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THE WHITE HOUSE

WASHINGTON

MAR 23 1994

NOTE TO KRISTINE M. GEBBIE

Through: George Walter

Subject: Health Care Reform Hearing -- UPDATE

- The House Veterans Affairs Hospitals and Health Subcommittee held a hearing on the VA's plans to implement national health care reform. From coverage of the hearing today, we understand that the VA is in the process of doing a plan, but it has not been cleared by the Secretary and is not expected to be completed for approximately two months (see attached summary).

- The Congress leaves for a two week spring break starting March 25 and will return on April 11. We plan to cover the hearing on Medicaid scheduled for tomorrow, March 24.

Alice M. Litwinowicz

Alice M. Litwinowicz

Hearing Summary
House Veterans Affairs Committee: Subcommittee on Hospitals and Health Care
Hearing on Health Care Reform Implementation by the Veterans Administration
March 23, 1994

Members Present:
Democrats: Rowland(CH-GA), Long(IN), Edwards C.(TX), Filner(CA), Kreidler(WA)
Republicans: Smith, C.(NJ), Bilirakis(FL), Linder(CA), Everett(AL), Buyer(TN)

Witnesses: Dr. Elwood J, Headley, Acting Deputy Under Secretary for Health Department of Veterans Affairs
Accompanied by: Mr. Keiner, Veterans Administration's General Counsel; Mr. Walters, Legislative Office Health Care Reform Office; Dr. Milbrant, Resource Manager; Ms. Neary, Construction Planning; Ms. Kirks, Construction Planning

Rep. Rowland opened the hearing by saying that the Hospitals and Health Care Subcommittee wanted to build upon H.R. 3600, the Health Security Act. The subcommittee, according to Rep. Rowland is aiming to improve the bill and make it more applicable to veterans.

Following the opening statements, Dr. Elwood Headley testified on behalf of the Veterans Administration (VA). He informed the subcommittee that the VA has been working with the Clinton Administration to define and preserve an independent health care system for veterans. This system would offer choices to both the veterans and their dependents. He said "The Health Security Act... is the only health reform bill which we have seen which recognizes the unique health needs of veterans and the importance of the VA health system and would preserve and strengthen that system." The VA health plans would guarantee a comprehensive benefits package to all veterans and their dependents who are enrolled with the VA. This package would include inpatient and outpatient care, prosthetics, durable medical equipment, home health services, hospice care, and prescription drugs. He informed the subcommittee that last fall, the Health Care Reform Program Office was established to develop an implementation plan for the VA to make the transition to a competitive health care environment. This office is currently editing the initial draft of the proposed changes that the VA would have to make to adapt to the President's plan. Since this revision has not been submitted to the Secretary for his review, it is not available. There are two key changes that the VA will have to make. They are in the areas of customer service and the establishment of an "integrated managed care delivery system." The VA would like to see prompt and accessible primary care, including health promotion and disease prevention, acute chronic and specialty care, and health education. According to Dr. Headley, H.R. 3600 would grant "provide the VA with the authority to implement alternative personnel systems for the management of

VA health personnel." He stressed that the organizational, administrative, financial management and information resource decision making authority would be placed at the lowest possible level.

Following testimony, Dr. Headley and his panel answered questions. Rep. Rowland asked what the two key recommendations by the VA would be to the Secretary. Dr. Headley responded that they would be concerning customer service orientation and decision making planning. Dr. Headley explained that the customer service orientation would involve culture changes, personnel initiatives, work place initiatives, defining roles, defining benefits and the proper addressing of veterans issues. The VA would like to educate all employees on customer service standards. Dr. Headley informed the subcommittee that such items as spinal cord care, blindness rehabilitation, and care for homelessness would be covered under the current appropriations as supplemental benefits. The panel informed the subcommittee that the VA has not taken a position on the abortion issue, but will offer the benefits package as prescribed in H.R. 3600. The panel told the subcommittee that the Clinton plan would offer comparable prescription drug benefits, expanded prothesis, and durable medical equipment. The panel informed the members that the price tag for this endeavor was not available at this time. The panel also explained to the subcommittee that the ambulatory care program is not ready yet. They also said that there still would be a need for tertiary care. The Republican members of the subcommittee expressed concern over whether the VA would maintain its independence under the Clinton plan. They were concerned that the VA would lose its voice and the veterans would suffer. The subcommittee suggested that a survey of other veterans programs around the world be taken.

Prepared by:CHarrington:ONAP:March 23, 1994:690-5560

Andrew Barrer, Ph.D

THE WHITE HOUSE

WASHINGTON

MAR 16 1994

NOTE TO KRISTINE M. GEBBIE

Through: George Walter

Subject: Health Care Reform Hearing -- UPDATE

- As reported at the staff meeting on Monday, we have continued to actively monitor health care reform activities and wanted to provide you with additional summaries of Congressional hearings.

- The three great problems of health care reform that have emerged are: How to finance universal coverage? How to contain costs? How to spread costs equitably so that sick and poor citizens aren't left out of any new system?

- Eight members of the House plan to go to the floor tonight to debate the statement: "Resolved: The Clinton health-care plan best represents the elements that should be included in health-care reform." Representatives Gephardt (MO), Waxman (CA), Stark (CA) and DeLauro (CT) will argue in support of the statement. Arguing against the plan will be Representatives Gingrich (GA), Bliley (VA), Thomas (CA) and Johnson (CT). The debate will be covered on C-SPAN and on National Public Radio, is the first in what is supposed to be a series of debates on major policies facing Congress.

- Yesterday the Ways and Means Subcommittee on Health voted to keep a provision requiring that employers pay for 80 per cent of the cost of health care for their employees. The amendment to strip the provision is one of the key issues in the debate - whether universal health-care coverage should be made possible largely by requiring employers to pay for health care coverage for their employees.

- We have attached summaries for your review and circulated them among staff.

Tab A: The Clinton Health Plan and Public Health, Consumer Protection and Civil and Privacy Rights

Tab B: Health Care Reform: Issues Relating to Inner-City and Rural Communities

Tab C:	Health Care Reform: HR1200, The American Health Security Act of 1993; HR 2610, The Mediplan Act of 1993; and Other Single-Payer Options
Tab D:	Hearing to Examine Health Care Coverage for Americans with Disabilities
Tab E:	Benefits Package Health Care Reform
Tab F:	Women's Health Care in the President's Health Care Plan

Should you have any questions or comments, we are available at your convenience to discuss.

Alice M. Litwinowicz

Alice M. Litwinowicz

TAB A

Hearing Summary
House Subcommittee on Health and Education
The Clinton Plan and Public Health, Consumer Protection and Civil and Privacy Rights
January 31, 1994

Members list:
Democrats: Waxman (CH-CA), Cooper(TN)
Witnesses:

Philip R. Lee, M.D., Assistant Secretary for Health, PHS
Nan Hunter, Deputy General Counsel, HHS

Panel 1: John Lumpkin, M.D., Director Illinois Dept. of Health
Fernando M. Trevino, Ph.D., M.P.H., Exec. Director American Public Health Association

Panel 2: Brian Lindley, National Consumers League (replaced Linda Goldoner from the National Consumers League)

Panel 3: Dr. William Gibson, CH. of National Board of Directors NAACP
Marcia Greenberger, Co-President National Women's Law Center
Tim McFeely, Exec. Dir., Human Rights Campaign Fund
Kathleen Frawley, J.D., M.S., R.R.A., Director Washington D.C. Office of American Health Information Management Association

Rep. Waxman opened the hearing by saying that the current public health policy on AIDS is unsuccessful. He also expressed concern over individuals rights to privacy as well as whether or not the Health Security Card will be a civil rights violation to over one third of the Latinos within the U.S..

Following the opening remarks, Dr. Philip Lee testified that the President's plan will improve the health of Americans and also reduce health disparities. The plan, according to Dr. Lee, emphasizes personal accountability, disease prevention and a close relationship between the personal care and public health systems. Under the plan, all Americans will have comprehensive benefits including clinical preventive services. Dr. Lee stressed that the President's plan focuses on keeping individuals healthy. Dr. Lee stressed that there is a real need for public health care reform. He exemplified this point by saying that "substance abusers are the fastest growing segment of the HIV/AIDS population, and substance abusers with AIDS are a major factor in the spread of multi-drug resistant tuberculosis." Dr. Lee told the subcommittee that the President's plan has three specific Public Health initiatives. They are to "strengthen the capabilities of communities to protect the health of their populations and address high-priority local health problems; improve the knowledge base for preventing disease and providing medical care; and assure access to necessary health services for all Americans." By improving the health of communities, it will strengthen the government's capacity to provide population-based health activities. The President' plan allows for a national prevention initiation program and a core health program that will support such functions as the surveillance of communicable and

chronic disease, control of communicable diseases and injuries, environmental protection, public education and community mobilization, accountability and quality assurance, public laboratory services and education of public health professionals. The Public Health initiative provides for new prevention resources and expanded health services. Dr. Lee told the subcommittee that AIDS/HIV infection still poses the top prevention challenge. Dr. Lee also explained to the subcommittee that the Health Security plan will improve quality care six ways. They include national quality measures, quality report cards, expansion of research outcomes and the development of clinical practice guidelines, the placement of regional professional foundations at the center of continuing education within the health care field, the state establishment of quality criteria and the simplification of paperwork for providers. Dr. Lee also informed the subcommittee that consumer protection would be monitored under the President's plan. The final area that Dr. Lee discussed was that of privacy under the health plan. He explained to the subcommittee that there are three core principles under the President's plan. They include any disclosure that is permitted by law will be minimal, every patient shall have the right to know where individual identifiable information may be located, and every patient shall have a right of access to individual identifiable information to copy or correct such records.

The subcommittee asked Dr. Lee where the appropriations would be found for his plan. Dr. Lee told the subcommittee that the administration would be willing to work with Congress to find the money for the initiatives. Dr. Lee also explained to the subcommittee that the administration was willing to work with the committee to set proper standards for the alliances. Rep. Waxman told the panel that there was a need for the continuation of the Public Health Service and that the infrastructure within must be geared towards targeted objectives. The subcommittee expressed concern on how the individual state health plans would be evaluated. Dr. Lee explained that each plan would be looked at to see if it has met the set goals, what treatments are offered and other pertinent standards as set by Congress. Dr. Lee said that plans will be monitored by the alliances, Public Health Service agencies, and by the consumer (quality report cards). Dr. Lee told the subcommittee that the administration would work closely with Congress to prohibit any sexual discrimination.

Dr. John Lumpkin applauded the President's proposal and strongly supports the eight core functions. He believes they are critical to the population and should not be funded through competitive means or at the discretion of the Secretary of Health and Human Services. Dr. Lumpkin believes that states must have a designated, predictable source of funding for core public health programs. He would like to see increased accountability within states, increased data collection for research, and the inclusion of public health professionals in the development and implementation of a reformed health care system within a health care plan.

Dr. Fernando Trevino testified in support of a health care

reform bill that offers universal coverage while removing financial, organizational, and social impediments. He strongly supports the President's core public health functions. Dr. Trevino also approves of a national initiative regarding health promotion and disease prevention programs, but he says that the programs are far to vague as presented in the President's plan. He believes that the plan should support the training of public health workers so that they may respond effectively to public health problems including AIDS.

Brian Lindley testified in support of the President's plan and applauded the attention given to data collection, analysis, and dissemination. He told the subcommittee that individuals would need to be able to obtain unbiased information concerning plans, options, and providers, as well as an advocate and a grievance procedure for patient complaints. Mr. Lindley stressed that the incorporation of comparative information, plan-specific information, and condition specific information was necessary. He also supported the administrations establishment of ombudsman offices, but called for more detail concerning how this program will be designed.

Dr. William Gibson testified on behalf of the NAACP. He explained to the subcommittee that the NAACP wants a health plan that addresses both the racial and socio-economic realities that currently exist in the country. The NAACP supports many parts of the Clinton proposal, yet they are concerned that the plan may be to vague and ambiguous in addressing certain issues. The NAACP also supports the inclusion of an anti-discrimination provision. They would like to see protection against redlining and other possible civil rights violations, possibly through the use of a "preclearance mechanism."

Marcia Greenberger testified before the subcommittee on behalf of the National Women's Law Center. Ms. Greenberger stressed that there are many significant barriers that inhibit women from obtaining adequate health care. Ms. Greenberger explained to the subcommittee that AIDS has been affecting women in increased numbers, particularly among young women of color.

Mr. Timothy McFeely testified on behalf of four national lesbian and gay rights groups, including the Human Rights Campaign Fund. He told the committee that many of the health concerns of lesbians and gay men remain extensive and unmet. He explained that the gay and lesbian community desired an investment in an aggressive national program of biomedical research. Mr. McFeely also told the subcommittee that the protection against discrimination for disabled persons must also extend to those in the gay and lesbian community who are infected by HIV/AIDS. He stressed that "lesbians and gay men must have the right to full health coverage free of bias on the part of health alliances, plans, or providers." Mr. McFeely testified that no plan should allow a health care provider to refuse services that are included in the benefits package. McFeely also stressed the need for the recognition of non-traditional families, confidentiality, early intervention services and a comprehensive benefits package that promotes prevention, primary care, long-term care, home and community-based health care,

prescription drug coverage and medical education.

Prepared by:CHarrington:ONAP:March 7, 1994:690-5560.

TAB B

Hearing Summary
House Subcommittee on Health
Health Care Reform: Issues Relating to Inner City and Rural Communities
February 7, 1994

Members Present:
Democrats: Stark(CH-CA), McDermott(WA)
Republicans: Thomas(CA), McCrery(LA)

Witnesses:
Honorable Charles Stenholm, M.C., Texas
Honorable Pat Roberts, M.C., Kansas
Honorable Craig Thomas, M.C., Wyoming
Honorable Philip Lee, M.D., Assistant Secretary for Health, HHS

Panel 1:
Sara Rosenbaum, Center for Health Policy and Research, George Washington University
James D. Bernstein, President-Elect, National Rural Health Association
Larry Gage, President, National Association of Public Hospitals
John M. Silva, President, National Association of Community Health Centers, Inc.

Panel 2:
Honorable Jim Moody, Visiting Professor, Wisconsin Medical College
Jon E. Vice, President, Children's Hospital of Wisconsin
Barbara Staggers, M.D., Director of Adolescent Medicine, Children's Hospital Oakland
Martin Goldsmith, President and CEO, California Children's Hospital Association
Honorable Edward H. McNamara, County Executive, Wayne County, Michigan

* This office covered panel one, the additional information is taken from written testimony.

Senator Charles Stenholm testified before the subcommittee on behalf of the House Rural Health Care Coalition. He explained that financial incentives are found within the Clinton Bill, H.R. 3600, for primary care providers to locate in rural areas, yet these financial incentives are not enough. He encouraged the subcommittee to look at incentives that would build integrated health care delivery and communications systems. Sen. Stenholm also urged the subcommittee to "consider options to help communities in the planning and implementation of delivery networks." The Senator was concerned about the effects of health care reform upon small businesses.

Senator Pat Roberts also testified on behalf of the House Rural Health Care Coalition. He supports the efforts made in the Health Security Act to invest in the expansion of primary care services in undeserved areas, although he was concerned about the funding and the administration of funds for these programs. He also expressed concerns for the funding of educational and prevention programs. Sen. Roberts was anxious about the regional

alliance caps that may be developed based on historical data, rationing, and in the formation of adequate delivery systems. Sen. Roberts stressed the importance of giving rural communities adequate time to build funds for electronic information systems.

Senator Craig Thomas testified on behalf of the House Rural Health Care Coalition Task Force on Hospitals and Clinics. He explained to the subcommittee that no matter what plan is adopted, rural people must have the same benefits, access and treatment as those who live in urban areas. He told the subcommittee that the President's plan does not necessarily fit all communities, especially those that are rural or urban. Sen. Thomas expressed concern over the slashing of Medicare reimbursement funds, and the delivery system as prescribed under the President's plan.

Dr. Philip Lee testified before the subcommittee on behalf of the Department of Health and Human Services. He explained that the plan would provide health security to all Americans including those living in rural areas and urban cities. In his written testimoy, Dr. Lee informed the subcommittee that HIV/AIDS is a serious problem in both inner cities and rural areas. For each HIV/AIDS case that is prevented, approximately $102,000 will be saved in health care costs. Under the President's plan, all Americans will receive a comprehensive benefits package including preventive services, mental health and substance abuse services. Under the Health Security Act, health care alliances will provide consumers with purchasing power, indignant populations will receive subsidies, practitioners providing care in undeserved areas will be eligible for tax credits, and safeguards will be implemented to prevent discrimination based on race, ethnicity, age, or gender. Dr. Lee told the subcommittee that the Ryan White Act will be maintained and strengthened under reform. He also stressed that the National Health Service Corps will be expanded and inner city and rural areas will be supported by new competitive grant and loan programs. Dr. Lee informed the subcommittee that through the Access Initiatives found within the plan, outreach and enabling services will be increased, mental health and substance abuse initiatives will be expanded, and two new programs will be instituted to reach out to school-age youth. Dr. Lee explained to the subcommittee the President's proposal concerning core public health functions as well as prevention initiatives.

Sara Rosenbaum stressed to the subcommittee that persons with HIV and other communicable diseases are at a particularly high need of comprehensive health services. She said that those with particularly high health risks are often found in undeserved communities. She explained to the subcommittee the need for the removal of access barriers for undeserved populations, as well as making insurance affordable, accessible, and of good quality. She also stressed the need for the direct financing of health providers and the adaption of health services to those within undeserved populations.

James Bernstein, in his testimony to the subcommittee expressed support towards a health care plan that would provide universal access, health care training programs, the retainment

of health care services for rural areas, and graduate medical reimbursements. He expressed concern over the use of historical data to determine the level of reimbursements for rural providers.

Larry Gage stressed to the subcommittee the need for "substantial safeguards," including mandatory open enrollment, limitations on advertising, and mandatory random assignment of "high risk" patients. He also wanted to see that urban safety net hospitals be maintained.

Martin Goldsmith testified before the subcommittee that there are three major problems within the Clinton Health Security Act. He is concerned about the proposed cuts in Medicare, the way the plan addresses the uncompensated care issue, and the potential side effects of how the plan would serve Medicaid recipients.

Dr. Martin Staggers emphasized the need for the designation of Children's Hospitals as essential providers. She told the subcommittee that there was a need for the preservation of disproportionate share payments to supplement the Medicaid program or a new fund that would ensure coverage for vulnerable populations. Dr. Staggers also stressed the need for the preservation of Title V programs for children with special needs.

Jon E. Vice told the subcommittee that the reform plan "should designate not only publicly primary care clinics but also public hospitals and children's hospitals serving the mentally undeserved as "essential providers."" He also explained to the subcommittee that there was a need for financing of graduate medical education, the assurance of access by children to designated pediatric centers of excellence, and that reform should address the needs of children with special care needs.

All members of the panels expressed support for provisions in the Health Security Act that would recognized those who currently care for the underserved as "essential community providers."

Prepared by:CHarrington:ONAP:March 8, 1994:690-5560

TAB C

Hearing Summary
Committee on Ways and Means: Subcommittee on Health
Health Care Reform: H.R.1200, The American Health Security Act of 1993; H.R.2610, The Mediplan Act of 1993; and Other Single Payer Options
February 9, 1994

Members Present:
Democrats Stark(CH-CA), Cardin(MD), Kleczka(WI), Lewis(GA)
Republicans Thomas(CA), McCrery(LA)

Witnesses:

Panel 1

The Honorable Jim McDermott, M.C. Washington
The Honorable John Conyers, M.C. Michigan
The Honorable George Miller, M.C. California

* Additional Panels were not covered by this office.

Following opening statements, Rep. Jim McDermott testified before the panel as a co-sponsor of H.R. 1200, the American Health Security Act (AHSA). He explained to the committee that the single payer plan guarantees universal coverage while maintaining the best aspects of the current delivery system. Rep. Mcdermott told the committee that under the AHSA every American will know exactly how much their health insurance will cost them in the future. He also explained that under the single payer plan, seventy-five percent of Americans will pay less than what they are currently paying, for a comprehensive benefits package that will include home, community-based, and nursing home long-term care, prescription drugs, comprehensive mental health and substance abuse benefits as well as a variety of preventive and acute care services.

Rep. John Conyers explained to the subcommittee that he was in support of the single payer health care plan. He told the members that the plan offered universal coverage, comprehensive benefits and strong cost containment. Rep. Conyers explained that the single payer plan offered the consumer free choice of provider and targeted medical assistance. He stressed to the subcommittee that this plan was not socialized medicine and was overwhelmingly supported by the Congressional Black Caucus.

Rep. George Miller informed the subcommittee that according to the Congressional Budget Office, H.R. 1200 would reduce national health care spending by between $114 billion and $175 billion per year starting in the year 2003 and that the plan would offer the benefits prescribed based on the financing method. He testified that the single payer plan will offer better benefits, maintain long term care and does not require co-payments and deductibles in addition to the premiums.

Following testimony, the panel answered questions. The panel explained that there were no out-of-pocket payments for acute care or preventive services. The subcommittee expressed concern over redlining, Medicare, and rationing.

Prepared by: CHarrington:ONAP:March 8, 1994:690-5560

TAB D

Hearing Summary
House Subcommittee on Social Security
Hearing to Examine Health Care Coverage for Americans With Disabilities
February 23, 1994

Members present:
Democrats: Jacobs(CH-IN)
Republicans: Bunning(KY), Houghton(NY)

Witnesses:

Panel 1:
Judith Feder, Ph.D, Principal Deputy Assistant Secretary for Planning and Evaluation, HHS
Helen Smits, M.D., Deputy Administrator, Health Care Financing Administration
Allan Bergman, Chair, Long-term Services and Support Task Force
Rebecca Ogle, Washington D.C.
Karen Vaughn, Indianapolis, Indiana

Panel 2: Linda Weindruch, Esq., Des Moines, Iowa
Chester Helms, National Council on Independent Living
Jodie Wildy, National Rehabilitation Caucus
Jerry L. Mashaw, Ph.D., National Academy of Social Insurance

Panel 3: Lawrence J. Gorski, Director Chicago's Mayor's Office for People with Disabilities
Paula Malek, American Disabled for Attendant Programs Today
Gerben DeJong, Ph.D., National Rehabilitation Research Center

Dr. Judith Feder testified before the subcommittee that the President's Health Security Act (HSA) is distinguished from other plans because of its long-term care benefits that it offers. The long term care benefits gives care to all those with disabilities through federal funding. The benefits set forth in the plan would be designed by consumers to be responsive to their needs.

Dr. Helen Smits testified that the HSA would guarantee services and protect against discrimination while offering recipients choices. The HSA requires all health plans to have contacts with academic health centers and to maintain essential community providers.

Allan Bergman testified before the subcommittee that 81 million people with disabilities would gain from the President's Health Security Act. He explained that under the HSA new work incentives would be implemented that would help individuals currently on Social Security Disability Insurance (SSDI) move into the mainstream. He informed the subcommittee that the HSA offers a tax credit for working age adults. He urged them to pass health care reform.

Following testimony the panel answered questions. The subcommittee asked how the plan would affect Social Security beneficiaries who are currently disabled. The panel informed them that the Social Security beneficiaries would be provided primary coverage through the alliances and that they had the option of buying supplemental coverage, although full scale

coverage would be offered in the alliances. The panel explained to the subcommittee that if an individual is working part time, the question of health care coverage would depend on the individual's income. If an individual's employment ends, that person would return to the Medicare system.

Ms. Rebecca Ogle testified before the subcommittee concerning her personal journey with a disability and the current health care system. Ms. Ogle is living with spina bifida. She urges the members of Congress to pass legislation that guarantees universal health care coverage for all Americans.

Karen Vaughn testified before the subcommittee about her experiences with paralysis, employment, and the Social Security Disability Program. Ms. Vaughn asked the members to "pass national health care reform consistent with the principles embodied in the President's Health Security Act."

Ms. Linda Weindruch testified about her personal experience with multiple sclerosis. She also testified in support of the HSA.

Mr. Chester Helms stressed that the current Medicare plan is inadequate. Mr. Helms explained that President Clinton's plan allows for Medicare coverage for prescription drugs, choices concerning home health care and the option to obtain insurance without two year waiting period. He informed the subcommittee that the HSA allows for "true equality for people in the arena of health care."

Ms. Jodie Wildy testified that rehabilitation must be an integral part of tomorrows health care system. She urged Congress to specify covered services and also made some recommendations for the President's plan. She stressed that provisions for orthotic and prosthetic devices should be consistent, language should refer directly to rehabilitation, the definition of rehabilitation hospitals and units must be amended, the definition of qualified facilities should be updated, specific therapies should be covered, community based residential treatment programs should be included as an additional site for rehabilitation services, and the state financing for rehabilitation services needs to be readdressed. Ms. Wildy also recommended changes in the administrative structure of the plan.

Ms. Virginia Reno testified o behalf of Dr. Jerry L. Mashaw Ms. Reno testified that the current Medicare system is inadequate. She explained to the subcommittee that his panel uncovered three findings. They are that universal coverage would be a major breakthrough for those living with disabilities, universal coverage would "foster early intervention to prevent diseases or impairments from becoming permanent work disabilities", and that health care coverage would offer prescription coverage, medical equipment, personal assistance services, and rehabilitation services.

Mr. Lawrence J. Gorski explained to the subcommittee that there are four key areas that are essential to health care legislation. They include universal access, no exclusions based on pre-existing conditions, long-term care options including home services, and funding for personal assistance services.

Ms. Paula Malek testified that currently there is not enough

money being spent on community-based attendant services. She stressed that under the health care plan, there should be standards set for attendant services community based standards, availability, maximum control placed in individual providers situation, provisions for emergency services, cost sharing, and the allowance of health related tasks to be performed by unlicensed yet qualified personnel.

Dr. Gerben DeJong testified that the President's Plan takes great steps in helping those with disabilities. These areas include, tax benefits, long-term and community based services and community ratings.

Prepared by: CHarrington:ONAP:March 14, 1994:690-5560

TAB E

United States Senate Committee on Finance
Hearing on a "Benefits Package" Under Health Care Reform
Thursday, March 3, 1994

Members Present:
Democrats: Moynihan (Ch-NY), Baucus (MT), Rockefeller (WV)
Republicans: Packwood (OR), Dole (KA), Danforth (MS), Chafee (RI), Durenberger (MN)

Witness List:
Panel I: Judith Feder, Ph.D., Principal Deputy Assistant Secretary, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services
Roger C. Herdman, M.D., Director, Office of Technology Assessment
Panel II: Susan Gleeson, Executive Director, Medical and Quality Management, Blue Cross and Blue Shield Association
Rhoda H. Karpatkin, J.D., President, Consumers Union of the United States, Inc.
Frank B. McArdle, Ph.D., Manager, Washington Research Office, Hewitt Associates LLC
Paige R. Sipes-Metzler, D.P.A. Executive Director, Health Services Commission, Oregon Department of Human Resources
William H. Straub, M.D., Senior Health Policy Analyst, Jackson Hole Group

Each Senator opened the hearing by making a few brief remarks. Senator Packwood opened by saying there was no way that a benefits package could provide "all things to all people." Senator Moynihan talked about the decisions made by the public about these matters. Senator Danforth said that the important question was: how does one say no? Senator Rockefeller asked the same thing adding that the Clinton plan wasn't a Cadillac plan that doesn't make false promises to the American people showing exactly what they will receive.

Judith Feder testified that the benefits question was one of importance, however, it is only one of the issues that need to be addressed. Dr. Feder gave various reasons about the need to specify a benefits packages: for fiscal responsibility, to provide security to purchasers of the benefits package by specifying a standard package of benefits, etc. She said with this done, choices among plans would be facilitated for consumers. The President's plan, she said, achieves these specifications. It provides a comprehensive benefit package, much like an average set of benefits that people are able to purchase today: "It [the Clinton plan] is comparable to the average coverage enjoyed by individuals with employment based private health insurance." She said that the Clinton plan provides many services including mental health and substance abuse treatments without lifetime limits on such benefits. She

also made a special point to mention the special need of people with disabilities as well as children and their need for long-term care being covered by a benefits package.

Roger C. Herdman said that "the public will judge reform based on the services received and what they pay." He then pointed to a chart which shows a box titled "Benefit Package." From the benefit package, the chart works through two "filters" where various influences come into play such as payment, expenditure caps, etc., leading finally to what the patient actually gets. Mr. Herdman spent some time explaining what the chart meant before speaking on how the way benefits are financed may effect not only the costs but also the benefits package as well. He ended his testimony by saying that there was "no completely scientific way to design benefits."

After the first two panelists finished, the Senators began asked questions about the general theme of whether or not it would be possible to say no to some things because, as Senator Packwood pointed out, not everything can be covered and a decision would have to be made about what was going to be in any list of benefits package. There was no decision as to what was going to be in such a package, only a reiteration of what wasn't going to be in President Clinton's plan. Senator Danforth led this line of questioning by asking Dr. Feder if she could "say no to certain kinds of benefits?" Dr. Feder tried to reiterate the administration's view that the Clinton plan does indeed say no to some benefits as well as leaving doctors with enough autonomy to be able to decided which procedures are necessary and should be covered on a case by case basis. There were also questions over having a 'standard plan' and a 'catastrophic plan.' During his allotted time, Senator Durenberger pointed out three basic functions of any benefit package. These functions were dealt with in one way or another by the five panelists of the second panel. They were 1) making markets work, 2) equity, the universal coverage issue, and 3) value judgements, what are we getting for our money

The first witness in the second panel was Ms. Sipes-Metzler, who addressed certain aspects of the Oregon system and pointed out some basic features of the Oregon Commission that decides which procedures are covered. Some of the points were that the commission needs to be neutral politically and the need for financial freedom. She closed by saying that in Oregon, the commission "blends public values with scientific findings." The second panelist, Susan Gleeson, gave a short history of Blue Cross and Blue Shield. One of the most interesting points about the organization was the fact that Blue Cross leaves to an extended panel of various people including members from the Kaiser Permanente firm, which Blue Cross is affiliated, the decisions of what is covered in their benefits package.

Rhoda H. Karpatkin, President of the organization that publishes Consumer Reports Magazine, summarized various points taken out of

the ten in her written testimony. The first was that consumers want comprehensive benefits. The second was that the private market has proven incapable of providing this. The third was that Cadillac coverage is a myth. The fourth was Congress shouldn't leave the benefits package to a benefits commission. Frank B. McArdle also gave nine issues, this time, however, sharing the microlevel experience of his office. Some of the issues were that planned designs change every year. Another idea was that the edge of major change was in the idea of benefit design. Another issue was that there is no 'one' plan design that will serve everyone well. There will have to be many different designs to take into account the differences throughout the nation. William Straub in his testimony said that a standard plan of benefits would be fundamental for "a seamless plan" meaning any health care reform initiative. He went on to say that, as Senator Durenberger said, standardization would facilitate in comparing different plans. He also said that Senator Durenberger touched on three points (mentioned above) that were addressed in his written testimony.

Prepared by Lord: ONAP: 690-5560: March 3, 1994.

TAB F

Hearing Summary
Senate Subcommittee on Aging
Women's Health Care in the President's Health Care Plan
March 9, 1994

Members Present:

Democrats	Mikulski(CH-MD), Kennedy(MA), Pell(RI), Wofford(PA), Moseley-Braun(IL), Murray(WA), Feinstein(CA)
Republicans	Hutchinson(TX)

Witnesses

Panel 1 Dr. Phil Lee, Asst. Secretary of Health, HHS
Dr. Susan Blumenthal, Deputy Asst. of Women's Health, HHS (Accompanied Dr. Phil Lee)
Dr. Samuel Broder, Director, National Cancer Institute

***Additional panels were not covered by this office, although testimony is available.**

There was no testimony covered by this office although the question period following panel one was covered.

The questions following the testimony of panel one primarily dealt with the issues of breast cancer and mammogram. Dr. Blumenthal informed the subcommittee that she would have a breast cancer strategy prepared by April 18, 1994 for their review. The panel informed the senators that the benefits package would be decided upon by Congress and would be an evolving package. The panel told the subcommittee that there would be increased graduate medical education as well as the establishment of a women's health issues curriculum. They also informed the panel that education for counseling of risks behaviors and chronic diseases would be implemented. The subcommittee was concerned over why the baseline for mammogram was over age 50 and not under age 40. The subcommittee found this very frustrating since in the past women have been instructed to have a mammogram every year as of age 40. The panel informed the subcommittee that recent evidence has shown that the need for a mammogram test has been reduced. The senators said that they have been witnessing a declining budget go to women's health care research and asked the panel whether or not the President's plan would hurt this particular area. The panel responded that it would not be hurt, but rather there would be increased funding for women's research within the NIH.

All the Senators were in support of coverage for women's health care issues.

Prepared by:CHarrington:ONAP:March 14, 1994:690-5560

Dr. Barrer

FEB 18 1994

NOTE TO KRISTINE M. GEBBIE

Through: George Walter

- The 103rd Congress (second session) has held a large number of health care reform hearings. We have monitored a number of these hearings, selecting the ones that would have direct impact on HIV/AIDS issues.

- No overall philosophy has emerged. The debate surrounds the overall business impact and cost shifting issues.

- We have attached summaries for your review and circulated them among staff.

- Tab A: President's Plan and Special Populations
  Tab B: Long Term Care
  Tab C: Health Care Reform in Indian Country
  Tab D: Member's Bills
  Tab E: The President's Health Care Reform Proposal
  Tab F: Issues Related to Managed Care
  Tab G: Long-Term Care and Quality Assurance in the Clinton Plan
  Tab H: Guaranteed Benefits Under the Health Security Act
  Tab I: Health Care Coverage for the Uninsured

Should you have any questions or comments, we are available at your convenience to discuss.

Alice M. Litwinowicz

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TAB A

Divider Title: _____

Hearing Summary
House Committee on Energy and Commerce
Subcommittee on Health and the Environment
The President's Health Plan and Special Populations
January 24, 1994

Members Present
Democrats: Waxman (Ch-CA), Brown (OH), Kriedler (WA), Richardson (NM)
Republicans: Bliley (VA), Greenwood (PA)

Witnesses
Panel 1: Kristine Gebbie, R.N., M.N., National AIDS Policy Coordinator, Executive Office of the President
Judith Feder, Ph.D., Principal Deputy Assistant for Planning and Evaluation, DHHS
Panel 2: Irwin Redlener, The Children's Health Fund
Neal Halfon M.D., Professor of Public Health and Pediatrics, UCLA
Joel Berenger, United Farm Workers
Laurance Nickey, M.D., Council on Public Health (El Paso, TX) Texas Medical Association
Panel 3: Christine Lubinski, AIDS Action Council
Pedro Zamora, Person Living With AIDS
Panel 4: Anne McDonald-Cacho, Bernad Cacho, Phillip Cacho, Consortium for Citizens with Disabilities
Burke Balch, National Right to Life Committee

Mr. Waxman opened the hearing by stating that the diversity of America means we have to address a range of health care circumstances. The hearing consisted of eight panels of which four were covered by the office.

Dr. Feder provided estimation of costs and documentation of financing of the Health Security Act (HSA) to the subcommittee. Ms. Gebbie testified that the current health care system does not meet the needs of people with special needs including those with HIV/AIDS and people with disabilities. She emphasized that the Health Security Act would offer universal coverage to everybody without exclusion or loss of coverage. She highlighted six specific areas in which the bill would benefit those with HIV and AIDS. These areas included pre-existing conditions, such as testing HIV positive, that will not exclude an individual from coverage; medical specialists with HIV and AIDS training who would be deemed essential providers; prescription drug coverage; discrimination, redlining and other means to prevent coverage would be eliminated; confidentiality will be guaranteed; and the Ryan White CARE Act would continue to provide supplemental services to persons with AIDS. Ms. Gebbie stressed that public health improvements would create the opportunity for rebuilding the infrastructure of prevention agencies so that they can be real partners with the care system and responsive to community needs.

In response to questions by the subcommittee members, Ms. Gebbie informed them that the President's plan would guarantee specialized services through the essential provider program and the Ryan White CARE Act. Dr. Feder explained how risk adjustment and reinsurance will be used to determine adequate payment for services for persons living with HIV/AIDS. The committee was informed that home and community-based care benefit would provide home care and that these "vast improvements may not address all needs but they are a vital first step." The committee questioned the panel concerning the Cooper and Michael bills. The panel responded that neither bill guaranteed coverage, but the HSA guarantees health coverage that will always be there, even if a person becomes sick. The panel informed the committee that special populations will be included, community ratings will be computed and prescription drugs will be covered. Mr. Brown asked why reform of the health insurance market was not enough? Ms. Gebbie told the committee that without health reform, HIV individuals would "slip through the cracks" because they need an array of things to keep healthy and functioning. Dr. Feder informed the committee that all children would be covered, health cards would be issued, emergency services retained and public health services maintained. Dr. Feder stated that illegal immigrants will retain emergency services under Medicaid and the President's bill supports Public Health Service programs. There will be a prohibition against using health security cards for any other reason than to obtain health care services.

In Panel 2, discussion focused on the Health Security Act in relationship to migrant workers, foster care and child care. Joel Berenger testified on behalf of the farm workers. He said that Medicaid is currently failing and that the key farm worker states lack interstate communication. Within these regions there is increased AIDS risk due to lack of screening and prevention programs. He believes that the Clinton proposal has a lot of potential but may leave the farm worker out. He was specifically concerned about portability, copayments being too high, and increased out-of-payments expenses. He was also concerned that an employment based plan that lacks services and does not guarantee coverage because of lack of portability and hour requirements. For example, many employers do not provide farm workers with 40 hours in an entire month and will not pay for premiums.

Dr. Halfon testified that the Clinton proposal goes a long way but not far enough. He cited that 30-40% of foster care children have chronic medical problems including HIV, who do not have coverage and that 60-80% have severe mental health problems. Dr. Halfon cited limitations for children in foster care under the Health Security Act, such as eligibility, benefit limits, limits for expanded benefits under Medicaid, financial responsibility for coverage, and limits on innovative service delivery approaches.

Irwin Redlener testified on behalf of "medically homeless children" defined as those children with no constant appropriate plan for health care. They currently number between 12-15 million American children. He believes the new plan can provide much

needed health care access including solving access problem like "HIV and a host of environmental health hazards which affect large population subgroups." He emphasized ten specific areas where health care reform must take place. He argues there must be universal access based on a "time certain" schedule; safeguards must be instituted so all may participate; the bill must have a complete listing of benefits that must be comprehensive, preventive, supportive and interventive; improvements of the public health infrastructure to do disease surveillance; screening and other core functions; description of access for specific populations; comprehensive health care needs to be brought to underserved populations; there must be safeguards to monitor that services are being provided as well as quality quantity and appropriations of these services; there must be measures that prohibit families from being locked into single point service; finally Congress must understand the needs of the special populations. He believes the HSA has the best chance of meeting the needs of the special populations in the U.S..

Laurance Nickey testified on behalf of the border communities. He highlighted such conditions as contaminated drinking water and uncontrolled sewage disposal that have attributed to large outbreaks of disease both in the U.S. and Mexico. He cited that there were over 61 million northbound legal border crossings between Juarez and El Paso. He used this example to emphasize the effects of public health on one side, affects the public health on the other side. He believes that the needs of the communities on both sides of the U.S.-Mexican border can be fulfilled through the establishment of the U.S.-Mexico Binational Commission For Health and Environment that would be under the auspices of both governments and be located on the border. This commission would construct and implement efforts to answer the problems that have developed long the U.S.-Mexico Border.

In response to subcommittee questions the panel believed that regional alliances were necessary and if rate blending was eliminated then discrimination would be enhanced. The panel did not believe that market forces would do the trick for migrants, or homeless children. Redlener believes that the President's plan provides a good planned delivery service. Dr. Halfon wanted safeguards implemented to insure services. He also called for the removal of generic kinds of health care plans that do not reach out to specific populations. The committee was concerned about too much flexibility within the federal framework. Redlener responded that safeguards need to be implemented as well as state plans need to be sent to HHS to show how they will implement specific programs. Dr. Halfon informed the committee that generic kinds of health care no longer work for special populations and that unscrupulous managed care is used as a means of exclusions.

In Panel 3 Christine Lubinski and Pedro Zamora testified. Ms. Lubinski testified that people living with HIV/AIDS are poorly served under the present system which is in a crisis. Even for those who are insured, discrimination by insurers, caps on

overall AIDS treatment, and exclusion for pre-existing conditions, and a range of other common insurance practices make obtaining health care a frustrating, financially debilitating and at times, a life-threatening experience for Americans living with HIV/AIDS. While Ms. Lubinski supports the McDermott single payer plan and believes there are areas of the Clinton plan that need to be strengthened, no other plan offers meaningful reform. Ms. Lubinski believes that the HSA must have universal coverage that is non-negotiable. Universal coverage requires true community rating, across the widest pool of consumers. She believes that both the employer and the government will have to make contributions to insure this. Ms. Lubinski stated that with universal coverage must come portability of coverage allowing the opportunity for persons with HIV/AIDS to work without jeopardizing the ongoing health care services vital for their functioning and well-being. Ms. Lubinski emphasized the need for a guaranteed comprehensive benefits package. Throughout her testimony Ms. Lubinski offered numerous recommendations for improving the HSA including creating a prescription drug coverage formulary at a national level; separate coverage for mental health and substance abuse services so one does not have to choose between them; modification of home and community based long term care services to enable those with AIDS and other terminal illnesses in the last 24 months of life to have access to these services; HIV counseling and testing as a preventive benefit apart from the deductible and copayment; enhanced subsidies for low income and disabled individuals; cap premiums in specific cases; and pro-rate-out of pocket payments on a monthly basis.

Mr. Zamora, is 21 years old, came to the United States during the Mariel boat lift in 1980 and is living with AIDS. He testified that he was infected his freshman year in high school and has no health insurance. Neither his employer nor he can afford health insurance. His physician was willing to accept $100 a month for medical care, but recent changes in Mr. Zamora's health require numerous tests and prescription drugs. Because of his low t-cell count, he needs a prophylaxis for pneumocystis pneumonia and must use aerosolized Pentamidine. He testified that HSA guarantees coverage and a core benefits package that would make a profound difference in his life.

In response to questions the panel stressed the need for choice concerning plans, doctors and providers. They also urged the committee to pass the Clinton proposal and incorporate risk adjustments. The panel was asked if reform would be enough and they responded no. The panel believes there must be community ratings and a risk pool large enough to reduce financial gains. The panel explained to the committee that individuals would be able to obtain preventive benefits including counseling and testing. They want to preserve CDC's HIV counseling and testing program.

Panel four included the Cacho family from Berkeley, California and Burke Balch from the National Right to Life Committee. The Cacho family testified that since their son was born their family premiums have increased from 16% of their

family income a year to 54% a year. Mr. Balch opposes the bill because it includes abortion and rations care.

Mr. Waxman and Mr. Greenwood discussed, with no resolution, whether health care was a "right" or a "benefit" in this country.

Prepared by:CHarrington:ONAP:February 2, 1994:690-5560.

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TAB B

Divider Title: _____

Hearing Summary
House Committee on Education and Labor
Subcommittee on Health Resources
Long Term Care
January 26, 1994

Members Present
Democrats: Martinez (Ch-CA), Mink (HI), Woolsey (CA)
Republicans: Goodling (PA), Castle (DE), Barret (NE)

Witnesses
Panel 1: Fernando M. Torres-Gil, Assistant Secretary for Aging, HHS
Robin Stone, Office of Planning and Evaluation, HHS
Bill Bensen
Panel 2: Cheryll Schramm, National Association of Area Agencies on Aging
Dr. Jeanette Takamura, National Association of State Units on Aging and Director, Hawaii Executive Office on Aging
Mary Daniels Levy, York County Area Agency on Aging
Ms. Rudin, Brookdale Foundation

Mr. Torres-Gil testified that the benefit under the Health Security Act (HSA) is a "trend towards home and community care that offers a complete long term care services plan." It is a plan that does not discriminate and is not means tested. It also offers choices. He emphasized that the HSA would offer support, respite, continuous benefits and the incentive to work. Mr. Torres-Gil cited four specific eligibility requirements for long term care in his testimony. Long term care would be available to those individuals who need hands-on or stand-by assistance, cueing or supervision to perform three of five activities of daily living, individuals with cognitive or mental diseases, individuals with severe mental retardation, and children under the age of six who suffer from chronic disabilities. In addition, Mr. Torres-Gil informed the committee that the program would be freestanding of Medicaid, it would offer a tax credit for those who wanted to continue employment and it would place primary program responsibility with the state. The state would be responsible for creating flexibility, designing a plan to meet recipient's needs, assessing individuals and creating plan of care, maintaining personal assistance services as well as offering a comprehensive benefits package. Mr. Torres-Gil was repeatedly questioned on finance issues. He explained to the committee that payments would be made on a sliding scale and not on a means test. Most recipients would be of low to moderate income. Mr. Torres-Gil stated that the new long term plan within each state must meet the needs of all recipients who in the past have received long term care. All recipients must meet eligibility requirements as outlined in the plan. Rep. Woolsey stressed that the plan must strictly lay out the benefits including where coverage ended. Woolsey also questioned whether or not skilled workers were available. Mr. Torres-Gil responded

that by the time the plan was phased in over the next five years, skilled workers would be available. The final issue was who would be administering the program. Mr. Torres-Gil responded that the states would monitor the programs, DHHS would monitor the states and their programs--but which agency or what person is still unavailable.

Panel two consisted of individuals who represented state and area agencies. Mary Daniels Levy testified that her program Area Agencies on Aging (AAA) offers a program called OPTIONS. Within OPTIONS individuals are offered home care on a long term basis instead of nursing home care. This was done for three key reasons: as an alternative that was desirable and feasible; as a point of access for home and community based care; and AAA would be the local level access point. OPTIONS offers a comprehensive assessment of need, needs that are met and paid not on a particular service but based on total cost of care. Ms. Rudin testified about her respite care grant program that provides group activities and a "break" period for both the care giver and the recipient. Dr. Takamura testified that HSA would provide an expansion of options and choices, it would target specific program resources to those most in need and offer maximum flexibility closer to the consumer. The HSA would allow individuals to function in a familiar setting. Cheryll Schramm testified that the new plan for long term care should be built around AAA's, have increased resources and run as a program that is geographically close to the consumer. All panelists agreed that there needs to be increased training, education and access to additional services. They also agreed that there is a need for long term care training and education so that volunteers could be maintained and that care givers will be able to work for a reasonable wage.

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TAB C

Divider Title: _____

Hearing Summary
Senate Committee on Indian Affairs
Health Care Reform in Indian Country and S.1757
Health Care Security Act
January 31, 1994

Members Present
Democrats: Inouye(CH-HI), Daschle(SD), Wellstone(MN)
Republicans: Domenici(NM)
Witness List
Panel 1: Judith Feder, Ph.D., Principal Deputy Assistant Secretary for Planning and Evaluation, HHS.
Michael Lincoln, Acting Director of the Indian Health Services, HHS.

Senator Inouye began the hearing by saying that the new plan seems to offer reductions in the Indian Health Services and the amounts being projected for coverage will in no way meet the needs of the Indian population.

Dr. Judith Feder testified that the American people are in support of health care reform. According to Dr. Feder the flaws in the current system threaten the health security of all Americans including the American Indians and Alaskan Natives. Dr. Feder explained to the committee that the President's Health Security Act (HSA) is based on six specific demands to address the reform issues. These demands are security, simplicity, savings, quality, choice, and responsibility. Dr. Feder's testimony centralized on the roles of federal and state government, alliances, employer and employee responsibilities, private health insurance reform, and proposals for long term care in relation to health care reform and primarily non-Indian people. Dr. Feder informed the committee that the reformed health care system must be grounded in federal/state/private sector partnerships. In Indian country the partnerships will be directly between the federal government and the tribes. Under HSA each state, community and private health care system will be responsible for providing specific federal guarantees to all citizens. According to Dr. Feder these guarantees include universal coverage, guaranteed comprehensive benefits, insurance reforms, standardized forms and administrative simplification, consumer protection, quality assurance, control of health care costs, and improved choice. Dr. Feder discussed how the National Health Board will be responsible for setting many of the basic federal standards. The Board will be responsible for approving each state's plan, calculating premium caps, determining appropriate risk adjustments and updating the guaranteed benefits within the plan. Dr. Feder explained that HHS will play an integral role in the new plan including enforcing state compliance, supervising Indian Health programs, taking new initiatives in the Public Health Service field as well as the enhancement of graduate medical education programs. According to Dr. Feder, the states will be responsible for development and implementation of a plan that would explain how the state would perform specific functions. The states would remain flexible and would designate an agency or official to coordinate state

responsibilities. Dr. Feder explained that the states would not play a role within Indian health programs unless the tribe opted for the state plan. According to, Dr. Feder, health alliances will be responsible for enrolling all individuals into a specific plan. The alliances will monitor quality and administer subsidies and information. They will also provide a base for community rating premiums. Under the HSA, all employers with the exception of Indian employers will contribute to the health care coverage of their employees. The employer will pay no more that 7.9% of their payroll with additional discounts available to smaller employers on a sliding scale basis. For larger companies the option of forming corporate alliances will be available. Each individual will be able to choose his/her health plan and will pay the remainder of the premiums after the employers deduction. Health plans, according to Feder will provide insurance coverage as well as information to the alliances.

Michael Lincoln testified on how the HSA proposes to deal with American Indians and Alaskan Natives. He explained that there were specific principles that the HSA would continue to uphold. They include that individual Indians should not have to pay for services that they are currently receiving; services guaranteed by prior legislation should continue; and the rights of tribes to assume operations of federal programs must be maintained. In his testimony, Mr. Lincoln explained that the Federal government had a responsibility to provide the Native Americans adequate health care. He also explained that the Indian Health Service(IHS) has a unique partnership with the Native American communities. The Indian population due to economic and cultural barriers have limited access to health care services. Lincoln cites that the HSA is the only health care reform proposal that addresses Indian issues. The HSA allows for the same benefits and coverage for Indians as other Americans. The HSA provides additional funding, benefits (including preventive and curative medical services) and loan programs to help develop a better infrastructure.

In response to panel questions, the panel informed the committee that under HSA all health organizations will be required to take all applicants. They also said that caps will be placed on costs and the costs will be guaranteed. Every member of the plan will receive an HSA card which will grant them guaranteed benefits as well as primary care preventive services and long term care which would be largely federally funded and available in forms of home care. The Indians will have the option of staying within the IHS/Tribal plan or to go out on their own to a private plan. This private plan would not be entirely federally funded. The committee desired assurances that the plan would be straight forward and it would address sanitation problems in Indian country. The committee also sent two message to the White House. The committee said that they commend President Clinton for his recognition of the need for health care reform. They also commend him on his unique relationship that he has formed with the Indians and the importance of making the Indians a cornerstone in the reform. The committee also warned the President not to send out the wrong

signals. They desire a sincere message from the Clinton Administration that says they are intent on what they are saying. The committee knows there will be big cuts in programming and personnel. These cuts will affect the Indian population and IHS. If the President cares so deeply he will watch these cuts and convey the correct signals to both the committee and the Native American population.

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TAB D

Divider Title: _____

Hearing Summary
House Subcommittee on Health and the Environment
Member's Bills
February 2, 1994

Members Present
Democrats: Waxman (CH-CA), Wyden (OR), Hall (TX), Brown (OH), Kriedler (WA), Dingell (MI)
Republicans: Biley (VA), Bilirakis (FL), McMillan (NC), Hastert (IL), Upton (MI), Paxon (NY), Klug (WI), Greenwood (PA)

Witness List
Panel 1: Hon. Jim Cooper (D-Tenn)
Hon. Fred Grandy (R-Iowa)

The hearing consisted of six panels of which the first panel was covered by the office.

Hon. Jim Cooper testified before the committee in support of his legislation the **Breaux/Cooper Bill (S.1579/H.R.3698)**. He explained to the subcommittee that congress has been given one month to fix the health care system in America. He urged everyone to be bi-partisan on this issue. Rep. Cooper gave credit to the Clinton Health Security Act, but cited that the bill that he was now presenting had been endorsed by the fifty Governors. The Governors approved of Rep. Cooper's utilization of managed competition to further health reform. The managed competition was based upon the Jackson Hole group plan, which was modified to be used on a federal basis by consulting with "regular" people and health care professionals. This plan according to Rep. Cooper is already being field tested. According to Rep. Cooper, the Cooper plan enhances choice and quality while maintaining costs. It places the responsibility upon the consumer who is the "shopper" for his or her own plan. Rep. Cooper explained to the subcommittee that the plan is affordable and will cover four times more people than the current system. Rep. Cooper told the subcommittee that no other plan comes closer to guaranteed private health care for everyone, health care that can not be taken away. Rep. Cooper explained that the plan differs in four distinct ways from the President's plan. These include less federal government involvment, the use of price controls, a uniform set of effective benefits, and the state's accessibility.

Hon. Fred Grandy also testified in support of the **Breaux/Cooper Bill**. Rep. Grandy explained that the American people do not want to remain with the current health care system and that the Cooper Bill is a companion piece that will achieve the goal of health care reform. The Cooper Bill according to Rep. Grandy offers insurance reforms to form accountable health plans, sliding scale subsidies, tax reforms, access to provisions for additional money that can be used for increased services and controls over individual specific rates. Rep. Grandy believes that the biggest trouble spots for passage of a health care reform package will be employer mandates versus tax caps on

deductibles.

Following testimony the panel answered questions from the committee. The panel explained to the committee that the theory behind the legislation was that the market competition and the market forces will combine and encourage the consumer to carefully invest in his/her's health care package. This plan according to Rep. Cooper creates a better "shopper". The committee questioned the panel about the belief that if tax caps were incorporated, the plans would become more expensive causing employers and consumers to look for inexpensive plans that may not allow for complete coverage. Rep. Cooper explained to the committee that additional tax deductions would be offered so that consumers would be encouraged to purchase a plan that best meets his/hers needs. This tax cap according to the panel would produce better shoppers. The panel supported market based control and less cost containment. By less cost containment, managed competition care would produce better consumers and providers. Under the Cooper Bill there would be no discrimination. The panel explained to the subcommittee that those individuals who shop for the cheapest package will receive different doctors and delivery services from those who invest in the more expensive packages. According to the panel, under the Cooper Bill there will be no discrimination and quality as well as information will be ensured. According to Rep. Cooper the quality of care will be insured, because if quality offered to employees goes down, the employees will leave. This will cause the employer to offer quality care. The Republicans questioned Cooper on why he did not use individual mandates. Rep. Cooper responded that individual mandates are hard to enforce, expensive and some employers may not support their employees under this plan. The panel agreed with the Clinton Bill that health care reform has to be an employer based plan. Rep. Cooper stressed that those people without health care access will now, under the Cooper Bill, have the tools to obtain it. They will no longer be shut out. Rep. Cooper also stressed that under the Cooper Bill, money will be saved unlike the current plan. The subcommittee what they will do with the money saved by dropping the Medicaid program. They responded that they will fund a new program for the poor and near poor individuals. This program will provide prescription drugs. There will be a system created for seniors that will grant them medical benefits including preventive care and the option to enroll in a managed care options package in which prescription drugs benefits will be offered. The **Breaux/Cooper Bill** does not want to repeal the long term care portion of Medicaid, just the acute medical costs. The bill according to the panel aims at giving states more control in building community-based programs. The panel was asked whether or not the plan would be able to achieve universal health care. Cooper responded that his approach had the best chance but he was not sure. The panel also explained to the subcommittee that there was no benefits package outlined in the bill, but they would be willing to work on an interim package and then let health professionals design a package. The final area that the panel was questioned on was the role of the National Health Board. The

panel felt that the board was a group of "unaccountable health czars" that had control over state run monopolies. The panel, through the endorsement of the Cooper bill wants to limit big government solutions and power.

The hearing was extremely heated and there was extensive bickering going on between Congressmen.

Prepared by CHarrington:ONAP:February 8, 1994:690-5560

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TAB E

Divider Title: _____

Hearing Summary
House Committee on Ways and Means
Subcommittee on Health
Health Care Reform:
The President's Health Care Reform Proposals
February 1, 1994

Members Present
Democrats: Stark (Ch-CA), McDermott (WA)
Republicans: Johnson (CT)

Witnesses

Panel 1: Representatives DeLauro (CT), LaRocco (ID), Sanders (VT) and Pomeroy (ND)
Panel 2: James Winn, M.D., Federation of State Medical Boards of the United States, Inc.
Dennis O'Leary, Joint Commission on Accreditation of Healthcare Associates
Margeret O'Kane, National Committee for Quality Assurance
David B. Nash, American Medical Peer Review Association
Paul Kerschner, Consumer Coalition
Panel 3: Ralph Snyderman, M.D., Duke University Medical Center
Spencer Foreman, M.D., Association of American Medical Colleges
Suzanne El-Attar, M.D., American Medical Student Association
Geraldine Bednash, Ph.D., American Association of Colleges of Nursing
Olen E. Jones, Jr., Ph.D., American Association of Colleges of Osteopathic Medicine
Panel 4: Not covered by the office.

Rep. DeLauro testified that while the President's plan is an improvement it does not go far enough with mental health care. Insurance plans have excluded coverage for neurobiological disorders, such as autism and Tourette's syndrome. Rep. LaRocco gave the Idaho perspective on health care reform. His district is one of the largest (500 miles from Nevada to Canada) and most rural. While the cost of care is the lowest in the nation, thousands are without health insurance. Rep. LaRocco emphasized Idaho is very "underdoctored" and access to health care means more than having insurance. He pointed out that "Becky's Burgers," a small restaurant in Orofino told him that health care reform would put her out of business. He concluded by urging the committee to retain what is best about our current system and create the kind of flexibility for the future that maintains individual choice, improves access and controls costs. Rep. Sanders does not support "managed competition" and believes the only way to provide universal, comprehensive, cost-effective health care coverage is through a Canadian-style single-payer system, administered by the State. Rep. Sanders pointed out how

the health care system has deteriorated over time and the longer nothing is done, the worse it gets. He supports universal care and cost containment.

Rep. Stark commented that "Becky's Burgers" like a lot of small businesses, really need to examine their current "real" costs of having no insurance coverage for employees. He mentioned that Hawaii established a one million dollar fund for small companies that could not "afford" to cover employees and very few employers actually needed the fund.

In the second panel, Dr. Winn testified that Section 1161 of the Health Security Act (HSA) would disrupt the existing system of professional regulation in this country, by overriding current laws that reasonably assess the skill and training for licensure. It is also unclear if some other method for evaluating competence would be instituted. Dr. Winn stated that the bill does not contain explanation on the actual methods of monitoring and enforcing provider quality standards. Dr. O'Leary made three recommendations to address the basic framework necessary for oversight of the diverse array of health plans in the current system and under health care reform: a core set of national quality standards for health plans as part of health care reform; enhance the concept of "report cards" to require that the federal government standardize all of the measures used and require that these "report cards" include information on health plan compliance with national standards; and require any national quality management group created in legislation, such as the proposed "National Quality Management Council" be required to include representation from those with expertise in direct quality evaluation (a better public/private partnership).

Ms. O'Kane testified that the Clinton plan moves away from the "punitive find the bad apple" approach and moves to asystematic, performance-based syst[illegible] for measuring and encouraging improvements in quality. She was concerned about the timetable for implementing a performance system might be unrealistically rapid and also mentioned the need for a medical research system that works to inform what is effective in medical care and how to appropriately measure quality. Dr. Nash emphasized three points: we must recognize that quality is a not by-product of the health care system, but a central tenet; we need to evaluate the "quality" of the quality of the report cards; and draw on the strengths we already have in our system. As an Agency for Health Care Policy and Research (AHCPR), PHS, grantee to evaluate how to use practice guidelines, Dr. Nash warned that no knows what percentage of physicians actually use the practice guidelines or how effective they are. Rep. Stark asked if there are obstacles for use of guidelines. Dr. Nash responded that there is distrust of expert opinion; as in politics, in medicine "all practice is local" in nature, that is, "my patients are different than those in the guidelines"; and physicians believe the guidelines undermine their authority.

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TAB F

Divider Title: _____

Hearing Summary
House Committee on Ways and Means
Subcommittee on Health
Health Care Reform:
Issues Relating to Managed Care
February 2, 1994

Members Present

Democrats: Stark (Ch-CA), Levin (MI), Cardin (MD), McDermott (WA), Lewis (GA)
Republicans: Thomas (CA), Johnson (CT)

Witnesses

Panel 1: **Philip R. Lee, M.D., Assistant Secretary for Health and Bruce Vladeck, Ph.D., Administrator, Health Care Financing Administration, DHHS**

* * *

Mark Nadel, Associate Director for National and Public Health Issues, General Accounting Office; accompanied by: Michael Gutowski, Assistant Director, Division of Health, Education and Human Services; and Ed Stropko, Assistant Director for Health Financing and Policy

Three additional panels of testimony not covered by this office.

Rep. Stark opened the hearing by asking if managed care saves money, serve patients well and how well do managed care plans work for low-income persons? One way of saving, he pointed out, is by managed care to lower hospital admissions. In a recent report, the General Accounting Office (GAO) stated a shift to managed care could save money. An August 1993 Journal of the American Medical Association article found that consumers do not like waits and telephone access delays in managed care. Rep. Stark is concerned that managed care plans, such as Kaiser Permanente, hold down costs by selective enrollment. Other problems, such as HMO marketing and enrollment practices, are of concern. He cited a Medicare HMO that enrolled a woman with dementia, residing at a local nursing home, who was assigned a doctor who does NOT make nursing home visits.

Rep. Cox commented that the proper mix of cost and quality is needed and asked that "we tear down these anecdotal examples" and provide "hard data" and a "solid methodology" about managed care.

Dr. Lee testified that the term "managed care" had been generically applied to many different organizational forms of integrated service delivery. The experiences of the various types of organizations differ, and we must distinguish among them in evaluating the success of managed care. He said managed care is characterized by selected providers providing a comprehensive set of services; explicit standards for participating providers and quality assurance and utilization review.

He explained how today's managed care has advanced; yet, critics fail to recognize the advancements that have been made since the mistakes were made in early years. He stated that managed care appears to lower hospital utilization, use less costly alternatives to expensive procedures or tests, use preventive examinations, procedures and tests, provide comparable quality of care, and also comparable patient satisfaction. There appear to be lower expenditures per enrollee, reduced hospital costs and premium rate of growth is slightly lower.

In order to guard against potential problems, the Health Security Act (HSA) requires plans to be responsible for meeting the health care needs of a defined population of patients, and restructures the insurance market to minimize risk selection. One of the most important aspects of the President's proposal for health care reform is the way it restructures both the personal health service and public health systems.

With a reformed private delivery system, Dr. Lee explained how public health can focus on removing barriers to care for low-income, isolated, excluded and chronically ill populations, through its access initiatives. The HSA would strengthen the current safety-net programs and integrate them with private health plans; increase the supply of providers in underserved areas; expand capacity in inner-city and rural areas; provide additional support for outreach and enabling services; support comprehensive education and health services for school--age children and adolescents; and support community based prevention and core public health functions; and expand access to mental health and substance abuse treatment services.

He pointed out that the quality of care will be addressed in HSA, including expansion of outcomes research and increase in the development of clinical practice guidelines, national quality measures, "quality report cards," dissemination of information by the regional professional foundations, States will establish quality criteria and certify health plans based on the criteria.

Dr. Vladeck discussed managed care under the Medicare and Medicaid programs and what has been learned about consumer protections and appraising quality of care. For Medicaid recipients, managed care offers a special promise, because many fee-for-service providers are reluctant to serve Medicaid patients. Forty five States now serve Medicaid recipients through managed care and the remaining States are planning to adopt some form of managed care arrangements in the near future. About five million Medicaid recipients are enrolled in managed care.

In Alabama, for example, by using prenatal care coordinators, women can obtain prenatal care and begin care much earlier in their pregnancies. Dr. Vladeck emphasized that Medicaid managed care plans must cost no more than the amount that would be spent

on comparable fee-for-service care and that they meet federal quality standards.

Nearly three million Medicare beneficiaries enroll in HMOs. In general, the quality of care in HMOs is comparable to that in fee-for-service. He pointed out that there is in both fee-for-service and managed care, considerable variance in both quality and cost-effectiveness. Dr. Vladeck stated that a recent study by Mathematica indicated HMOs spend roughly 10 percent less than if Medicare beneficiaries had been served under a fee-for-service arrangement. The Medicare program does not share in these savings. Dr. Vladeck explained that managed care programs have demonstrated their ability to meet the special needs of low-income and elderly individuals.

Rep. Stark expressed disappointment that the Department of Health and Human Services continues to work "in secret" and have provided no cost estimates. HCFA has still not issued regulations to protect beneficiaries from physician incentive plans. He asked how we can lock some in managed care, if we're not sure there is quality? Dr. Lee responded that an individual can disenroll on demand, there will be quality monitoring under HSA. He emphasized there are standards and a process detailed in the HSA plus data systems to move rapidly to improve quality.

Rep. Stark asked if it were possible to sue the gatekeeper under HSA? Dr. Lee said if necessary, a person could forego the administrative procedures and sue the plan and the physician. Rep. Johnson said the plan "specifically prohibits sueing."

Rep. Stark remarked that there would be a "catch-up" problem with quality and there are no "tools" to measure, yet the Administration is rushing to a "fourth generation" of HMOs or managed care, with no data collection or tools except anecdotes.

Rep. Lewis asked Dr. Lee how the HSA will protect minority health providers from being "shut out." Dr. Lee assured the subcommittee that there were strong civil rights protections in the legislation.

Rep. Stark commented that the Department's witnesses responses only "scratched the surface" and at times were a direct contradiction. For example, in many rural areas, sparsely populated areas there is no managed care or fee-for-service. He asked that detailed information be provided for the record on the difference in provision of service in fee-for-service versus managed care. He expressed concern that national policy would be made pushing managed care, when in fact, managed care is more prone to deny access than fee-for-service.

Rep. Stark noted that there is a "bit of sloppiness" in the amount of details that the Department provided in testimony. He would like evidence, if it exists, each time in the testimony it

implies there is data to back up a claim of how well managed care works.

Mr. Nadel testified that managed care lacks a common definition and has been used to characterize a wide range of health care plans that select a network of physicians and hospitals, negotiate reimbursement levels, and apply controls on the use of services. He stated that "certain managed care plans have a potential for providing care at lower cost." There is little evidence that employers' overall health care costs have been constrained by using managed care. A major constraint on consumers of managed care is their more limited choice of physicians. To gain greater employee acceptance, employers are offering newer types of managed care plans, with more flexibility, but with less cost-saving potential.

Rep. Stark asked if there is no evidence managed care is saving money for employers, why are we crossing our fingers and relying on past trends, and requesting more managed care? Rep. Johnson expressed dismay that the GAO did not adjust premium surveys for differences in enrollee characteristics or benefits covered; yet provided a chart that showed "for most years HMO premiums grew slightly slower than indemnity plan premiums."

Preparedby:ALitwinowicz:ONAP:February 4, 1994:690-5560.

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TAB G

Divider Title: _____

Hearing Summary
House Committee on Energy and Commerce
Subcommittee on Health and the Environment
Long-Term Care and Quality Assurance in the Clinton Health Plan
February 3, 1994

Members Present
Democrats: Waxman (Ch-CA), Wyden (OR), Kriedler (WA)
Republicans: Bliley (VA), Greenwood (PA)

Witnesses

Robyn I. Stone, Dr.P.H., Deputy Assistant Secretary for Disability, Aging and Long Term Care Policy, DHHS

Panel 1: Orien Reid, Long Term Care Campaign
Anthony J. Young, National Association of Rehabilitation Facilities
Tess Canja, American Association of Retired Persons

Panel 2: Ken Wessel, National Association for Home Care
Sharon Grigsby, Visiting Nurse Association of America

NOTE: There were four additional witnesses in Panel 2 and five in Panel 3 that were not covered by this office. Because of the floor debate on earthquake relief, Mr. Waxman delayed the testimony of those witnesses to the afternoon.

In opening remarks, Mr. Waxman commented on how the elderly and disabled want to stay in their homes as long as possible and that the real "health care catastrophe" is there is no true health care reform without long term care. Long term care must include home care and nursing home care. He said the Clinton bill makes important first steps, while only modest in the area of nursing home care, begins to focus on "real health reform."

Dr. Stone testified that from the onset the President and First Lady have made long-term care an essential component of their commitment of comprehensive health care. She stated that "any one of us on any particular day or any of our children could become disabled as result of an accident or chronic illness."

She explained the new home and community-based services program offers highly individualized services tailored tot he unique needs of people with severe disabilities. Eligibility is based on a person's level of functional or cognitive impairment, with no limits by income or type of disability. Because people of all ages are equally eligible, this program goes a long way toward promoting an equitable intergenerational division of the "long-term pie." There are four mandatory eligibility categories:

- people who need hands-on or stand-by assistance or cuing or supervision or perform three of five activities of daily living (eating, bathing, dressing,

toileting, and transferring);

- people with severe cognitive or mental impairments;
- people with severe mental retardation; or
- people with severe mental retardation; or children under six who have chronic disabilities and would otherwise require hospitalization (after age six, children's eligibility is measured by using the three criteria).

The new long-term care program is a Federal-State partnership and a free-standing program separate from Medicaid, Medicare, and the health alliances, so States have flexibility to design creative packages. Dr. Stone stated the bill establishes a national budget for the new home and community-based services with no individual entitlement. The plan would also improve long-term care insurance.

Mr. Waxman questioned how this benefit would work, especially since it is voluntary on the part of the States? Dr. Stone explained the 28 per cent match rate is high and it is expected that all States would participate. Mr. Waxman asked what would happen if the funding was not enough to cover all four groups. Dr. Stone believes the funding should be adequate to cover the 3.1 million persons estimated to be eligible for this program.

Mr. Wyden asked what DHHS would do about "fly-by-night" artists in home care both the genuinely corrupt and the poorly trained case managers? Dr. Stone responded that the States would ensure providers are scrupulous. There will be two advisory groups (including consumers) and the State plan must be approved.

Orien Reid testified about the difficulties obtaining care for her mother, who had Alzheimer's disease. Tess Canja supports the President's bill because eligibility does not depend on age or income and it will create more jobs to provide assistance and caregiving. She believes there needs to be stronger incentives for states to participate; more reliable funding; and more measures to prevent vulnerable populations from bankruptcy to receive health care.

Mr. Wessel believes the bill could be strengthened by lowering the eligibility standard, because only one-third of the 10 million disabled persons who live in the community would qualify; States would have too much flexibility to implement the program, specifically, in determining the level of benefits; and allow home care agencies to perform case management functions. Ms. Grigsby testified that a minimum set of benefits should be offered patients in each State and financing for the program be adequate to assure quality and access.

Preparedby:ALitwinowicz:ONAP:February 10, 1994:690-5560.

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TAB H

Divider Title: _____

Hearing before the Senate Committee on Labor and Human Resources
Guaranteed Benefits Under the Health Security Act
February 4, 1994

Members Present:
Democrats: **Bingaman (D-NM)**
Republicans: **Kassebaum (R-KA)**

Witnesses:
Panel 1: **Edwin Hustead; Hay Huggins**
Margaret H. Jordan; VP of Health Care and Employee Services, Southern California Edison
William H. Straub; Jackson Hole Group

Panel 2: **Cindy Mann; Massachusetts Law Reform Institute**
Gail Shearer; Consumers Union
Ronald Burd; President Deveraux Foundation

Senator Bingaman opened the session saying that Senator Kennedy was occupied on the Senate Floor with some business. He welcomed the participants of the first panel and asked them to read their statements.

Mr. Hustead, in his presentation, compared the costs of private insurance to the average individual and the costs to the individual under the Health Security Act S.1779 as introduced by Senator Kennedy. According to Mr. Hustead, the value of the S.1779 high cost sharing plan is similar to the value of the range of indemnity plan benefits. S.1779 is below average for medium and large employer plans already in place, but if full dental coverage is phased in for adults, S.1779 would be much better than most employer plans. Mr. Hustead, after questioning from Senator Bingaman, clarified statements made about savings by adding or subtracting benefits. Adding benefits would add more cost, while subtracting benefits would only see those cost transferred somewhere else.

The second presenter was Margaret Jordan. Ms. Jordan gave three reasons in her case for the adoption of comprehensive benefits in any health care reform. The first was that patients and physicians make better choices than do "benefits specialists." The second was that comprehensive benefits are essential to early diagnosis. Three, comprehensive benefits help to provide continuity for the patient allowing appropriate care without "the need to interrupt care, be moved to a different setting, or avoid a treatment due to a limitation in coverage." Her remarks were made pertaining to her organization's (Southern California Edison) interest in having a "guaranteed uniform package of comprehensive health benefits provided for in the Health Security Act."

William Straub spoke on the behalf of The Jackson Hole Group. Mr. Straub believed that providing a set of comprehensive

benefits at the outset would be costly and delay access of those in need, the poor. He thought that because the present system was inefficient, it would be better to wait a few years before introducing all of the benefits. He also spoke about the dangers of looking only at one comprehensive plan, mentioning numerous alternatives like providing a basic plan first and adding benefits in the future or phasing in access to coverage as the finances permit.

All three people from the first panel believed in the importance in a comprehensive benefits package being offered in any health reform bill. Mr. Straub summed it up nicely when he spoke of a set of benefits that "runs seamlessly across the country" meaning the same comprehensive benefits for all people.

The second panel dealt with more specific issues surrounding the issue of comprehensive benefits--the effects of the poor, the effects of the consumer, and the incorporation of mental health benefits in any comprehensive benefits package.

Cindy Mann of the Massachusetts Law Reform Institute spoke with great passion as she talked about health care reform for the poor and how it wouldn't bring "health care any closer to these people [the poor] unless there is a strong and uncompromising commitment to make a comprehensive package of benefits affordable to them." In Ms. Mann's opinion, the poor need a health care package that they can afford and that gives them a comprehensive package of benefits so that they don't have to give up their jobs in order to get better health care through the government than they could get if they would stay at work. Ms. Mann also mentioned the need for a comprehensive benefits package for persons living with AIDS so that they are able to afford the medications they need but cannot afford, even with a job.

Gail Shearer of the Consumers Union spoke from a consumers perspective of health care reform. Her comments, briefly summarized, said that "Consumers want comprehensive health care benefits." She pointed to a Gallup survey commissioned by her organization, Consumers Union, which was completed in April 1993, that showed that "Virtually all (close to 90 percent in each case) of those polled favor universal access to a comprehensive health plan...." She extended her comments speaking about how these comprehensive benefits cannot be designed by Congress, how participation cannot be voluntary, and how the private market is not up to this job.

Ronald Burd of the Deveraux Foundation testified last before the committee. His comments were around the importance of mental health benefits being incorporated into any comprehensive benefit package. Mr. Burd said that "There should be a comprehensive, flexible package of mental health benefits that are provided through a system of organized care, with a full continuum of services made available which are not subject to arbitrary limits in amount or duration that are not imposed on other health care

benefits." The justification of these benefits are one: we already pay the direct and indirect costs of mental disorders. Money spent on mental disorders was $148 billion compared to $160 on cardiovascular disease, and $99 billion on respiratory diseases. Two, by experience it is know that arbitrary limits on the treatments of persons with serious emotional disturbances are "morally and medically undesirable." The third reason is that properly administered mental health treatment is effective. Mr. Burd also spoke of the overstated costs of comprehensive benefits, the special need of children, and the maintenance of existing benefits.

Overutilization of the system was a concern for the presiding Senator Bingaman from New Mexico. He questioned the group on panel II about how one could give comprehensive benefits and also reduce the overutilization of the health care system. Ms. Mann said that the poor now under-utilize the system using the emergency room as their preventative care center, costing the hospital even more. Mr. Burd said that in the mental health field, because of the stigma of a mental health disorder there wasn't any overutilization. However, with incorporation within a comprehensive package, that threat might arise and would need to be taken care off through changes in admissions standards to facilities.

All participants seemed to agree that there needs to be comprehensive benefits in any health care package.

Prepared by: Lord: ONAP: 690-5560: February 4, 1994.

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TAB I

Divider Title: _____

United State Senate Finance Committe
Hearing on Health Care Coverage for the Uninsured
Thursday, February 10, 1994

Members Present:
Democrats: Moynihan (CH-NY), Baucus (MO), Riegle (MI), Rockefeller (WV), Daschle (SD)
Republicans: Dole (KA), Roth (DE), Grassley (IA)

Witnesses:
Panel I:
Barbara Lyons, Assoc. Director, Kaiser Commission on the Future of Medicaid
Gail A. Hensen, Assoc. Professor, Institute of Gerontology and Department of Economics, Wayne State University

Panel II:
Anne Marie O'Keefe, Director of Public Policy, Washington Business Group on Health
Raymond Scalettar, M.D., Member, Board of Trustees, American Medical Association
Gerry Shea, Director, Employee Benefits Department, AFL-CIO
Phyllis Torda, Director of health and Social Policy, Families USA

Chairman Moynihan opened the hearing by welcoming the guests and explaining that it was a concern for this issue that animates most people in this field.

Barbara Lyons, filling in for Diane Rowland, Senior Vice President of the same organization, summarized a study by the National Education Campaign where they looked at the size of the uninsured population and also the implications for these people being uninsured. What they found was that most uninsured people are under 65, work either all or part of the year, and are above the poverty line. The reason, according to Ms. Lyons' testimony, for people becoming uninsured is almost always economical, not personal. (Ms. Lyons' written testimony provides "information on the characteristics of persons without health insurance in the United States, and the nature of health insurance offering among small businesses, where many of the uninsured work. The dynamic aspects of noncoverage and the special insurance problems of the near elderly").

The second presenter was Gail A. Jensen. Ms. Jensen summarized a few key points about the uninsured populations. Between 1989 and 1992, the uninsured increased by 4.1 million. Ms. Jensen gave numerous reasons for this occurrence. The first was the loss of 600,000 full time jobs and an increase of 1 million part-time jobs which are usually uninsured positions. Another reason for the increase in the uninsured people is the increase of small firms with employees between 1 and 49 people. The smaller the firm, the less likely that insurance is provided. Ms. Jensen also spoke at some length on a range of people 55 to 64 who are at high risk for catastrophic illness yet remain uninsured. For

these people the problem is with purchasing private, individual insurance that is too expensive. Senators Moynihan, Dole, and Rockefeller questioned Ms. Jensen on the problem of the 'near elderly' pointing out that employer mandated insurance probably wouldn't cover these people because many are retired.

Anne Marie O'Keefe testified about a proposal by her group to "build on the best of what we have." According to her, the Clinton plan would turn business into passive players: "This design would remove the positive forces of competitive purchasing from the health care marketplace, and wipe out many of the important advances that employers have achieved." The 200 members of WBGH, mostly Fortune 500 companies, set about to solve the health care problem once it was detected. In what she called "organized systems of care," Ms. O'Keefe said that these systems "integrate financial risk with responsibility for outcome. These OSCs provide a full continuum of care, and are accountable to patients and purchasers for its cast and quality." The remainder of her remarks were on the specifics of these systems of care.

The second presenter of the second panel was Dr. Raymond Scalettar. Dr. Scalettar said that the doctors of the AMA know full well about the uninsured problem and the lack of affordibility of insurance in the patients they treat. Dr. Scalettar said that the AMA wants universal coverage achieved through a mixture of employer and individual mandates. He also said that special medical savings accounts needed to be set up in families. He also believed that physicians needed autonomy in treating their patients. In order to do this, health care reform needs to take a close look at liability reform. The AMA must, according to Dr. Scalettar, "have the opportunity to be the patients lobbyist." In a question/answer session, Senator Rockefeller questioned an apparent change in the AMA's position during the first half of th 1980s when they supported employer mandates to supporting a mixture of employee and individual mandates. Dr. Scalettar responded by saying that the was only reporting what is now supported by the House of Delegates, a group of 435 doctors representing all of the members the AMA.

Gerry Shea gave labors perspective on the uninsured. According to Mr. Shea, the unions support strongly "the initiative of the committees and the administration in the Health Security Act." Mr. Shea pointed to the shifting of health costs from the employer to the employee, an area of concern for the unions. He said that the burden of paying for health care was being moved to the individual. By the year 2000, Mr. Shea said, 30 percent of after tax income would be used for health costs in unionized facilities: "There isn't a union leader who hasn't shaved waged to protect health benefits already established for employees."

The last panelist was Phyllis Torda. Ms. Torda said that 2.25 million people lose their health insurance each month. To stop this trend, three things can be done: create a single payer system, develop an individual mandate system, or develop an

employer mandate system. According to Ms. Torda, the employer mandate system would be the "fairest and most practical way to reach universal coverage." If there is an individual mandate, employers might use the subsidies individuals receive as an excuse to drop established coverage. An employer mandate, according to Ms. Torda, wouldn't 1) unravel the system already in place; 2) help level the playing field; and 3) require a smaller tax burden.

Prepared by Lord: ONAP: 690-5560: February 17, 1994.

Hearing Summary
House Subcommittee on Aging
"Long Term Care in Health Care Reform, Part I"
April 11, 1994

Members Present: Mikulski (Chair-MD)
Witnesses:
Panel 1: Fernando Torres-Gil, M.D., Assistant Secretary for Aging, HHS
Accompanied By:
Robyn Stone, Dr.P.H., Deputy Assistant Secretary for Disability, Aging and Long Term Care Policy, HHS
Bill Bensen, Deputy Director of Operations, HHS
Mary Harahan, Chief Deputy, Long Term Care and Aging Policy, HHS
Panel 2: Paul McCarty, Executive Director, Nevins Family of Services, Board of Directors, Alzheimer's Association
Anthony Young, Director of Residential and Community Support, American Rehabilitation Association, Board of Directors, Consortium for Citizens with Disabilities
Joan Kuriansky, Executive Director, Older Women's League, Board of Directors, Long Term Care Campaign

Key Issues:

***The subcommittee is pushing DHHS to define standards for the training of care givers and the quality of long term care found in the Clinton Bill.**

***Panelists testified that the issue of long term care is more than an elderly issue, it is an issue affecting families and particularly woman.**

Following opening remarks by Sen. Barbara Mikulski (MD), Dr. Fernando Torres-Gil provided testimony to the subcommittee. Dr. Torres-Gil told the subcommittee that the President's plan provides us with the opportunity to build upon the strengths of the current system in addressing the problems facing the elderly, individuals with disabilities, and families dealing with these problems. He also said the act "takes important steps to help individuals who need long term care." Dr. Torres-Gil explained to the subcommittee the problems currently facing individuals in need of long term care including the lack of resources and finances available. Dr. Torres-Gil told the subcommittee that the President's plan is not means tested, does not discriminate by age, protects individuals and families in decision making, and offers public services and incentives to use private insurance. He also said that the "focal point of this reform is a major expansion in home and community-based care services; in addition, the plan liberalizes Medicaid nursing home requirements, allows Medicaid home care to continue...provides tax credits to help defray the costs of personal assistance services for working people with disabilities, and establishes regulations, consumer education and tax incentives for private long term care insurance." In his testimony, Dr. Torres-Gil explains the

expansion of home and community-based care as well as the allocation of funds under the Clinton plan.

Following testimony, the panel informed the subcommittee that certain aspects of the plan including the monitoring of the implementation of the home and commuity-based care benefit and where in the Department of HHS long term care would be managed, have not been determined. The panel told the subcommittee that each individual state would be responsible for administering their own plans. The minimum standards for the plan and who would be responsible for overseeing this plan have not been determined. The panel told the subcommittee that quality would be insured through consumer involvement and periodic assessments.

Paul McCarty supports health care reform specifically as it relates to long term care. He discussed the health care model from Massachusetts that offers home health care using outside contractors. He cited that the Massachusetts program has problems including those involving inadequately trained case managers and insufficient funds to assist families. He suggested national standards for care givers and increased specialized assessment of individual needs.

Joan Kuriansky informed the subcommittee that the issue of long term care is a family issue. She said that "one third of all people who need long term care are children and younger adults under the age of 65." Ms. Kuriansky said that long term care is a particular issue for women who are the primary care givers. The responsibilities of being a care giver threatens women's economic security. She approved of the President's plan since it "emphasized the importance of helping individuals and families choose appropriate services at home and in the community without diminishing the services currently available." Ms. Kuriansky explained to the subcommittee that although the costs are high for long term care under the President's plan, it is much lower than the cost of doing nothing at all.

Anthony Young (accompanied by his personal assistant, David Fields) spoke of his personal battle with his disability. He informed the subcommittee that under the current health care system, his personal needs are not being met. Mr. Young told the members that the Consortium for Citizens with Disabilities (CCD) supports a comprehensive long term services program including "supported living services, personal assistance services, supported employment, assistive technology devices and services, and an array of community support services." He applauded the Clinton plan for making a new commitment to long term services, placing an emphasis on home and community services, and attempting to cover all people. He informed the subcommittee that the Clinton Plan needed to be improved in the area of eligibility criteria. Mr. Young believes that the "3 out of 5 activities of daily living" criteria will leave many needy individuals without coverage. He suggested that Congress examine specific areas of the plan including basic service package, the definition of personal assistance services, Medicaid long term services for people with low income, consumer involvement, institutional bias, equity in co-payments, payment rates, attention towards children, private long term care insurance,

quality assurance, case management, and the overall infrastructure.

Following testimony, the second panel informed the subcommittee of the need for information about resources being offered to families, patients and care givers concerning long term care by various organizations and governmental agencies. The panel told the members that they viewed quality in terms of outcomes and wanted specific standards for long term givers and the benefits.

Prepared by:CHarrington:ONAP:690-5560:April 11, 1994