator Pryor in the upcoming months and years.

Despite his bitterness over last year's health care reform debate, Senator Chafee is still one of the better liked Members of the Senate. He has an extremely dry wit that almost always livens up Finance Committee hearings. Although in recent years he has hesitated to go against party line (possibly a result of his loss of an important Republican leadership position and his desire to regain it or some other post), his general operating mode is to find a way to cut through the politics and develop a reasonable and bipartisan approach to health care and other issues on and off the Committee. He also is a true moderate Republican who does truly want to reform the health care system and, as such, also has some potential to ally himself with a number of Republicans and join a moderate Administration health care reform proposal. Like Danforth and a number of others on the Committee, it is important to build a particularly positive relationship with this Rhode Island Senator.

Chafee sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- *geographic adjustment factor (Sec. 114);*
- *oral cancer drugs (Sec. 128).*

MEDICAID:

- *review and revision of geographic practice cost index (Sec. 114).*

Senator Dave Durenberger.

Senator Durenberger is one of the Committee's most well versed Members on health care reform. He also is one of the few Members (Orrin Hatch being the one other notable exception) who has served concurrently on the Labor and Human Resources Committee (the other major health care committee, with jurisdiction over PHS, the FDA, and the NIH) and the Finance Committee. He knows insurance issues better than anyone on the Committee and he is not shy about sharing his wisdom/knowledge. He is a moderate who is viewed by the Republican leadership as somewhat of a loose cannon. Because of this and his long-standing interest in health care reform, Durenberger, too, is a candidate to be a possible and important ally.

In the last Congress, he joined Senator Bentsen as the lead Republican on the Texas' Senator's incremental (insurance market reform, etc.) health reform initiative. He has been a key health care player for years, however. He now is the Ranking Republican on Jay Rockefeller's Subcommittee on Medicare and Long Term Care, and he has served as either a Chairman or Ranking Member of this Committee (or its previous namesake, the Subcommittee on Health) for years. In addition, he joined Senator Pryor, the late John Heinz, and Jay Rockefeller in serving (as a Vice-Chair) on the Pepper Commission. He joined Heinz and all the other Republicans in voting against the access recommendations of this Commission, but he did vote for the long-term care recommendations).

It is important to note that it was unclear that Durenberger was going to vote against the Pepper Commission recommendations until very late in the process. An important offshoot of this experience, though, was that he and Jay Rockefeller became very close during this experience. This relationship was further cemented in 1990 when they joined together in drafting landmark physician payment reform legislation. This legislation is now working to reorient the skewed specialist-biased reimbursement system in favor of primary care providers. Although this new law is not flawless, it worked to increase his expertise in this area. In past years, he developed an impressive legislative initiative achievement list related to rural health care, long-term care, and hospital-based reimbursement reforms.

The other Democrat he has a fairly good relationship with is David Pryor. He has worked with him in the last two years to help scare the pharmaceutical industry into being more responsive to the legitimate price sensitivity concerns that Pryor has raised. Although he has not advocated the Pryor approach to drug cost containment, he has expressed great sympathy to it.

Most recently, Durenberger has focused on state-based comprehensive care initiatives. This is because he does not believe that a consensus yet exists for national reform and because his own state is tired of waiting. Minnesota has a long tradition of moving ahead on health care reforms and is THE nation's capital of managed care/HMO delivery systems. It is one of the 5 or 6 states that has gone ahead and passed legislation to implement its own reform proposal. The primary shortcoming in Minnesota's new law is that it cannot raise the money

it needs to finance its program without ERISA waivers. These waivers are necessary to allow the state to implement a provider tax on all patients WITHOUT running afoul of the ERISA law, which protects self-insured health plans from these taxes. Without the waivers, it will probably be impossible to finance the Minnesota plan. As such, Durenberger has recently advocated legislation to provide such waiver authority for states like Minnesota. (It is important to note, however, that ERISA waivers are granted out of the Labor Department and he probably will not spend too much of your time asking questions about this.)

It is impossible to predict questions from Senator Durenberger. He frequently offers a rather long-winded discussion that preps his question and then asks for feedback to his extended train of thought. Sometimes this can be difficult to follow and it is necessary to pay close attention. He likes to engage in substantive exchanges, but is not likely to be openly or visibly disappointed if you cannot address a question directly. The only likely question (extracted from his staff) is one related to the administration of the Department in general and HCFA in particular. He apparently has some ideas that he would like to share with you and would like to hear what you, as an experienced administrator, are thinking in this regard.

Durenberger sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- * - continuing special payment for Medicare dependent rural hospitals (Sec. 102);
- separate payment for interpretation of EKGs (Sec. 111);
- delay change in paying for anesthesia services from actual to average time spent (Sec. 113);
- repeal of reduced payments under Medicare for new physicians (Sec 112);
- Medigap duplication;
- standards for durable medical equipment (Sec. 121).

Senator Charles Grassley.

Senator Grassley is one of those Senators who can give the impression (because he is far from a detail-oriented person) that he is less than sharp and is not a significant player. This is not the case. Although he may not be extremely quick, he has a very sensitive and accurate gut for politics and policy and, with a very capable staff, he has managed to become quite an effective Member of the Committee.

It is important to note, however, that before he came to the Finance Committee, he served on the Labor Committee and, in the mid-1980's he Chaired the Subcommittee on Aging -- the Committee that has jurisdiction of the Older Americans Act. (This Act -- which was reauthorized during his tenure there -- is, of course, the authorizing legislation for the popular programs administered by the Administration on Aging.)

Grassley's primary health care interest has been related to rural health care. He, again like most other Members of the Committee, has been greatly concerned about perceived inequities in reimbursement to rural providers. As such, he may well ask questions about the new Administration's commitment to looking into this issue. (The answer is, without committing to anything of course, that Clinton and Gore, coming from rural states, are extremely sensitive to this issue and that you have every intention of working with them and Grassley, et. al., in looking into this matter.)

In addition to rural health issues, it is very possible that he may ask questions about HCFA and its insensitivity to consumers and providers. Other issues that may well come up, according to his staff, are: Will higher income Medicare beneficiaries pay more in premiums? What will be the HHS Secretary's role in the development of health care? What about the need for flexibility at the state and local level? What is the individual's responsibility with regard to containing health care costs? What about social behaviors that may place added burdens on society? Although he may ask you a series of questions, he is more likely to focus on a couple, probably related to rural health care, and submit the rest for the record. It is unlikely that his questioning will be overly tough and/or unreasonable.

Grassley sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- review and revision of geographic practice cost index (Sec. 114);
- standards for durable medical equipment (Sec. 121).

Senator Orrin Hatch.

Although there will be another Republican Finance Committee Member announced within the next few weeks (to replace Steve Symms), Senator Hatch currently serves as the newest addition to the Committee. (He replaced the late John Heinz R-PA). He is one of the most intelligent individuals in the Senate, but has yet to really get a comfortable grasp of the Finance Committee.

Up until 1993, he served as either the Chairman or the Ranking Republican of the much more conflict-oriented Labor and Human Resources Committee. In this capacity, he became extremely well informed about PHS, NIH, and FDA issues. Although he is well known for his very conservative philosophy, he has in recent years appeared to become more open to more traditionally moderate approaches. For example, although he is close with the drug industry, he has been willing to push them to be more responsive on pricing issues. Having said this, he is one of the fathers of the Orphan Drug Act and is very sensitive about the need for significant reform of this law.

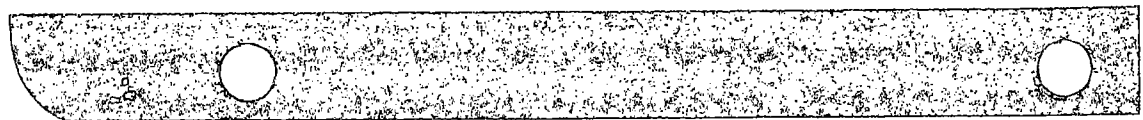
On health reform issues, he can be expected to be very supportive of market-oriented reforms to the health care system. In that vein, he will be extremely uncomfortable with employer mandates and discussions of global budgeting and enforcement. He may ask you a variety of questions with regard to these issues. Probably of most importance in preparing yourself for questions, Senator Hatch is the most likely to ask some difficult questions with regard to abortion and proposals to cover the service (and, he'll likely argue, provide more incentives for abortion). These and other possible questions are outlined in the Q&A document.

Hatch sponsored or supported the following provisions in H.R. 11:

MEDICARE:

- *new physicians (Sec. 112).*

WORK PLANS



Health Care Working Group Toll Gate
Meeting Schedule

Week of February 10	Toll Gate 1 Review	4 hours
Week of February 25	Toll Gate 2 Review	4 hours
Week of March 9	Toll Gate 3 Review	8 hours
Week of March 19	Toll Gate 4 Review	4 hours
Week of March 29	Toll Gate 5 Review	8 hours
Week of April 19	Toll Gate 6 Review	8 hours
Week of April 29	Toll Gate 7 Preparation Meeting	As long as necessary
Week of May 3	Toll Gate 7 Review	As long as necessary

**The "Toll Gates"
Policy Substance**

Toll Gate 1 (February 10)

Each task group presents a detailed work plan outlining the questions they expect to explore, who they will contact, what data they will seek, what their output will look like -- discussion aims to ensure methodology is thorough and broad enough.

Toll Gate 2 (February 25)

Each task group presents a revised work plan, a statement of issues, an outline of options, a more detailed methodology for answering all questions needed to "flesh out" the options -- discussion aims to ensure that options considered are broad enough and that methodology is thorough enough to cover the options.

Toll Gate 3 (March 9)

Synthesis of work for a presentation of options to the President and Task Force members. This concludes broadening phase. All serious options are put "on the table." This is final check to be sure that sufficient breadth has been achieved.

Toll Gate 4 (March 19)

Each task group narrows options and makes draft recommendations, making explicit all analysis, logical links and assumptions which support conclusions.

Toll Gate 5 (March 29)

Synthesis of revised draft recommendations into a comprehensive set of proposals for presentation to the President and the Task Force to receive direction. Presentation should seek decisions on key issues so that proposals can be drafted.

Toll Gate 6 (April 19)

Further draft of program -- with numbers, legal, and political audits complete. Final unresolved issues get resolved. Contrarian review.

Toll Gate 7 (May 3)

Final review of legislation. Final audits of synthesized proposals.

WORKING GROUP MEETING SCHEDULE

THURSDAY, 2/11

TIME:	GROUP	ROOM	GROUP	ROOM
8:30 TO 10:30	IIA BENEFITS	211	IIID PREPARATION OF HEALTH CARE WORKERS	CHECK IN 213
10:30 TO 12:30	IIB EMPLOYER PARTICIPATION	211	IVA MEDICARE	CHECK IN 213
12:30 TO 2:30	IIC COVERAGE OF UNEMPLOYED / LOW-INCOME POPULATIONS	211	IVB DoD	CHECK IN 213
2:30 TO 4:30	IIIA QUALITY ASSURANCE	211	IVC VETERANS	CHECK IN 213
4:30 TO 6:30	IIIB ADMINISTRATION, REIMBURSEMENT AND PATIENT INFORMATION SYSTEMS	211	IVD FEDERAL EMPLOYEES	CHECK IN 213
6:30 TO 8:30	IIIC MALPRACTICE AND TORT REFORM	211	VI SHORT TERM COST CONTROLS	CHECK IN 213

WORKING GROUP MEETING SCHEDULE

FRIDAY, 2/12

TIME	GROUP	ROOM	GROUP	ROOM
8:30 TO 10:30	VII PUBLIC FINANCING	211	IA BUDGETS AND CAPS	CHECK IN 213
10:30 TO 12:30	VIII HEALTH POLICY INITIATIVES FOR UNDERSERVED POPULATIONS AND PREVENTIVE HEALTH	211	IB HIPC ORGANIZATIONS	CHECK IN 213
12:30 TO 2:30	IX MENTAL HEALTH	211	IC ORGANIZATIONS, BOARDS, FEDERAL AND STATE OVERSIGHT	CHECK IN 213
2:30 TO 4:30	XI ECONOMIC IMPACT	211	ID INSURANCE REFORM	CHECK IN 213
4:30 TO 6:30	X LONG TERM CARE	211		
6:30 TO 8:30	XII QUANTITATIVE ANALYSIS	211		

WORKING GROUP MEETING SCHEDULE

SATURDAY, 2/13

TIME	GROUP	ROOM	GROUP	ROOM
8:30 TO 10:30				
10:30 TO 12:30	IIIC MALPRACTICE AND TORT REFORM	211	VI SHORT TERM COST CONTROLS	324
12:30 TO 2:30	IIIB ADMINISTRATION, REIMBURSEMENT AND PATIENT INFORMATION SYSTEM	211	IVD FEDERAL EMPLOYEES	324
2:30 TO 4:30	IIC COVERAGE OF UNEMPLOYED / LOW- INCOME POPULATION	211	IVB DoD	324
4:30 TO 6:30	IIIA QUALITY ASSURANCE	211	IVC VETERANS	324
6:30 TO 8:30	IIB EMPLOYER PARTICIPATION	211	IVA MEDICARE	324

WORKING GROUP MEETING SCHEDULE

SUNDAY, 2/14

TIME	GROUP	ROOM	GROUP	ROOM	GROUP	ROOM
8:30 TO 10:30						
10:30 TO 12:30						
12:30 TO 2:30	IIA BENEFITS	211	IIID MALPRACT- ICE AND TORT REFORM	CHECK IN 213	VIII HEALTH POLICY IN- ITIATIVES FOR UNDER- SERVED POPULA- TIONS AND PREVENTIVE HEALTH	324
2:30 TO 4:30	XII QUANTITA- TIVE ANALYSUS	211	X LONG TERM CARE	CHECK IN 213	IB HIPC ORGANIZA- TION	324
4:30 TO 6:30	XI ECONOMIC IMPACT	211	ID INSURANCE REFORM	CHECK IN 213	IX MENTAL HEALTH	324
6:30 TO 8:30	VII PUBLIC FINANCING	211	IA BUDGETS AND CAPS	CHECK IN 213	IC ORGANIZA- TIONS, BOARDS, FEDERAL AND STATE OVERSIGHT	324

HEALTH CARE REFORM
WORKING GROUP GUIDELINES

During the next hundred days, the attention surrounding the health care reform effort will escalate. Due to the sensitive nature of the topics being researched and the tight timeframe under which we're operating, the following guidelines must be followed to help us manage the flow of requests and inquiries:

- 1) Please direct all press to Bob Boorstin, at 456-7151, or to Anne Lewis (Deputy Assistant Secretary for Public Affairs at HHS) at 690-6853. In Bob's absence, call Jason Solomon, at 456-7151. It is important that you observe this request to help the Communications group be responsive to all inquiries.
- 2) Any inquiries to or from state and local organizations should be directed to John Hart in Intergovernmental Affairs at 456-2897. In his absence, call Christine Heenan at 456-2929.
- 3) Any inquiries to or from Congressional sources should be directed to Chris Jennings through Christine Heenan at 456-2929.
- 4) Any inquiries from interest groups or individuals, or any data that you need from these groups, should be directed to Mike Lux at 456-2930.

<u>Type of Inquiry</u>	<u>Department</u>	<u>Phone</u>	<u>Contact</u>
Media	Communications	456-7151 690-6853	Bob Boorstin, Jason Solomon. Anne Lewis
State and Local Governments	Intergovernmental Affairs	456-2896 x2929	John Hart Christine Heenan
Congress	Congressional Relations	456-2645 X2929	Chris Jennings Christine Heenan
Interest Groups/ Individuals	Public Liaison	456-2930	Michael Lux

This is an expansive process involving hundreds of people. It is important that we follow these paths to ensure that information flow is as timely and consistent as possible. Thanks.

DRAFT

I. NEW SYSTEM ORGANIZATION

PRELIMINARY WORK PLAN

February 10, 1993

WORK PLAN OUTLINE: OVERVIEW

NEW SYSTEM ORGANIZATION

AGENDA FOR FEBRUARY 9 MEETING AND OUTLINE OF WORK PLAN

1. Distribute core reading materials to cluster group members
2. Review relevant work undertaken by the transition team.
Distribute transition materials --without recommendations.
3. For each task group, define first and second order questions according to three criteria: which are core issues that are fundamental to the resolution of other issues; which need to be addressed before other issues can be addressed; which need to be addressed in legislation, as opposed to being assigned to decision-making by the national board, the states, or purchasing cooperatives.
4. Identify starting points, or givens, in New System Organization, especially with regard to HIPC organization and managed competition: i.e., those issues around which most advocates of managed competition and purchasing cooperatives agree: e.g., employee choice, all employers of under a specified size with purchase through the HIPC, all plans accept all comers, etc..
5. Identify data/research needed, by task group. Identify if and where appropriate data and information exist. Identify sizable research projects that must be undertaken.
6. Identify who, which task group, will undertake what research and how it will get done.
7. Establish timetables for initial reports and data and options presentations to Cluster group for each task group.
8. Identify remaining specific cluster group expertise needs; e,g, anti-trust, governance.
10. Place cluster group members in appropriate sections.
11. Schedule regulator task group and Cluster group meetings

TASK GROUP BY TASK GROUP WORK PLAN NEW SYSTEM ORGANIZATION

TASK GROUP ONE PRINCIPLES AND OPERATION OF PURCHASING COOPERATIVES

**SOME FUNDAMENTAL ISSUES: PRESENTATIONS ON THESE TOPICS SHOULD BE
MADE BY FEBRUARY 18**

1. What principles of managed competition and purchasing cooperatives must be consistent across the system? Which can be allowed to vary by state and/or HIPC?

--What is the federal government going to mandate and what is going to be left to the national board, the states and HIPCs?

--What needs to be in federal legislation --criteria, parameters, etc..

2. What criteria, and how strict a set of criteria, should be imposed on health plans? Should there be a specifically and federally defined definition of an "Accountable Health Partnership," or should plans of more varying nature be allowed to compete equally.

3. Powers of the HIPC: Price-taking to regulation. To what extent is the HIPC just a price-taker? To what extent should it be involved in health planning and/or regulation? What can the HIPC do and on whose authority? The role of the HIPC in selecting plans and enforcing a budget. (Overlap with Section Two and Three).

4. Who has to purchase insurance through the HIPC? Who can opt out of the HIPC, under what circumstances, and under what criteria?

OTHER ISSUES

1. Contracting with health plans; criteria for contracting with plans. What should participating health plans look like. What criteria must they meet?

A. Integration of insurance/provider functions; Physician relationships with health plans. (Some overlap with Task Group Two).

B. Should the federal government demand anything from plans with regard to acceptance of Medicaid and Medicare enrollees?

2. Eligibility and enrollment issues: employees, the unemployed, retirees, other. (Do some of these issues belong with other clusters?)

3. Consumer education and information in the HIPC. What should the government demand of HIPCs?

4. Consumer cost consciousness, including the impact and necessity of placing a cap on tax-free benefits. Where should that cap be set? Should it apply to what the employer can contribute or to what the individuals can accept? What might be done to maximize cost-conscious consumer choice if the tax cap is not imposed? Are there any limitations on the IRS's capacity to determine and collect what is taxable income, especially if the cap is different in different regions?

5. Fee for service in the HIPC: who should run it and how? If regulation is applied in the FFS plan how will that affect competitive relationships between HMO's and FFS? Should an effort be made to make FFS affordable, or should the market determine its true cost?

6. Capital issues: What can/should be done to encourage the growth of integrated health plans? (Overlap with Section Two).

7. Analysis of potential administrative and other savings to government, providers, health plans, private sector and consumers.

8. Establishing criteria for participating plans: how specific should they be, and is it a national, state or HIPC function.

9. Managed competition, HIPCs and anti-trust issues. What, if any laws must be adjusted to increase the capacity for integration in health plans and for HIPC flexibility in managing competition.

10. Maintaining competition: how does the HIPC allow for, or encourage, new entrants in the market? How does it prevent collusion between plans, especially when there are relatively few competitors?

11. Benefits and consumer choice: should benefits be identical across plans, or should some plans (PPO's, FFS) be allowed to offer modified benefits in terms of cost-sharing?

SOME RESEARCH PRIORITIES: RESEARCH PLANS AND ASSIGNMENTS SHOULD BE FINALIZED BY FRIDAY, FEBRUARY 13

1. Review public and private systems that might serve as models.

2. Assess potential impact of tax-cap provisions

3. Assess, given proposed functions, administrative costs of the HIPC and potential savings to; small and large employers, consumers, providers.

4. Attempt to simulate, predict behavior of consumers under various managed competition scenarios.
5. Research existence of relevant anti-trust laws in different states that may have to be altered in a new system.
6. Assess capital needs that may be required for plans, or for increasing capacities for managed competition. Review start-up costs of plans in different locations and circumstances.
7. Determine, on state by state basis, the distribution of large and small employers.
8. Assess data on labor mobility. How often to individuals change jobs --by region, size of employer, and nature of job. Assess impact and value of preserving portability of insurance.
9. Compile data of health plan choices now available to individuals, and trends. Are individuals getting fewer choices? of plans? of providers?.
10. Assess data on current benefits. To what extent are they being reduced?
11. Consider seeking additional, more specific information on the public's of the present system and alternative systems.
12. Phasing in HIPC's: Who joins the HIPC first? When, and at what pace?

**TASK GROUP TWO
SPECIAL ISSUES IN PURCHASING COOPERATIVES
AND MANAGED COMPETITION**

**SOME FUNDAMENTAL ISSUES: PRESENTATIONS ON THESE TOPICS SHOULD BE
MADE BY FEBRUARY 18**

1. Safety nets and under-served populations. What powers will the HIPC have to employ other than competitive approaches in serving these populations? To what extent does the HIPC have to engage in planning to serve these populations? What restrictions, if any, should be placed on the planning flexibility of the HIPC? What might be relationships between the HIPC and publicly funded community health centers?

2. Areas where managed competition might work but can't work yet. What can the federal or state governments or the HIPC do to encourage the growth of competition between integrated health care systems?

3. Areas where managed competition may never work. Who determines where managed competition can or cannot work and who has the authority to invoke other means of purchasing/paying for health care? What are the HIPC's powers to set rates, budget hospitals, contract with centers of excellence, etc.? Can/should the HIPC ever bear risk?

OTHER ISSUES

1. How might the HIPC address physician supply problems, and tertiary care needs, especially in rural areas? What powers would it need to do so? Could a HIPC run a competition for the field rather than within a field?

2. Protecting low-income individuals in the HIPC. What can/should be done to assure that low-cost plans do not become second-tier plans? What special concerns must be addressed if the HIPC enrolls Medicaid and Medicare-eligible individuals?

3. HIPC's and rural areas. Should there be separate HIPC's for rural areas? Could rural areas be covered as part of neighboring HIPC's? What special structures or approaches need to be invoked when a HIPC region includes areas that might be suitable for managed competition and areas that are not so suited? Might it be appropriate to establish only one state-wide rural HIPC?

SOME RESEARCH PRIORITIES: RESEARCH PLANS AND ASSIGNMENTS SHOULD BE FINALIZED BY FRIDAY, FEBRUARY 13

1. What are the requirements of managed competition in terms of numbers of competitors, enrollees, hospitals, density of population etc.?
2. What have various states, regions, done to encourage health plans to be established?
3. What might states, HIPCs do encourage movement of PPO's into HMO's. What legislative changes may be required?
4. What evidence may exist that rural areas will be advantaged by the establishment of a purchasing cooperative? What will be savings in administrative costs, broker fees, and other costs that tend to be high in these areas?

TASK GROUP THREE GOVERNANCE ISSUES

**SOME FUNDAMENTAL ISSUES: PRESENTATIONS ON THESE TOPICS SHOULD BE
MADE BY FEBRUARY 18**

1. What functions is the HIPC expected to perform. What are the powers of the HIPC? Defining those functions and powers is critical to defining the appropriate form for the HIPC.
2. What is the appropriate division of function and authority between the federal government, the states and the HIPCs? Is the new system a unitary system, a federal system, or a confederacy?

OTHER ISSUES

1. The National Board: structure, appointments to, powers, functions.
 - A. Technology Assessment
 - B. Data Collection
 - C. Benefits (not what they are, but how they are adopted)
 - D. Budget
 - E. Other
2. Division of functions between nation and state boards and HIPCs (statewide and regional).
3. State opt-out and/or waiver procedures and rights
4. Relationships and division of functions between state regulators (Department of Insurance, Health) and HIPCs. Who will regulate solvency, consumer protection, quality, issues?
5. HIPC governance and structure: HIPC boards, functions, legal constructs, relationships to federal and state boards. Can the size, bureaucracy, etc. of the HIPC be limited? How should we deal with the public perception of another layer of government?
6. Powers of the HIPC (See Task Force One, (2 and 3); especially in planning and regulation circumstances for managed competition are imperfect
7. Size of HIPC regions: geography and population; statewide v. regional HIPCs.
8. Regulation of employer plans not in the HIPC: who will do it? What changes may be required in ERISA.
9. How fast can states establish HIPCs? Should state model legislation be developed and included in federal legislation? Should the federal government be prepared to run a state HIPC if the state fails to establish one?

SOME RESEARCH PRIORITIES; RESEARCH PLANS AND ASSIGNMENTS SHOULD BE FINALIZED BY FRIDAY, FEBRUARY 13.

1. Review state and federal government structures for potential models for national and state boards and HIPC's.
2. Outline the functions the system as a whole needs to perform and determine which level of accountability (federal, state, HIPC) should be responsible for it.
3. Review models of shared state and federal authority (e.g. Medicaid) to analyze alternative federal-state relationships.
4. Review recent history of health planning for lessons.

TASK GROUP FOUR A GLOBAL BUDGET

**SOME FUNDAMENTAL ISSUES; PRESENTATIONS ON THESE TOPICS SHOULD BE
MADE BY FEBRUARY 18**

1. Alternative means of defining a budget; Should the budget focus on mandatory spending (by government, employers, and consumers) only, or on mandatory and discretionary spending?
2. Alternative means of determining increases in budgets; Congress and the Federal Board. Processes to be employed: technology assessment, consideration of benefits, determinations of potential for greater efficiency, advisory panels, etc.
3. How are budgets to be enforced: by the federal government, by states, by HIPCs? What carrots and sticks are offered states or HIPCs for meeting or not meeting budgets? What are the relationships between focus on a low-cost plan and imposition of a budget?

OTHER ISSUES

1. Spending that may be outside the HIPC; should it be included in a budget?
 - a. Medicare and Medicaid
 - b. Veterans
 - c. Research
 - d. Large employer outside the HIPC
 - e. Some safety net spending, if not in HIPC
 - f. Academic institutions, physician training
2. Budgets and the states: Amounts of flexibility given to states and HIPCs within states. Is the state given a budget, or is each HIPC given a budget? How are budgets allocated, and by what governmental entity?
3. Budgets and regions where managed competition may not be viable. If budgets are based on premiums paid to the HIPC, how is the budget determined and enforced where there is not sufficient competition. Can a state spend more if it chooses to, and how would that amount be incorporated into the budget?
4. Budgets and the phase-in period before HIPCs are fully established.
5. The relationship between the budget and rate-regulation.

SOME RESEARCH PRIORITIES; RESEARCH PLANS AND ASSIGNMENTS SHOULD BE FINALIZED BY FRIDAY, FEBRUARY 13

1. What budget-related data is now available and what is not available?
2. What sets of additional data are needed to establish what kinds of budgets?
3. Assessment of a need to set budgets on spending outside the HIPC.
4. Analysis of spending on a state-by-state basis. Assess impact of a per cent increase limit imposed on each state. Should there be different rates of increases for states?
5. Review budget processes in other countries for appropriate models.

TASK GROUP FIVE INSURANCE REFORM

(IT SHOULD BE EMPHASIZED THAT IN THE CONTEXT OF THE REFORMS CONTEMPLATED HERE, INSURANCE REFORM MEANS SOMETHING DIFFERENT THAN WHAT IT HAS MEANT IN THE RECENT SMALL GROUP REFORM DEBATE. MANY OF THE ISSUES IN THAT DEBATE --PRE-EXISTING CONDITIONS, GUARANTEED ISSUE AND RENEWAL, ETC.-- ARE TAKEN AS GIVENS IN THE REFORMS CONTEMPLATED HERE).

1. Underwriting issues: community rating, age rating; inside and outside the HIPC. Can/should discounts be provided for wellness programs for non-smoking etc..

2. ERISA: regulation issues pertaining to those large employers outside the HIPC. Will self-insurance be allowed in the new system, and if so with what restrictions?

3. Merging of workers compensation and other health insurance parts of auto, business liability, etc. into the new health care system. What adjustments will managed care plans have to make in order to service workers compensation claims?

4. Risk-adjustment: What is needed, and under what circumstances will risk-adjustment problems be simplified? Risk-adjustment issues must be reviewed in the context of risk-selection in the HIPC and enrollment of individuals in plans.

5. What needs to be established in the way of guarantee funds? What provisions need to be made for the potential failure of plans that cannot effectively compete in the new system?

6. Override of state anti-managed care laws. What must the federal government do to secure the necessary environment for the growth of managed care health plans.

SOME RESEARCH PRIORITIES; RESEARCH PLANS AND ASSIGNMENTS SHOULD BE FINALIZED BY FRIDAY, FEBRUARY 13

1. Distributional effects of pure community rating in the HIPC.

2. Assessment of the present risk-adjustment technology.

SECTION LEADERS: TENTATIVE ASSIGNMENTS

I. PURCHASING COOPERATIVES: Rick Kronick, Rick Curtis

II. SPECIAL ISSUES IN MANAGED COMPETITION: Lois Quam, Christine Williams

III. GOVERNANCE: Larry Levitt: need additional help here, hopefully from Congress

IV. BUDGETS: Sherry Glied, Larry Levitt

VI. INSURANCE REFORM: Gary Claxton

SOME ADDITIONAL INDIVIDUALS TO BE CONSULTED

1. Alain Enthoven
2. Members of the Jackson Hole Group (Lynn Etheredge will be involved part time on the Cluster Group)
3. Paul Starr; Cluster 6
4. Alan Krueger (Workers compensation): if not already involved
5. Appropriate political scientists, experts in goverance structures (to be identified)
6. Managers of potential HIPC models: FEHBP, Ca. PERS, Minn., private sector (Xerox, Bank of America)
7. Other