Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	From: Miaria Ochoa, To: Sara Grote, Re: Agenda [partial] (1 page)	4/12/93	b(6)
002. fax	From: David Abernethy, To: Chris Jennings, Re: April 14, 1993 Meeting [partial] (1 page)	4/13/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Wednesday April 14 [1993]

2014-0483-S
sb332

RESTRICTION CODES

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

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

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

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

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

WEDNESDAY, APRIL 14

M E M O R A N D U M

TO: Hillary Rodham Clinton April 13, 1993
FR: Chris Jennings
RE: Ways and Means Subcommittee Meeting

Because of its jurisdiction, Members, staff resources and expertise, the House Ways and Means Committee and its Subcommittee will probably be the most influential body in the Congress as it relates to health care. As challenging as it may be, we must have and continue to build a close and productive working relationship with the Committee.

With this in mind, you, Ira and Judy are scheduled to meet with the Ways and Means Subcommittee on Health in the Roosevelt Room tomorrow morning. This meeting was originally requested by the Subcommittee following the last Subcommittee Members' meeting with Ira and Judy on March 31st.

To focus discussion, the Subcommittee Members requested that the meeting review two major issues: (1) System Organization: Federal and State Roles and (2) Cost Containment: Short-Term and Long-Term (but will focus primarily on short-term). In terms of meeting format, the Subcommittee has suggested that you or Ira, for each issue, give a brief 15 minute presentation, followed by a 45 minute Q&A session. Attached for your use is a summary of the direction and options Ira and his work groups have been discussing for all of these issues.

In preparation for this meeting, Pete Stark suggested that all the Subcommittee Members submit questions that they may pose during your meeting. The questions will be focused on the two issues outlined above. As of 6:30 tonight the questions had yet to arrive, but we will send them over as soon as they arrive.

Lastly, as you will recall, the last time you met with the Committee, we had a press leak problem. At some point during the meeting, without being overly confrontational, you may want to discuss the importance of keeping these meetings quiet, so that we can have as constructive and productive a working relationship as possible. This, in my mind, is entirely appropriate and should be well received by most.

April 13, 1993

Attached are three sets of memoranda related to proposals for national health reform:

Tab A: A description of the role of state and federal government

Tab B: A description of a national health budget and administrative simplification as sources of long-term cost containment

Accompanied by a longer paper related to global health budgeting

Tab C: A brief description of options for short-term cost controls

Accompanied by a slightly longer description of each option and a paper providing further details about each option

APRIL 13, 1993

SUMMARY OF ISSUES UNDER NATIONAL HEALTH REFORM:

FEDERAL/STATE RELATIONSHIP
LONG-TERM COST CONTAINMENT
SHORT-TERM COST CONTAINMENT

In the new system, we assume a cooperative federal-state relationship. The federal government will not regulate the new system heavily; rather, it will set parameters to ensure that the national goals of universal access, high quality care and cost containment are met.

States will have substantial flexibility and authority to implement the new system. They will have the financial responsibility to meet a budget and will be responsible for overruns. The federal government will provide the states with the tools to enforce the budget.

This memorandum describes preliminary proposals for national health reform related to federal-state relations, long-term cost controls obtained through a national health budget and through administrative simplification and options for short-term cost controls. Specific options described represent one set among several under consideration and are intended for illustrative purposes.

FEDERAL GOVERNMENT ROLES AND RESPONSIBILITIES:

Under national health reform, the federal government will:

- Establish guarantees for health-care coverage and delivery to be carried out by the states

- Ensure protection of citizens if states fail to meet federal standards

- Establish an employer and individual responsibility to contribute to health insurance costs

- Enforce a national health budget, holding states accountable for spending to meet the budget

- Determine the annual increase in the national health budget

- Establish and oversee formulas for adjusting payments to health plans based on demographic and clinical characteristics of enrolled patients

- Update and refine the comprehensive benefit package

- Establish and oversee federal subsidies for low-income persons and eligible small employers

- Establish and implement national quality and access standards

- Manage and analyze national collection of information related to health care access, quality and coverage

- Establish a mechanism for assessment of health technology and emerging treatments

- Oversee federal funding for training of health professionals

- Provide technical assistance and start-up grants to support the development of consumer health alliances and health plans

- Administer any limits placed on tax-deductibility of employer contributions to premiums in excess of locally established benchmark premium

- Override state anti-managed competition laws and other statutes inconsistent with the principles of the new health care system

- Delegate these functions variously to a national health board and an executive branch agency

STATE GOVERNMENT: ROLES AND RESPONSIBILITIES:

Under national health reform, the states will:

- Establish at least one consumer health alliance

- If they choose, opt out of the consumer health alliance structure and operate as a

single payer that negotiates directly with providers or sets all-payer rates

• Set boundaries for consumer health alliances to ensure:

  - Minimum population of one million, or entire state population if less than one million

  - No discrimination against low-income or high-risk populations

  - Contiguous boundaries

• Administer and assure compliance with national health budget

• Establish and enforce performance standards for consumer health alliances under federal rules, including:

  - Enrollment in health plans of all persons residing in assigned geographic area

  - Inclusion of a range of health plans within budget targets

  - Solvency requirements

  - Appointments to, composition of, and membership on policy-making boards

  - Administrative expenses

• Protect people enrolled in health plans or health alliances in case of financial failure

• Operate a state health plan if necessary to correct gaps in the market

MEDICAID:

Under national health reform, Medicaid beneficiaries will enroll in health plans offered through consumer health alliances:

- Medicaid beneficiaries will receive subsidies toward the cost of premiums and co-payments on the same basis as other low-income people

- Health plans will provide supplemental services such as transportation and clinical case management as appropriate to ensure access to care

- States will continue to contribute to the cost of care for low-income people:

  - Initially under a requirement for maintenance of effort and later subject to a new formula determined by a commission and adopted by Congress through an expedited procedure

  - Requirements for maintenance of effort could include all state health expenditures, not just Medicaid

LONG-TERM COST CONTAINMENT: A NATIONAL HEALTH BUDGET

National health reform will establish a budget for health care spending consisting of two parts:

- The federal government will enforce an annual budget for spending through consumer health alliances
  - Determined by the average premium (weighted by enrollment in each plan) for the comprehensive benefit package
  - Enforced at the state level
  - States held accountable for spending in excess of the budget
  - States and health alliances will meet budget limits through:
    - Authority to negotiate and regulate premiums
    - Authority to freeze enrollment in plans
    - Authority to set and regulate payments to providers
    - Authority to approve investments in health resources and technology
- Self-insured plans also will be required to meet state budgets

The federal government will enforce budget limits through the following mechanisms:

- Allow states to share in savings for federal subsidies if costs increase less than budgeted
- Require states that exceed budget to submit plans for correction
- Require states to finance additional cost of subsidies to small employers, individuals and families if budget exceeded

- If budget exceeded in successive years:
  - Impose a penalty tax on providers, with revenues to pay for federal subsidies
  - Implement rate setting
  - Operate consumer health alliance
- Consistent with the national health budget, the federal government will constrain payments to providers to limit spending for its programs

LONG-TERM COST CONTAINMENT: ADMINISTRATIVE SIMPLIFICATION

National health reform will establish rules intended to reduce burdensome data collection and information processing while assuring privacy and security of personal health information:

- Simplify information collection requirements for billing and enrollment purposes
- Require use of national, standard forms
- Require use of national, standard data sets for financial, clinical, quality and other information
- Develop national procedures for coordination of benefits until new health system fully implemented
- Develop and adopt unique provider, patient, plan and employer-identification numbers
- Set national communication standards for electronic data interchange
- Set uniform national rules regarding privacy and security
- Simplify utilization review

GROUP 4: GLOBAL BUDGETS

Note: The budget structure presented here presumes the following:

- *That states would have substantial latitude, and that the federal government would be unwilling to create an uncapped federal liability for low-income subsidies in a system that is not largely within its own control. These assumptions, taken together, lead to a system in which states are financially accountable for the cost of low-income subsidies in excess of the allowable increase in the budget.*

- *That there should be a federal guarantee to slow health spending (including private spending). This assumption leads to the need for a federally-defined outside limit on the rate of increase in health spending (at least for the guaranteed comprehensive benefits within the purchasing cooperative), with some sanctions if spending within a state rises at a more rapid rate. It is presumed that elements of the federal program (e.g. a limit on the tax favored status of health coverage) would restrain spending.*

1. HOW IS THE BUDGET DEFINED?

a. **Private spending budget.** There would be a budget for private health care spending that would be defined as the average premium (weighted by enrollment in each plan) for the guaranteed comprehensive benefits.

The budget would not include spending for supplemental benefits, balance billing (if permitted), out-of-pocket costs (though consumer costs for the comprehensive benefits would be expected to rise along with the budget), and public health.

[Note: The viability of a budget only on the guaranteed benefits presumes that the guaranteed package is relatively comprehensive. To the extent that is not the case, a budget applied to supplemental coverage as well might be appropriate.]

i. **Enforcement inside the purchasing cooperative.** The budget would be strictly enforced inside the purchasing cooperative.

States would have broad authority to control health care spending, and

the ability to delegate this authority to purchasing cooperatives. Among the tools available to states/purchasing cooperatives would be:

(1) Negotiating/regulating health plan premiums.

(2) Regulating provider rates.

(3) Limiting enrollment in high cost plans, which would lower the weighted average premium in the purchasing cooperative. Enrollment could be limited either directly (e.g. preventing new enrollment in a high cost plan) or through financial incentives (e.g. surcharging high cost plans and subsidizing low cost plans).

(4) Health resource planning.

ii. **Enforcement outside the purchasing cooperative.** For employers outside the purchasing cooperative, the budget would be a target (i.e. it would not be strictly enforced). States would not be accountable for spending in excess of the budget target outside the purchasing cooperative.

Under the assumption that large employers are permitted to join the purchasing cooperative on a voluntary (risk adjusted) basis, we presume that the target for spending outside of the HIPC would be largely self-enforcing. That is, large employers unable to control spending would choose to join the purchasing cooperative.

[Note: The viability of a **strictly enforced** budget only inside the purchasing cooperative presumes a large market share for the cooperative — e.g. at least all employers with fewer than 1,000 employees — and some limitation on the tax preferred status of employer-sponsored health benefits.]

Alternative Approach: *Some suggest that budgetary control should be applied to employer health plans outside the purchasing cooperative as well. Two reasons are cited:*

- *Health spending outside the purchasing cooperative could affect spending inside the purchasing cooperative, particularly in areas where large employers comprise a significant share of the market.*

- *A budget imposed only on the purchasing cooperative could raise difficulty equity issues. If per capita spending inside the purchasing cooperative were substantially lower than outside, two tiers of quality might develop (or be perceived as developing).*

It would difficult to enforce directly a budget on self-insured employers outside the purchasing cooperative. However, large employers exceeding a spending target could be required to join the purchasing cooperative. This would bring these employers under the budgetary control of the purchasing cooperative. This approach would work as follows:

- ***Multi-year Target.*** *Large employer spending would be monitored on the same multi-year budget cycle as used for states and purchasing cooperatives. A multi-year budget is particularly important for individual employers, since even large employers experience substantial random variation in costs from year to year.*

- ***Spending Targets.*** *If the rate of increase in spending for the guaranteed comprehensive benefits by a large employer exceeded the allowable increase in the federally-defined budget over the multi-year cycle, the employer would be required to join the purchasing cooperative. The Society of Actuaries would develop a methodology for separating the cost of the guaranteed benefits from an employer's total health expenses (which might include supplemental benefits).*

- ***Premium for Large Employers.*** *A large employer required to join the purchasing cooperative would pay the purchasing cooperative the same premium that would have been charged if the employer had joined the cooperative voluntarily.*

b. **Public spending budget.** There would be a budget for federal Medicare spending. [Note: We are working on options for how a Medicare budget could be defined and enforced.]

Federal spending for low-income subsidies would also be limited, as described in Section 6b below.

2. HOW IS THE BUDGET UPDATED?

A budget update formula will be written into national law. This budget update formula will define the population weighted average increase in the Federal spending and premium budgets for the following year.

Budget update formula (for example):

projected CPI + demographic adjustment + 2 percent

(this implies a projected average total rate of increase for the private sector of about 6% per year over the next decade, rather than the current projected average of 9% per year)

A Medicare budget would be designed to reflect growth in enrollees.

The budget update should be phased in over some period, for example three years. In year 1, the budget would be projected CPI + age-adjustment + 4 percent. In year 2, the budget would be projected CPI + age-adjustment + 3 percent. In year 3, the budget would be the long-run budget.

3. HOW IS THE BASELINE ESTABLISHED?

A Commission (or Board or Agency) will determine the budget baseline for each State. The baseline budget will reflect historical spending patterns as of December 1992 measured as:

a. Expenditures determined from the National Health Expenditure data state breakdowns for 1991 and additional State expenditure data that will be collected in the first year after passage of this legislation and adjusted using a utilization factor determine by HCFA to reflect the varying uninsurance rate across States; or

b. Premiums computed based on two premium surveys undertaken in each State and adjusted to reflect the prevalence and cost of State and Federal government-provided care in each State.

4. HOW IS THE BUDGET ALLOCATED TO STATES?

There are two options: a formula, or a Commission that will determine the allocation for each multi-year budget period.

a. Formula example. Note, in particular, that the period for narrowing differentials could be compressed (e.g., to 5 years) or extended and that the rural offset figure could be adjusted.

In the first year of the global budgeting system, a state's budget will largely reflect its historical expenditure level. At the end of seven years, each state will have the same budget except for adjustments for differences in demographics and input prices.

Let

H_i = historical expenditure level for state i, trended forward by national target growth rates to year 1 of budget

T = national budget level

T_i = adjusted national budget level for state i = $T*P_i*D_i$

B_i = actual budget for state i

P_i = input price index for state i

D_i = demographic adjustment for state i.

In year 1, $B_i = (.14*T_i)+(.86*H_i)$. Each year the weights change by .14 so that in the seventh year $B_i=T_i$. This transition is similar to the PPS and Medicare fee schedule transitions.

P_i is a weighted average of expenditure-specific input price indices (e.g., hospitals, physicians, and drugs) where the weights for P_i are based on national spending patterns. Initially, the HCFA hospital wage index would be used for hospital expenditures, although eventually a broader wage index could replace it. The Geographic Cost of Practice Index (GCPI) would be used for physician expenditures. However, the GCPI will be multiplied by 1.20 for "very rural areas" (defined, for example, as areas with population densities below 50 persons per square mile) to recognize the difficulty of attracting physicians to these areas. Drug expenditures will not be adjusted for geographic variations – the index will be 1 everywhere.

b. The Commission would make its determination based on the factors described below. Congress will vote on the annual allocation to States on an up-or-down vote. If Congress rejects the Commissions recommendations, the allocation would be the baseline. The Commission shall allocate funds so as to narrow variations in spending due to practice pattern variations and differences in health resource endowments.

Updates of the budget baseline should reflect two sets of factors:

i. *Historical spending patterns (this factor would tend to keep the budget levels for all States unequal);*

ii. *Factors that should affect the level of health spending:*
- *population aging*
- *input costs*

(these factors would tend to equalize spending differences due to practice patterns)

5. ADJUSTMENTS TO REFLECT PERFORMANCE

If a State consistently fails to meet its performance targets, it may apply for additional funding through other Federal programs (CDC, HRSA). Funds received through these programs would not be counted against the State's maximum budget.

6. WHAT HAPPENS IF A STATE EXCEEDS THE BUDGET?

[Note: In the initial years of implementation, there may be significant uncertainty about the expected cost of coverage, particularly with respect to state-by-state variations. It might therefore be appropriate to structure the budget as a "target" rather than as a "cap" (i.e. it would not be strictly enforced). Whether this is a viable strategy depends, at least in part, on the structure of the system in the short-term and on the speed with which the program is phased in.]

a. **Multi-year budgets.** Monitoring a state's performance against the budget would occur on a multi-year basis (either two or three years). That is, each state's multi-year budget would be expressed as the compounded sum of the annual budgets over the multi-year period.

In each year of a multi-year budget, a state would be financially accountable for the additional cost of low-income subsidies if spending that year rose faster than the federally-defined budget (as described below).

b. **State accountability for low-income subsidies.**

i. If health spending in a state rose faster than the federally-defined budget, then the state would have to finance the additional cost of low-income subsidies. If a state did not provide the additional funding, other federal funding for the state (e.g. federal highway funds) would be reduced.

States would not be financially accountable for economic factors — e.g.

an increase in unemployment — since federal financing for subsidies would account for the number of people receiving subsidies.

(Note that spending rising faster than the federally-defined budget would mean that employer and consumer premiums would also rise.)

ii. If health spending in a state rose slower than the federally defined budget, then the state would retain the savings in federally-financed low-income subsidies that would result from lower than budgeted health care spending in the state.

iii. State financial accountability for low-income subsidies would compound over time. For example, consider a state that exceeded the federally-defined budget by 1% in a given year, but then tracked allowable budget increases thereafter. The state would always be spending more than was budgeted, and would therefore have to finance the additional low-income subsidies that result.

iv. Technically, state financial accountability would be tied to the amount the state is over (or under) budget relative to the **weighted average premium** in the purchasing cooperative, regardless of how subsidies are structured. For example, if total subsidies in a state were $1 billion and the state exceeded the budget (i.e. the weighted average premium in the purchasing cooperative) by 1%, then the additional state financial responsibility would be $10 million.

(Subsidies may very well be based on the benchmark premium, which could increase at faster or slower rate than the weighted average premium. However, tying state financial accountability to the benchmark premium would provide a strong incentive for a state to hold down the cost of the benchmark plan, potentially resulting in a deterioration in quality in that plan relative to others.)

v. The National Health Board (or a Commission) would prepare a formula with the characteristics described above. The formula might appropriately be designed in conjunction with development of maintenance of effort provisions for state Medicaid spending.

c. **Outside limit on state health care spending.** As described above, the federally-defined budget update would determine the level of federally-financed low-income subsidies, with states financially accountable for subsidies in excess of this amount.

There would also be established an outside limit on spending for the comprehensive benefits in a state's purchasing cooperatives. This would be expressed as a "band" (e.g. 3%) above the federally-defined rate of increase in the budget. For example, if the federally-defined budget increase were 6% a year over a multi-year period, then the outside limit on spending would be 9% a year.

i. The outside limit would apply to a state's multi-year budget. A state exceeding the limit in the first year of a multi-year budgeting period could make up the difference in the following year.

ii. Unlike the federally-defined budget for low-income subsidies, the outside limit on spending would be "re-based" each multi-year budgeting period.

That is, the baseline for determining the outside limit on spending for a multi-year budgeting period would be state's actual spending during the previous period. A state would **not** be permitted to "bank" the amount by which it was under the outside limit as a cushion for future years.

d. **Sanctions for exceeding the budget.** States exceeding the outside limit on spending — either over one multi-year budget cycle, or alternatively over two cycles — could be sanctioned as follows (three options):

i. **Federal oversight of purchasing cooperatives.** If spending in the first year of a multi-year period exceeded the federally-defined outside limit, the state would be required to submit to the federal government a plan for restraining spending.

If spending exceeded the outside limit over an entire multi-year budgeting period, the federal government would have authority to take over operation of the purchasing cooperatives in the state. The federal government could operate or oversee a state's purchasing cooperatives — using any of the cost containment tools available to a state — until such time as a state submitted a credible plan for restraining spending in the future.

ii. **Federally-imposed financial penalty.** An example of this type of sanction would be a tax on providers, with revenues flowing to the federal government. This sanction would not be used as a mechanism to recoup the additional cost of low-income subsidies, but rather as a penalty for exceeding the budget.

iii. **Federally-imposed ratesetting.** If spending exceeded the outside limit over an entire multi-year budgeting period, the federal government would implement rate-setting systems in that state, which would assure compliance with the federally-defined budget.

- In order to implement rate-setting systems that are best suited to local circumstances, the federal government would have flexibility to implement different systems in different states and various approaches by provider type.

- For staff model HMOs and other fully-capitated delivery systems, the federal government would impose the expenditure limit through limitations in premium increases.

- The federal government's systems would remain in effect until the state provided the federal government with evidence that its proposed expenditure restraint policies would achieve conformance with the federally-defined budget.

- In carrying out its functions, the federal government could require states, health plans, providers, and insurers to submit relevant information to assess compliance with the expenditure limits and to assure timely and effective implementation of any necessary federal actions.

budprop2.wp

Short-term cost control options

Option 1: Insurance premium regulation

- Would set allowable rates of increase for insurance premiums (or premium equivalents for self-insured firms).
- Limits one of the most visible costs to consumers and introduces the concept of operating under a budget.

Option 2: All-payer rate setting

- Would extend Medicare payment methodology to all payers and set rates to control spending.
- System already in use; familiar to providers.

Option 3: Provider price controls

- Would control prices based on historical levels, without regard to whether or not the charges were excessive in the first place.
- Could be imposed immediately.

Option 4: Marginal revenue ~~taxes~~

- Would impose a temporary revenue surtax on providers whose revenue growth exceeds a target.
- Could be imposed immediately.

Option 5: Voluntary controls

- Would require enlisting industry in voluntary controls and passing standby authority for the President to impose mandatory controls if the voluntary goals are not met.
- Mandatory control option could be developed during a trial period for the voluntary controls.

Short-term cost control options

Option 1: Insurance premium regulation

This option calls for setting allowable rates of increase for insurance premiums (or premium equivalents for self-insured firms).

Regulating premium increases limits one of the most visible costs to consumers and introduces the concept of operating under a budget. It may also thwart price gouging during the transition.

However, implementing premium regulation requires a complex administrative apparatus. Limiting premium increases may lead to "dumping" of insured individuals with costly health conditions, denials of treatment or reimbursement, or bankruptcy of insurance companies. Effectiveness also depends upon enlisting states as enforcers.

Option 2: All-payer rate setting

This option calls for extending the Medicare payment methodology to all payers and setting rates to control spending.

Health care providers and insurers that have served as carriers or fiscal intermediaries for Medicare all have experience and mechanisms in place to implement this method of cost control. Some states that have adopted all-payer rate setting have had success in controlling costs in the private sector.

However, experience under Medicare indicates that volume increases may offset some savings. Cost shifting to unregulated sectors may occur until rates are established (for outpatient services, for example).

Even if rate-setting aims to make no aggregate change in provider payment levels, it will redistribute income among providers, since the new rates will differ from current charges. Providers will face a double shakeup--first, rate-setting; then, managed competition. Turning health care upside down once might be thought enough.

Option 3: Provider price controls

This option would control prices based on historical

levels, without regard to whether or not the charges were excessive in the first place. Prices would be decontrolled as managed competition becomes fully operational.

Price controls can be imposed immediately. They do not threaten any sharp change in current provider incomes.

However, price controls are likely to trigger an increase in volume, which will offset some savings. They are hard to enforce, especially on physicians. The longer they are in place, the greater the inequities and unintended consequences.

Option 4: Marginal revenue taxes

This option imposes a temporary revenue surtax on providers whose revenue growth exceeds a target.

The surtax can be imposed immediately and will deter volume increases. Although evading the controls would be a form of tax evasion, providers may well find ways to game the system and legally avoid the tax. They could also respond to marginal revenue taxes by turning away patients.

This option is untested and could adversely affect the development of efficient plans experiencing rapid growth.

Option 5: Voluntary controls

This option calls for enlisting industry to adopt voluntary controls, with standby authority for the President to impose mandatory controls if the voluntary goals are not met. A mandatory control option could be developed during a trial period for the voluntary controls. This option might make providers more favorable to the plan.

This option does not ensure cost savings.

AN OPTION TO FREEZE AND CONTROL PROVIDER PRICES

This option is designed to reduce aggregate health care spending as much as possible and as soon as possible.

TIMING:

- o First, prohibit increases in provider prices.
- o After 3 to 9 months replace the freeze with a system that is flexible and enforceable. Officials from Carter's Council on Wage and Price Stability (CWPS) state that an inflexible freeze of longer than 5-6 months would lead to rapidly declining compliance.
- o Decontrol prices gradually, as managed competition addresses the causes of cost growth.

GENERAL DESIGN:

- o As with all price control options, ban increases in balance billing and limit balance billing, e.g., to 20%. To facilitate enforcement, allow consumers to sue providers who violate balanced billing guidelines for triple damages.
- o To combat anticipatory price hikes, begin the freeze by requiring that prices be rolled back a constant percentage.
- o For administrative simplicity, do not control wages or input prices.
- o In stage 2, set price growth, e.g., equal to inflation. Anticipate volume offsets, e.g., of 50 % for physicians. Define criteria for special exemptions, and establish a review process.

DESIGN BY SECTOR:

Physicians: MDs typically earn a fee for service, (FFS), or a fixed "capitated" payment per patient. Physicians' revenues were $152 billion in 1991, (20% of NHE) and are projected to grow at 5.8% annually in real dollars during the 1990s; 361,000 MDs are office-based.

- o For FFS payments, all private third party payers, including self-insured employers, would freeze usual and customary rates, effectively capping reimbursements to MDs. Third party payers that do not use usual and customary rate screens to limit payments to physicians would be mandated to use an acceptable screen within 3 months of the date the freeze begins. To be 'acceptable' the usual and customary screen would be derived from a data base that meets Federal quality standards, e.g., a random sample of sufficient size, etc.

- o For capitated payments, health plans would freeze payment schedules to preferred provider organizations, or to independent practice associations. Changes in bonuses, or other compensation would be banned.

Hospitals: Payments to hospitals are based on charges, capitation, or private DRGs. For-profit and not-for-profit

hospitals could be treated identically. Revenue of 7000 hospitals was $324 billion in 1991, and is expected to grow at 5.8 % annually in real dollars during the 1990s.

o DRGs and capitated payments are typically negotiated by the health plan with the hospital. Prohibit health plans from increasing payments above historic levels.

o For hospitals paid on the basis of charges, the lack of standardized billing codes may prompt the spurious redefinition of products. Therefore ban charge-based billing and base payments on average revenues per admission. These are calculable using IRS revenue data, and HAA admissions data.

HMOs: Premia for staff model HMOs could either be frozen and controlled or left alone. Compliance by 550 HMOs could be monitored Federally.

OTHER: Dentists, medical labs and some nursing homes are also compensated by third party payers. These could also be subject to controls.

ENFORCEMENT:

o Require quarterly compliance reports of all third-party payers, including HMOs and self-insured employers to a Federal Office of Health Care Cost Control.

o Interested third party payers may monitor provider prices more cost-effectively than Federal agencies. Additional record keeping by health plans and by providers, nonetheless, appears necessary.

o CWPS in 1978 used 300 staff to supervise voluntary price controls for 2000 large manufacturing firms.

EFFECTIVENESS: The medical services deflator during the Nixon price controls grew by about 2% less than in preceding periods. Medical care spending growth during the freeze was about 2.5% less than earlier periods, and during Phase 2 about 1% less.

MARGINAL REVENUE TAXES

SUMMARY: Impose temporary revenue surtaxes on providers whose revenue growth exceeds a target.

DESIGN: The tax could begin at two cents on the dollar for revenues greater than a base, e.g., last year's adjusted gross revenue, as reported to the Internal Revenue Service. It would rise linearly to 30 cents on the dollar for revenues greater than 115 percent of the base. Variations would include beginning the tax above the base, raising it more sharply as revenue increases above the base, and giving different tax schedules to different classes of providers. Since the IRS collects revenue data from all providers, including not-for-profit hospitals, this approach could be effective January 1994.

New providers, e.g., recently graduated physicians, could be given special schedules so that their base revenue is the average revenue for new physicians in their specialty. Corporate mergers could be taxed using the sum of the base revenues of the merged entities. Other new physicians' practices could simply be given a base equal to the average revenue of their type of practice.

SCOPE: This approach, with variations, could be applied to hospitals, physicians, nursing homes, medical labs, and dentists.

ENFORCEMENT: Despite the extensive experience of the IRS, the extent of compliance is uncertain, because providers would try to shelter revenue. Accounts receivable could be given to collection agencies with understandings to undertake long-term investments. Medical practices could be reorganized, and billings collected by entities without visible connections to the practices. Medical practices that own rental income could sell these assets to allow for greater tax free growth in medical revenue.

Relatively low tax rates, carefully drafted legislation and strict enforcement could increase compliance. In addition third party payers could be required to report to the IRS summaries of payments made to particular providers.

EFFECTS: Unlike price controls, marginal revenue taxes would not increase the volume and intensity of services. By causing physicians to take more leisure, they may lead physicians to cutback either patient loads or the intensity of service. Prices may rise. A graduated revenue tax allows some flexibility to all providers.

ALL PAYER RATE SETTING OPTION

Extend Medicare payment methodology to all payers and set rates so that spending is controlled.

I. Implementation Schedule

For 1994:

- DHHS completes initial schedule modifications for hospital inpatient, physicians
- DHHS uses Medicare data or limited private data to calculate conversion factors/standardized payment amounts
- DHHS establishes volume controls using Medicare as a proxy
- DHHS completes Medicare software adaptation
- During first 6-9 months after enactment, insurers adopt rates or contract with Medicare contractors

For 1995:

- DHHS will complete rates for hospital outpatient services
- More extensive private data for physician conversion factors and volume standards/controls will be available
- DHHS will refine data to handle uncompensated care and other hospital adjustments
- DHHS may include hospital outpatient services in ratesetting, covering about 75% of health spending
- DHHS will begin/consider development of a wider variety of volume control mechanisms, including medical group controls, bundled payments for some ambulatory services, etc.

II. Administration and Monitoring

- Requires start-up costs for both the federal government and insurers, to a lesser degree for providers
- Requires establishment of a national all-payer database which may be valuable for other purposes

- Requires continued data collection for updating prices, enforcing volume standards, and accomodating potential savings slippages

III. Implications of All Payer Rate Setting

- Slow phase-in schedule limits scope of spending controlled:
  - Would cover only about 60-65% of total health care spending during the first year. Could not implement rates for outpatient hospital during first year.
  - Volume controls would be limited to withholds and for physician spending would have to be based on Medicare experience as a proxy during first year.
- Negative consequences may inhibit smooth transition to managed competition:
  - Provider dislocations
  - Lock-in of current resource allocations in a way inconsistent with managed competition
- Imposing structure could potentially smooth the transition to managed competition by:
  - Continuing controls for fee for service sectors
  - Standardizing service definitions for payers and consumers
  - Serving as a point of reference for the purchasing cooperatives in rate negotiation

TIMELINE FOR IMPLEMENTING ALL PAYER RATESETTING APPROACH

For July 1994 Implementation

April 1993	Complete detailed workplans for APRS, for hospital, physician, and other services
May 1993	Begin developing payment rates for pediatric, OB-GYN, and preventative services
June-Aug. 1993	Developmental to develop hospital and physician conversion factors
June-July 1993	Modify Medicare software packages to accommodate changes for non-Medicare
Aug.-Sept. 1993	Validate software, test in large Medicare contractors
October 1993	Legislation enacted
October 1993	Begin training private insurers in use of software, payment rules (e.g., surgical global packages, DRG bundling)
Nov. 1993 to March 1994	Large insurers install conversion programs to use Medicare adapted software
May-June 1994	Small insurers contract with Medicare contractors to price claims

For 1995

May to December 1993	Developmental work to develop hospital specific and physician area conversion factors
Oct. 1993 to Sept. 1994	Insurers would adopt converted software, validate before paying claims
Dec. 1993 to Aug. 1994	Payment rates for hospital outpatient services would be developed and provided to insurers
Fall 1994	Standardized claims forms and structure for data collection would be available to be adopted by private insurers
Jan. 1995	Implementation of APRS for hospital (inpatient and outpatient), physician, lab, medical equipment, and ambulatory surgery settings

Health Insurance Premium Regulation as an Interim Measure

I. Why

- Premiums are highly visible. Consumers will gain immediately and help enforce it;
- Creates incentives to control costs without requiring governmental micro-management;
- Compatible with capitated payment systems;
- Promotes move to managed competition (e.g., cost-effective provider networks, global budgets)
- May be necessary to prevent opportunism by some insurers during transition.

II. What

Set allowable rate of increase for:

- Actual premiums for policies currently in force;
- Average premium per covered life for each insurer in states that have already implemented small group reforms;
- Premium equivalent (applicable premium) for self-insured firms.

III. How

- Maximal use of existing state regulatory resources;
- For self-insured firms, use IRS authority to audit and enforce premium equivalents filed pursuant to COBRA;
- Supplement state departments with federal resources

  -- People or technical assistance in most states

  -- Complete office in nine relatively small states.

Primary State functions:

- Certify compliance with target;
- Respond to consumer complaints;

- Recommend hardship adjustments to the cap;
- Implement a credible random audit process;
- Guarantee continuity of coverage for currently insured.

Primary Federal functions:

- Retain ultimate authority and responsibility for premium control program, including setting the targets;
- Review state certifications of non-compliance, choose and apply penalties, including: premium tax surcharges, fines, corporate income tax surcharges, revoke the right to self-insure;
- Make final determinations of hardship exemptions;

IV. Problems and Solutions

Without consumer protections, this could INCREASE uninsured.

Therefore, for the currently insured, require limited market reforms, including: guaranteed renewability, limited pre-existing condition restrictions, no medical underwriting, retroactive reinstatement, and balanced billing limits.

Allow higher rates of increase to states who wanted greater reform or to expand access quicker.

Mechanisms for insuring continuity of coverage for the currently insured:

- Market absorption;
- Guaranteed issue for currently insured;
- Residual pools -- carriers of last resort, state high risk pools, joint underwriting agreements.

V. Implementation Requirements

- Pennsylvania regulates coverage for 12 million people with a staff of 40. Most states would need at least a few more trained staff, and a Federal staff of at least 100-150 would be required. Three months between the passage of legislation and the start of the program would be highly desirable.

Increase Use of Managed Care as an Interim Cost Control Measure

This option focuses on increasing the use of managed care in the public and private sectors and fostering greater competition among plans.

A. Private Sector Options

- Give employees in companies with multiple plans greater incentive to choose lower-cost providers

  For employers offering their employees a choice of health care plans, employers would pay a set dollar amount regardless of the cost of the plan. The amount could be set at the lowest-priced option, the highest-priced option, or some amount in between. Employees would be allowed to take the difference between the employer contribution and the price of the plan they chose as additional wages or as tax-free savings contributions. At Alcoa, this led to an increase from 15 to 68 percent in the number of persons in lower cost plans. At Xerox, this practice lowered rates of increase for <u>all</u> plans because they were put into price competition with each other. Larger employers without multiple plans could be encouraged to offer multiple options through tax incentives.

- Give employees in small firms the option of choosing to join larger Federal or state pools.

  The Federal Employee's Health Benefits Plan or state employee's health plans could be opened to small employers on a risk-adjusted basis. Government plans offer a wide selection of plans, group rates, and reduced administrative costs. This would be coupled with a defined contribution requirement as for employers offering multiple plans.

- Reduce the tax code bias towards excessive health spending

  This could be accomplished either by imposing a limit on the amount of employer-provided health benefits which may be deducted or excluded from income. The cap should be set so that individuals choosing a low cost plan receive the full tax deduction and exclusion.

- Remove barriers to managed care

  Remove state laws that limit managed care plans' ability to contain costs, such as:

  - willing provider requirements

- open pharmacy requirements
- benefit mandates
- utilization review restrictions
- freedom of choice requirements
- restrictions on negotiating discounts with providers

- Implement standardized performance/quality measures

  Hospitals would be required to report in a standardized, severity-adjusted format the extent of variation in physician practice patterns (resource utilization, length of stay and charges per patient) and clinical indicators of quality (mortality and morbidity rates, readmissions, and rates of immunizations, C-sections, pap smears, etc.). Health plans and employers could then use these quality-cost comparisons to manage hospital networks better.

  In Cincinnati, four large employers convinced all 14 of the city's hospitals to submit such data. After a single year, the hospitals reduced their average length of stay per patient by 0.6 days and their average charges per patient by 5 percent, for a one-year savings of $75 million.

B. Public Sector Options

- Increase the use of managed care in Medicare

  Medicare beneficiaries would be offered an open annual enrollment in qualifying area HMOs and the traditional Medicare fee-for-service plan. HMOs would bid for the right to serve the Medicare population and would offer a more generous benefits package than traditional fee-for-service Medicare. Beneficiaries and fiscal intermediaries would be given some of the savings from a move to lower-cost plans.

  Alternatively, if the integration of Medicare into the managed care institutions is not to occur for several years, a Medicare PPO could be established in each state. Beneficiaries who joined the PPO would be given some share of the savings, as well as additional benefits.

- Require increased coinsurance for Medigap policy-holders

  Medigap coverage of Medicare's cost sharing requirements has been estimated to add 24 percent to Medicare's costs because of induced demand. Increased cost sharing would lower the burden of this induced demand to the government and make Medicare HMOs more attractive to beneficiaries.

- Remove barriers to use of managed care in Medicaid

  Currently, states must receive HCFA and legislative waivers in order to use managed care effectively for their Medicaid populations. Those restrictions, intended to ensure quality care, would be repealed and replaced with quality, marketing and solvency standards.

THE WHITE HOUSE

WASHINGTON

DATE:	**Wednesday, April 14, 1993**
TO:	**The President** **The First Lady**
RE:	**Diplomatic Credential Ceremony**
TIME:	**6:15 p.m.**
LOCATION:	**Blue Room**
DRESS:	**Business**
NO. OF GUESTS:	**100**
FROM:	**Ann Stock**

5:40 p.m. Ambassadors arrive South Portico and are escorted to State Dining Room.

6:15 p.m. THE PRESIDENT and THE FIRST LADY arrive State Floor and proceed to Blue room to begin Credential Ceremonies.

Richard Gookin, Acting Chief of Protocol, introduces THE PRESIDENT and THE FIRST LADY to the Ambassador from the Republic of Peru and his family.

THE PRESIDENT and THE FIRST LADY pose for photos with the Ambassador and his family.

THE PRESIDENT and THE FIRST LADY escort appointed Ambassador and his family to seating area for exchange of documents and a brief conversation, where they are joined by Tony Lake, Deputy Assistant Secretary of State, and appropriate NSC staff.

THE PRESIDENT and THE FIRST LADY are introduced to remaining Ambassadors and families, at seven minute intervals.

The Ambassadors are from:

The Republic of Mali
The Kingdom of Lesotho
The State of Kuwait
Mexico
Hashemite Kingdom of Jordan
Sweden
The Republic of Latvia
Austria
The Republic of Azerbaijan
Israel
The State of Qatar

THE PRESIDENT and THE FIRST LADY depart.

THE WHITE HOUSE

WASHINGTON

DATE:	**Wednesday, April 14, 1993**
TO:	**The First Lady**
RE:	**Latina Health Care Meeting**
TIME:	**3:00 p.m. - 4:00 p.m.**
LOCATION:	**State Dining Room**
DRESS:	**Business**
NO. OF GUESTS:	**30**
FROM:	**Ann Stock**

3:00 p.m. THE FIRST LADY is announced into State Dining Room.

THE FIRST LADY proceeds to seat in front of fireplace. Seated will be:

Mrs. Gore
Hon. Lucille Rybal-Allard
Hon. Ileana Ros-Lehtinen
Hon. Nydia Valazquez

Participants will introduce themselves.

Hon. Lucille Roybal-Allard will make opening remarks.

Hon. Ileana Ros-Lehtinen and Hon. Nydia Valazquez will make remarks.

THE FIRST LADY will make remarks.

Mrs. Gore will make remarks.

Dr. Helen Rodriguez-Trias and Dr. Barbara Menedez will give overview of two health issues.

THE FIRST LADY and Mrs. Gore will monitor Q & A.

Dr. Elena Rios will give summary of recommendations.

Hon. Lucille Roybal-Allard will give closing remarks.

4:00 p.m. THE FIRST LADY departs.

Date: 13-Apr-1993

RESIDENCE EVENT TASK SHEET

Type of Event: MEETING
Group: LATINA HEALTH CARE MEETING
Date: 14-Apr-1993 **Time:** 3:00pm to: 4:00pm **Guests:** 30 **Dress:** BUSINESS
Site: STATE DINING ROOM **Rain Site:** N/A
Principals: THE FIRST LADY
from: 3:00pm **to:** 4:00pm **Remarks:** Yes _ No * **Time:**
Receiving Line: Yes _ No * **Time:** **Site:**

USHERS' OFFICE: **#Chairs:** 30 **Tables:** NO **Platform:** NO
Serving Time: N/A **Location:** N/A
Coat Check: Yes _ No _
Food/Beverage: N/A

TOUR OFFICERS: **Entry Gate:** **Exit:**
Parking: Yes _ No _ **Location:**
Comments:

CALLIGRAPHERS: **Place Cards:** Yes _ No * **Handouts:** Yes _ No *
Other: NONE

WHITE HOUSE PHOTO: Yes * No _ **Time:** 2:00pm **General Edit:** Yes * No _

MILITARY OFFICE: **Social Aides:** 0 **Carriage Call:** Yes _ No *
Door Openers: Yes _ No * **Honors:** Yes _ No *

Type of Music	Site	Time

WHCA: **Podium:** Yes _ No * **Type:** N/A **Location:** N/A
Announcer Mike: Yes * No _ **Other Mikes:** Yes _ No *
Site: N/A
Recording: Yes _ No * **Other Requirements:**

PRESS: Yes * No _ **Details:** POOL SPRAY AT BEGINNING
WH Television: Yes _ No _

SPECIAL INSTRUCTIONS:

5 SEATS IN FRONT OF FIREPLACE
25 CHAIRS, THEATER STYLE, FACING FIREPLACE

Social Office Contact: ANN STOCK **Phone:** x7136 **Fax:** x6235
White House Staff Contact: JULIE HOPPER **Phone:** x7560 **Fax:** x
Group contact: **Phone:** ( ) - **Fax:** ( ) -

Reimbursable: Yes _ No * **Bill:**

Date: 13-Apr-1993

RESIDENCE EVENT TASK SHEET

Type of Event: CREDENTIALING CEREMONY
Group: AMBASSADORS
Date: 14-Apr-1993 **Time:** 5:40pm **Guests:** 100 **Dress:** BUSINESS
Site: DIP RM, SDR, RED RM **Rain Site:** N/A
Principals: THE PRESIDENT AND THE FIRST LADY
from: 6:15pm **to:** **Remarks:** Yes * No _ **Time:**
Receiving Line: Yes _ No _ **Time:** **Site:**

USHERS' OFFICE: **#Chairs:** **Tables:** **Platform:**
Serving Time: **Location:**
Coat Check: Yes * No _
Food/Beverage: PER GARY WALTERS

TOUR OFFICERS: **Entry Gate:** SOUTH PORTICO **Exit:**
Parking: Yes * No _ **Location:**
Comments:

CALLIGRAPHERS: **Place Cards:** Yes _ No * **Handouts:** Yes _ No *
Other: TOE CARDS

WHITE HOUSE PHOTO: Yes * No _ **Time:** 6:15pm **General Edit:** Yes * No _

MILITARY OFFICE: **Social Aides:** **Carriage Call:** Yes _ No _
Door Openers: Yes _ No _ **Honors:** Yes * No _

Type of Music	Site	Time
HARPIST	STATE DINING	5:20pm

WHCA: **Podium:** Yes _ No * **Type:** N/A **Location:** N/A
Announcer Mike: Yes * No _ **Other Mikes:** Yes _ No *
Site:
Recording: Yes * No _ **Other Requirements:**

PRESS: Yes * No _ **Details:**
WH Television: Yes * No _

SPECIAL INSTRUCTIONS:

Social Office Contact: ANN STOCK **Phone:** x7136 **Fax:** x6235
White House Staff Contact: CHRISTY KENHY **Phone:** x2224 **Fax:** x
Group contact: **Phone:** ( ) - **Fax:** ( ) -

Reimbursable: Yes * No _ **Bill:** STATE DEPARTMENT

SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: WEDNESDAY, APRIL 14, 1993
DRAFT: #2

PREV RON — The White House

9:00 am — **RADIO CONFERENCE CALL**
1. HRC's Office

Contact: Lisa Caputo
456-2856

10:00 am-
12:00 pm — **MEETING W/ DAN ROSTENKOWSKI and DEM. MEMBERS OF THE WAYS AND MEANS COMMITTEE**
2. Roosevelt Room
CLOSED PRESS

Format:

Participants: Approx. 24 Members Attending
(See briefing for more info.)

Staff Contact: Melanne Verveer
456-2538
Chris Jennings
456-2645

Contact: Virginia Fletcher
225-4061

12:05 pm — **LUNCH**

1:00 am-
1:15 am — **PRIVATE MEETING W/Maggie and Patti**
HRC's Office

1:15 am-
1:30 am — **PRIVATE MEETING W/Maggie**
HRC's Office

1:30 am-
1:45 am — **PRIVATE MEETING W/Ira and Carol**
HRC's Office

1:45 pm-
3:00 pm — **PHONE/OFFICE TIME**

3:00 pm-
4:00 pm — **LATINA HEALTH CARE MEETING**
3. Map Room

Format: HRC to make brief remarks

Participants: Approx. 20 attendees
(See briefing for more info.)

CONTACT: [illegible]

Contact: Maria Ochoa
225-1766

Staff Contact: Melanne Verveer
456-2538

4:15 pm-
6:00 pm

PRIVATE MEETING
Roosevelt Room

Staff Contact: Maggie Williams
456-1660

5. 6:15 pm-
7:45 pm

****OPTIONAL****
MEETING W/ AMBASSADORS
Blue Room
POOL PRESS

Staff Contact: Ann Stock (456-7136)

RON

The White House

NSC
credential ceremony
check w/ Brenda
X2224
FRAN

12:10pm
left req w/
Will Itz

copy will be provided tomorrow —
will Ito - exec. sec.
call at
#6630
Row Cuker
BRENDA Hilliard
X2224

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

April 13, 1993

put in

TO: Chris Jennings

FROM: David Abernethy

SUBJ.: Questions for tomorrow's meeting

****

Attached are the questions we discussed. The first set are from the Chairman of the Subcommittee. I am enclosing the copies of the questions from individual members so that you will be aware of their concerns. Please call me if you have any questions.

LUCILLE ROYBAL-ALLARD
33d DISTRICT, CALIFORNIA

Committee on Banking, Finance, and Urban Affairs
Subcommittee on Housing and Community Development
Subcommittee on Consumer Credit and Insurance

Committee on Small Business
Subcommittee on SBA Legislation and the General Economy
Subcommittee on Minority Enterprise, Finance, and Urban Development

Copy

Congress of the United States

House of Representatives

Washington, DC 20515-0533

Mailing Address:
324 Cannon House Office Building
Washington, DC 20515
Telephone: 202-225-1766

DISTRICT OFFICE:
255 East Temple St
Suite 1860
Los Angeles, CA 90012
Telephone: 213-628-9230

April 6, 1993

Ms. Diana Bonta
Director, City of Long Beach
Department of Health and Human Services
2655 Pine Avenue
Long Beach, CA 90806

Dear Ms. Bonta:

Thank you for your assistance and participation in the upcoming meeting with Ms. Hillary Rodham Clinton. I am very pleased to inform you that there is a good possibility that Ms. Tipper Gore will be joining us at the meeting with Ms. Clinton, which has been scheduled on April 14, 1993, 3:00 p.m. at the White House.

As Latinas concerned with the health care needs of our families, we have a unique perspective on the health policy needs of our communities. This meeting presents an unprecedented opportunity to share this perspective with Ms. Clinton and to have input in the shaping of this country's universal health care program. I appreciate you sharing your expertise and your valuable time to participate in this process.

I would also like to invite you to a luncheon pre-meeting on April 14th at 12:00 noon, in room B-339 of the Rayburn House Office Building on Capitol Hill. This informal gathering will give us an opportunity to get to know one another and to go over the agenda and format prior to the meeting with the First Lady and Ms. Gore.

Attached for your information, I have included a listing of all the women who have confirmed their attendance to the meeting. If you have any questions, suggestions, or need additional information, please feel free to call Maria Luisa Ochoa of my staff at (202) 225-1766.

Warmest Regards

LUCILLE ROYBAL-ALLARD
Member of Congress

gp

x6774

HRC/HRD -
- don't need everyone to talk
- dialogue, not just presentation

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	From: Miaria Ochoa, To: Sara Grote, Re: Agenda [partial] (1 page)	4/12/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Wednesday April 14 [1993]

2014-0483-S
sb332

RESTRICTION CODES

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

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

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

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

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

04/12/93 16:57 ☎ L.Roybal-Allard 001

LUCILLE ROYBAL-ALLARD
33d DISTRICT, CALIFORNIA

Committee on Banking, Finance, and Urban Affairs
Subcommittee on Housing and Community Development
Subcommittee on Consumer Credit and Insurance

Committee on Small Business
Subcommittee on SBA Legislation and the General Economy
Subcommittee on Minority Enterprise, Finance, and Urban Development

Mailing Address:
324 Cannon House Office Building
Washington, DC 20515
Telephone: 202-225-1766

DISTRICT OFFICE:
255 East Temple St
Suite 1880
Los Angeles, CA 90012
Telephone: 213-620-9230

Congress of the United States
House of Representatives
Washington, DC 20515-0533

THIS FACSIMILE IS BEING TRANSMITTED FROM
THE WASHINGTON, DC OFFICE OF

CONGRESSWOMAN LUCILLE ROYBAL-ALLARD

Fax # (202) 226-0350
Office # (202) 225-1766

(H) 232-4938

Kim -
Here is
the "fun agenda"
- Sara

TO: Sara Grote

FROM: Maria Ochoa

DATE: 4/12 YOUR FAX #: 456-2317

No. of pages to follow: 1

Message :

Sara - This agenda has not been approved by the Congresswoman. Please make any changes/suggestions & call me.

** Also please add Congresswoman Ros-Lehtinen Staffer to the list, her name is Elizabeth Rodal SS# (b)(6) DOB

THANK YOU

001

Delete - Milagros - Davila, I will be substituting her name for someone else. As soon as I have the replacement

Revised

Tentative Agenda

ROUNDTABLE DISCUSSION ON CRITICAL HEALTH ISSUES AFFECTING LATINO CHILDREN AND LATINAS IN THE UNITED STATES

The White House
Washington

April 14, 1993

A G E N D A:

I. Introductions & Photos.....Participants

II. Opening Remarks.....Hon. Lucille Roybal-Allard

III. Remarks by.....Hon. Ileana Ros-Lehtinen – Miami, FL
Hon. Nydia Velazquez

IV. Remarks by.....Mrs. Hillary Rodham Clinton
Mrs. Tipper Gore

V. Overview of 2 Health Issues — I speak – 7 min

A. Health Status and Policy Issues of Latinas and Latino Children in the United States

B. Latino Access to Health Care: A discussion for Health Care Reform — I speak – 7 min

VI. Questions.....Participants & Mrs. Clinton

VIII. Summary of Recommendations

IX. Closing Remarks.....Hon. Lucille Roybal-Allard

***

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. fax	From: David Abernethy, To: Chris Jennings, Re: April 14, 1993 Meeting [partial] (1 page)	4/13/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Wednesday April 14 [1993]

2014-0483-S
sb332

RESTRICTION CODES

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

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

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

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

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

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

April 13, 1993

TO: Chris Jennings

FROM: David Abernethy, Staff Director

SUBJECT: April 14, 1993, Meeting

****

These are the dates of birth and Social Security numbers of the Members and staff of the Subcommittee on Health of the Committee on Ways and Means who will be attending the meeting scheduled for 10:00 a.m. on April 14, 1993:

MEMBERS:

Pete Stark
Born (b)(6) 002
SS#

Sander Levin
Born (b)(6) 002
SS#

Ben Cardin
Born (b)(6) 002
SS#

Mike Andrews
Born (b)(6) 002
SS#

Jim McDermott
Born (b)(6) 002
SS#

Jerry Kleczka
Born (b)(6) 002
SS#

STAFF:

David Abernethy
Born (b)(6) 002
SS#

Tricia Neuman
Born (b)(6) 002
SS#

James Reuter
Born (b)(6) 002
SS#

The Members of the Subcommittee will be driving to the meeting on Wednesday:

Pete Stark
Maroon 1985 Mercedes 500 SEL 4-Door
California Tag "1PFL380"

Sander Levin
Light Brown 1987 Mecury Sable 4-Door
Michigan Tag

Ben Cardin
Gray 1991 Cadillac 4-Door
Maryland Tag

Mike Andrews
White 1983 AMC Wagoneer
Texas Tag "HOUSE 25A"

Jim McDermott
White 1980 Chevrolet Malibu 4-Door
Washington Tag "WA-7" (U.S. House of Rep.)

Jerry Kleczka
Navy Blue 1988 Jeep Cherokee
Wisconsin Tag "GDKMC"

Brenda Hillard

VA Kelly

247

(0)

Maria Melan

225-1766

Jim Kohl

OPA - 5pm

reinforce new different not the same as in both Caucus meetings

at other events greatly appr

- Because they were present ~~very~~ limited into Sem.

- ~~most~~ int 1 min. each

- purpose in dialogue & not talking at great benefit -

wealth of talent

— Other women not had the oppor -

— HRC very good at ~~following~~ up —

To make this

How to // Background Lucille & Nydia

~~grassroots perspective~~

really wanted

11-12%

5-6% Sen

- give HRC visibility which will be helpful down the road w/ Hisp. women.

for the long term

Sense of urgency 'Doesn't this admin. recog & have access

Lucille R-A speak to other members

waves

P-N - 4155