

# Withdrawal/Redaction Sheet

## Clinton Library

| DOCUMENT NO.<br>AND TYPE | SUBJECT/TITLE                                              | DATE       | RESTRICTION |
|--------------------------|------------------------------------------------------------|------------|-------------|
| 001. letter              | To: Chris Jennings re: name and address (partial) (1 page) | 01/19/1999 | P6/b(6)     |

### COLLECTION:

Clinton Presidential Records  
Domestic Policy Council  
Devorah Adler  
OA/Box Number: 20469

### FOLDER TITLE:

Long Term Care [Folder 2]

2012-0463-S

rc777

### RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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

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

PHOTOCOPY  
PRESERVATION

January 19, 1994

"Long Term Health Care Reform"

Mr. Chris Jennings:

At last! I am grateful for the fact that someone wants to give "tax credits" for "in home" long term health care. I have been at this for four years and totally frustrated at the thinking of the IRS on Nursing Home Care vs Home Care.

First, how was \$1000- credit arrived at? The IRS allows total write off of NHC which includes Room & Board, Housekeeping, accounting and Nurses aide etc - while Home Care can write off only Nurses aide - what a discrepancy!

I left a NH after 6 months in that the care was inadequate. I will spare you all the details.

We are a "middle class" family. My husband is a total invalid. I am unable to lift or bathe him (I do all the cooking & housekeeping) therefore, I hire nurses aide - And when they don't show up I hope you can understand how desperate I feel.

Personally, I agree that "tax credits" are the only way to go - prove that you spend the money before you get the credit. Too many people know how to work the system.

My husband is 80 yrs old and I am 77

# Withdrawal/Redaction Marker

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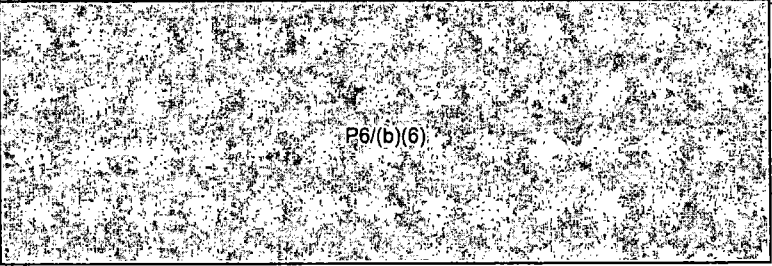
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And bless you for thinking about those  
of us who "stand by their man". I'm tired,  
old, and a prisoner in my own home.

Thank you for any consideration  
that might result - it will be greatly  
Appreciated.



P6(b)(6)

COO1]

PHOTOCOPY  
PRESERVATION

# Center for Independent Living

2539 Telegraph Avenue  
Berkeley, CA 94704  
(510) 841-4776  
(510) 848-3101 TDD  
(510) 841-6168 FAX



436 14th Street #218  
Oakland, CA 94612  
(510) 763-9999  
(510) 444-1837 TDD  
(510) 763-4910 FAX

President Bill Clinton  
The White House  
1600 Pennsylvania Avenue  
Washington, DC 20500

January 21, 1999

Dear Mr. President:

*Thank you for joining us in  
a scent-free environment*

***"No one should have to choose between keeping health care and taking a job. And, therefore, I especially ask you tonight to join hands to pass the landmark bipartisan legislation proposed by Senators Kennedy and Jeffords, Roth and Moynihan, to allow people with disabilities to keep their health insurance when they go to work."***

State of the Union, January 19, 1999

I was your invited guest at the January 13th ceremony in the East Room, "Economic Opportunities for All Americans." Three years ago I knew where the public monuments were in Washington. On that Wednesday, I knew and work with more than half the people in the East Room of the White House.

I have dialogued with countless people with disabilities and gone to thousands of meetings over the last three years to foster the community dialogue and consensus policy development that is summed up in your public policy statement above.

I commend your Domestic Policy Council. I write to salute and thank Gene Sperling, Chris Jennings, and Jean Lambrew for their difficult roles in shaping the debate into the realm of legislative reality. I thank Carol Rasco before them. I met Carol in Petaluma, CA in May of 1996. I said to her, "Carol, you don't know me, but we are bringing Social Security Work Incentive reform to Washington and President Clinton in his second term." Her answer was classic, she said, "We need to do a teleconference!"

Three hundred teleconferences later, the disability community has become a contributing partner in a precedent setting fundamental shift in public policy for people with disabilities. A key public policy figure in your Administration is supposed to have told Ed Roberts before he died, the founder of the independent living movement, "Ed, independent living is a dead idea without employment."

Mr. President, that accurate statement will become public policy in your second term of office because of the leaders of many agencies in your Administration and their partnering with the Congress and a proactive disability community. The Work Incentives Improvement Act of 1999 is an interconnected group of policy objectives that will increase employment for people with disabilities.

A final word of gratitude and deep appreciation goes to the round the clock community building of Mr. Jonathan Young (White House Office of Public Liaison) that we are lucky enough to be working with.

Respectfully submitted:

A handwritten signature in black ink, reading 'Bryon R. MacDonald'. The signature is fluid and cursive, with a large, sweeping 'M' at the end.

Bryon R. MacDonald  
Benefits Counselor/Community Advocate  
Oakland Office  
email: bmacdonald@cilberkeley.org,  
bryosemite@aol.com

January 27, 1999

Chris C. Jennings  
Deputy Assistant to the President for Health Policy  
Old Executive Office Building Room 216  
Washington, DC 20502

Dear Mr. Jennings:

As organizations that advocate for health care quality and access, we are pleased that you have chosen to highlight long term care in your fiscal year 2000 budget. You have placed this issue in the public debate at a time when the current haphazard system for long term care financing is on the brink of disaster as the baby boomers age and the number of people who need long term care skyrockets.

While we applaud your Administration's attention to this pressing problem, we have concerns about the direction you are proposing to go. In the area of long-term care, because costs are so high, solutions that fail to spread the risk broadly across society will inevitably leave millions falling through the cracks. Modest tax relief and the promotion of private insurance are not substitutes for a program grounded in social insurance principles.

Please consider three of our specific concerns:

The \$1,000 tax credit is a symbolic step that will provide some relief to a fraction of those in need, but it will not protect even the targeted population from financial crisis. Nursing home care averages \$50,000 per year. Home and community based care, while less expensive, is estimated to cost \$8,000 to \$10,000 per year. The high threshold requirement of needing help with three activities of daily living or having a severe cognitive impairment assures that those who qualify will have among the highest costs. Moreover, many people most in need will receive no help at all because the tax credit will only be available to those with tax liability.

The program to provide unsubsidized private long-term care insurance to federal employees is a move in the wrong direction. Younger people have generally refused to buy these types of policies when offered by their employers; estimates of premiums for two adequate policies bought at age 65 are about \$3500 per year. Private long-term care insurance is not and will likely never be a viable option for the vast majority of working families.

The support for caregivers outlined in the initiative will do little to relieve the isolation and stress faced by family members and paid caregivers alike. The grants to states for supportive services provide a modest expansion of

services Area Agencies on Aging already offer, but with an unacceptable cost-sharing requirement that has never before existed for such programs. Worse yet, badly needed support for paid caregivers are absent from this initiative entirely. Until measures are taken to increase resources and hold both the nursing home and home care industries accountable for providing living wages, health insurance benefits and adequate training to their workers, quality of care will continue to be compromised by high injury rates and high turnover rates. Such poor working conditions place added stress on informal caregivers as well as on the individual needing care, addressing these issues for paraprofessionals was a major recommendation of your Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Thank you again for placing these crucial issues on the national agenda. While we are aware of the budget constraints and political obstacles that threaten to thwart any meaningful long term care reform, we ask you to consider the points we have raised. We look forward to opportunities for organizations such as ours to work with the Administration to set a tone for the long-term care debate that recognizes the importance of upholding the principle of social insurance in solving this problem that can mean financial catastrophe for many families.

Sincerely,

Consumer Federation of America  
Center for Disability and Health  
National Council of Senior Citizens  
National Health Law Program  
National Multiple Sclerosis Society  
Neighbor to Neighbor  
Network: A National Catholic Social Justice Lobby  
Service Employees International Union  
Union of Needletrades, Industrial & Textile Employees  
United Church of Christ, Office for Church in Society

demographics and the costs are going to require reform anyway. I mean, if my numbers are right, I think that the Medicare spending would have to grow at half the rate of economic growth for the next decade just to extend it for another five or six years.

So what I'd like for you to talk about is whether you think it's a good thing to dedicate some of the surplus to Medicare, and whether you think it can be used as an excuse not to make any further changes in the program, or whether it would actually facilitate changes?

I think we need to get this out. And I really don't know what she's going to say, but I've been very concerned about that because when I made this suggestion, I did not intend to say that, whoop-de-do, now we don't have to make any changes in the program. What I was trying to do was to make it possible for us to change the program without pricing it out of the reach of Americans, millions of Americans.

So, Laura, you want to talk about that?

DR. TYSON: Well, frankly, I was very surprised when I heard that reaction to your speech. When I heard the speech, as a member of the bipartisan Commission on Medicare, I was in a hotel room and I started cheering -- because I know the numbers, we've all looked at the numbers on Medicare, and there is a serious financing problem.

It's a very complicated problem; it's not just a demographic problem. It has to do with health care costs, with technology, with the delivery system. And even the most conservative projections about the growth of health care costs, combined with the change in the demographics, show clearly that additional financing for Medicare will be required. And that is even with an ambitious reform program.

I think that we must all face the reality. There are things we need to do to make Medicare a better program, to modernize it, to include adequate benefits, to make it more efficient, to make it more equitable. After you do all of those things -- and we've looked carefully at the range of things you can do -- you still need additional money.

And I feel that a dedication of the surplus, the hard-won surplus of the American people, to this very important program will secure the program. It will allow the commission to come forward with reforms. I don't think we could have come forward with reforms without some agreement on some source of funds to get us through the next several years.

Now, let me also just end by saying Medicare is a problem we're going to have to revisit time and time again because there is a huge amount of uncertainty in terms of how people get care, in terms of shift to prescription drugs, in

MORE



terms of the possibility of having drugs that are individualized to the genetic background of each individual. We're engaged in a huge technological revolution in health. So what I think we're going to try to do in the commission is put in place some reforms that we believe will allow Medicare to remain modern and to be flexible as health care changes. But we can't do any of that without some additional money.

So all I have to say is I cheered the proposal and I'm optimistic now that we can get something done.

THE VICE PRESIDENT: I'd like to ask Dr. Reinhart a question, following up on that one. One of the reasons why after all the deliberations here the President made the decision to dedicate -- recommend dedicating some of the surplus to Medicare, is that we've learned from our studies here that you really cannot extend the life of the trust fund for any substantial period of time without really significant reductions in Medicare.

I know you've spent so many years studying the details of this issue. Tell us why you think resources are part of the answer -- and significant resources are part of the answer, from a health, economic, budgetary perspective.

DR. REINHART: Well, Mr. Vice President, every projection I have seen that seems plausible suggests that even the present benefit package, which people say is inadequate, will be eroded unless additional money is brought into this program. I think any expert will tell you that.

And we now have the opportunity, the unique historic opportunity to provide those monies. And I think it would be sinful not to do so. I support this initiative because it is prudent, it is fair and it is civilized. What do I mean by "prudent"? By prudent is exactly the point that every projection shows we will fall short.

Now, our method in the '80s was to create a huge deficit, then look at each other and look at each other and look at God and say we cannot be our brother's keeper because we have a deficit -- and we thought God bought the argument. (Laughter.) Fair enough. What are we going to do in the '90s or in 2010? We have the surplus and we look at God and we say, we cannot help the elderly who now trade food for medicine -- that was on the front page of the Wall Street Journal.

So, therefore, I consider this civilized. And, finally, I consider it fair, because the baby boom created -- helped work to create the surplus. And the President proposes to put that surplus aside to help finance health care for the baby boom when they are retired. That strikes me as socially fair. So on these three counts I have in the press, as you may have read, wholeheartedly supported this, and I hope the American people will, too.



# NATIONAL RURAL HEALTH ASSOCIATION

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Susan Wilson  
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Washington, D.C. 20036-1610

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## POLICY INSTITUTE

NATIONAL RURAL HEALTH ASSOCIATION

February 8-10, 1999  
Washington, D.C.

Date: Jan 27, 1999

To: Chris Jennings

Fax  
Number: 456-7431

From:

- ☐ Darin Johnson, Government Affairs Director
- ☒ Linda Rouse, Government Affairs Special Assistant
- ☐ Doretha Harris, Senior Administrative Assistant
- ☐ Other \_\_\_\_\_

Subject: Coalition letter to FCC Chairman

Kennard regarding implementation of the

Universal Service program

Pages (Including Cover Page): 3

Dorinda M. Williams  
Executive  
Vice President

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January 21, 1999

The Honorable William E. Kennard  
Chairman  
Federal Communications Commission  
1919 M Street, NW, Room 814  
Washington, DC 20554

Dear Chairman Kennard:

On behalf of our nation's rural and frontier health care providers and beneficiaries, we are writing to express our shared concerns regarding the current implementation of the rural health care portion of the universal service program as well as our strong support for expansion of the program.

Our collective memberships are extremely concerned that the Federal Communications Commission (FCC) has not fulfilled its commitment to implement the rural health portion of the universal service program. We believe that it is absolutely critical that the FCC work with the Rural Health Care Corporation (RHCC) and the health care community to resolve issues that have arisen and are impeding the progress of the program. For those issues raised below that cannot be implemented by the FCC, we strongly urge you to communicate the FCC's support for such changes needing legislative action to Members of Congress and the appropriate congressional committees.

First, in order for the universal service program to meet Congress's intent to provide rural and frontier Americans better access to quality health and mental health care services, it is absolutely necessary to modify the manner by which the eligible telecommunications services are deemed eligible for support. Given that there is very little, if any, difference in urban and rural monthly rates and that toll charges are not eligible for support, the program now primarily supports only mileage charges associated with T-1 lines. The exclusion of ISDN, POTS and other toll services from receiving support has severely limited the potential utilization of the program by rural health care providers. In addition, to date no one has qualified for the Internet component of the program because there is almost ubiquitous local access to the Internet. Furthermore, it appears many telehealth applications are moving away from dedicated point-to-point T-1 type services to switched, lower bandwidth applications such as the ones previously mentioned. The reality of this shift in technology is that the current universal service program structure does not provide discounts for these types of telehealth applications.

Second, provider eligibility for the program must be expanded to include rural home health care agencies, skilled nursing facilities, public health agencies and other health care providers without regard to their tax status. Rural and frontier communities are served by a wide variety of independent health care providers and the current eligibility limitations deny the benefits of telehealth to thousands of rural and frontier residents.

Third, the requirement that a telecommunications company needs to be an "eligible telecommunications carrier" (ETC) must be eliminated. While the intent of the 1996 Telecommunications Act was to increase competition between the local and long distance carriers, in reality, the ETC requirement has precluded long distance companies from participating in the program. This has prevented up to 35 percent of rural health care providers from benefiting from universal service discounts.

As a result of the above discussed issues, it has become increasingly apparent that the application process must be streamlined and simplified to better reflect the realities of how telehealth is practiced in rural and frontier areas. Numerous rural health care providers have contacted our associations regarding the program's burdensome application process, which currently takes up to 17 weeks to complete. The current application process requires rural providers, already pressed for time and resources, to complete a multi-step application process. Once approved, they must negotiate prices and discounts directly with the telecommunications companies. This entire process would have to be completed by the health care provider on an annual basis. As an alternative, we are proposing the FCC consider an across-the-board percentage discount for all rural telehealth services. Such a process would not require negotiations between the rural health care provider and the telecommunications company.

While we are pleased that an additional seat was added to the full USAC board and designated for a rural health representative, we continue to have strong reservations regarding the structure and exact role of USAC's Rural Health Care Advisory Committee. We urge members of the FCC staff with oversight responsibilities for the program and USAC's rural health representatives to meet and discuss these issues with the rural health care community to ensure that the views of this community are fairly and adequately represented and that the program is being implemented in a timely and effective manner.

In closing, we respectfully request a meeting with you to discuss ways to implement the current universal service program and to expand the program to better meet the original intent of Congress. To schedule a convenient time to meet and if you have any questions, please call Darin E. Johnson, the NRHA's Government Affairs Director, at (202) 232-6200.

Sincerely,

National Rural Health Association  
American Academy of Family Physicians  
American Association of Homes and Services for the Aging  
American College of Nurse Practitioners  
American Hospital Association  
American Medical Association  
American Psychological Association  
American Telemedicine Association  
Association of Telemedicine Service Providers  
California Telehealth and Telemedicine Center  
Federation of American Health Systems  
Hospice Association of America  
National Association for Home Care  
National Association of Community Health Centers  
National Association of Rural Health Clinics  
National Grange  
National Organization of State Offices of Rural Health

Office of Economic Policy

Department of the Treasury  
Washington, D.C. 20220

FAX

Date: 1/29/99Number of pages including cover sheet: 11

|       | Name           | Fax Number   | Phone Number |
|-------|----------------|--------------|--------------|
| To:   | Chris Jennings | 456-5557     | 456-5360     |
|       | Jeanne Sambre  | 456-7431     | 456-5377     |
|       |                |              |              |
|       |                |              |              |
|       |                |              |              |
|       |                |              |              |
|       |                |              |              |
| From: | Mark McClellan | 202-622-2633 | 202-622-0563 |

Remarks: URGENT ☒ For your review ☐ Reply ASAP ☐ Please comment

For our internal briefings & Principals —  
comments appreciated, & hope it's helpful for you

### Unresolved Issues for Medicare Reform

| Issue                            | Breux Plan 1/26/99                                                                                                                                                                                                  | Preferred Outcome / Options                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Design of Premium Support</b> |                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Required Benefits                | Benefit categories (e.g., hospital services) would be specified as FEHB does, but details are left for plans to choose – subject to approval of oversight board. Presumably current Medicare benefits are included. | Must maintain at least the benefits in Medicare today, plus a prescription drug benefit (below). Some question about whether certain benefits need to be specified in more detail (e.g., minimum length of stay for mastectomy) – though all plans are likely to be subject to Executive Orders on patients' rights, as Medicare and FEHB are now.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Drug Benefit                     | Exploring options (including Medigap mandate?). Republicans have expressed concerns about substituting public for private dollars, and fears of "government price regulation" of drug companies.                    | Must be included, but key questions on specifics:<br>(1) Voluntary or mandatory: probably voluntary with significant beneficiary contribution to limit cost to program (e.g., 50% subsidy for premium); subsidizing premium limits adverse selection pressures but opt-in rules would also be needed<br>(2) Front-end coverage (relatively low copays and/or deductibles and modest limit on total benefits per year, e.g. \$1000-1500 with indexing) or catastrophic coverage (higher deductible and/or copay, but no limit on benefits)<br>(3) Drug purchasing mechanism: Probably would rely on govt. contracts with private prescription benefit managers, who could manage formularies and negotiate favorable contracts, just as they do now for private insurance plans<br>(4) Other design issues: Do deductibles and copays count toward overall plan limits? Income-related premium (e.g., no cost for current Medicaid beneficiaries, subsidies for others)? Strength of financial incentives for beneficiary to use generics and therapeutic equivalents, to reduce cost of plan? |

| Issue                               | Breaux Plan 1/26/99                                                                                                                                                                                                                                                                                                                                                                                   | Preferred Outcome / Options                                                                                                                                                                                                                                                                                   |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Premium Support Formula             | For typical beneficiary, govt. pays a fraction of premium (88-90%) up to a premium "cap." Cap is equal to the national average premium (based on prior-year enrollments?); beneficiary pays full premium above this. At hearing, Breaux stated that average beneficiary share for current benefits will remain at current level (12%), but no written details on how to guarantee this support level. | Prefer explicit commitment to maintaining current level of support for current package of benefits. Need to specify how this would work in practice – e.g., 88% of premium of traditional fee-for-service (FFS) Medicare plan? What if FFS Medicare adds benefits like drug coverage or stop-loss protection? |
| Updates to Level of Premium Support | Unclear. Appears that premium cap would grow with national average premium (which in turn is likely to depend on how basic benefits are defined); also verbal commitment at hearing that standard beneficiary share for current benefits will remain at 12%.                                                                                                                                          | Need explicit statement that premium support will increase with health care costs, to limit growth in beneficiary financial exposure. Could be tied to private-sector medical cost growth if concern that linkage to Medicare cost growth would encourage premium increases.                                  |

| Issue                                            | Breau Plan 1/26/99                                                                                                                                                                                                                                                                                                                                                                  | Preferred Outcome / Options                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Low-Income Protections / Income-Related Premiums | Medicaid, QMB, and SLMB eligibles pay no premiums up to cost of traditional FFS Medicare plan (and presumably no cost-sharing for Medicaid and QMB?). High-income beneficiaries – above \$50K for couples and \$40K for singles – pay higher fraction (25% not 10-12%) of premium up to national average, and apparently higher fraction (125% not 100%) for premium above average. | Need explicit statement of low-income protection, at least at level implied by current Breau plan. High-income premiums may not raise much revenue and create administrative problems (few elderly households are high-income; would need asset tests to raise significant revenue). Democrats also have concerns about Medicare becoming a “welfare program.” High subsidies for all income groups are needed to keep beneficiaries from dropping Medicare - Breau plan provides this even for wealthy, who get 75% subsidy up to national average (around \$5700 today). But making them pay more than 100% of premium above average would create this risk if average plan deteriorated. Details: Are higher premiums for high-income phased in? |
| Premium Bidding                                  | Little detail - national bidding (national premium for traditional FFS Medicare; regional or national bids by private plans, with “geographic adjuster” for regional variation in health care costs) or regional/ local bidding.                                                                                                                                                    | Regional bidding (like FEHB), or national bidding, with “appropriate” regional adjustment. Appropriate regional adjustment might include (a) adjustment for all or part of regional variations in Medicare costs or private insurance costs, (b) adjustment for regional variations in overall cost of living only (to reduce the large variation in Medicare utilization). Transition period needed if regional adjustments are small. Need to define relevant market in which competition will take place - FEHB regions? counties, as in Medicare AAPCC payments?                                                                                                                                                                                |
| Geographic Variation in Premium Support          | Appears to establish a national schedule for premium support; suggests geographic adjustments limited to general cost differences, not the large variations in average utilization across regions.                                                                                                                                                                                  | Should account for regional variations in premiums, either by defining premium support cap on regional basis or by using regional adjuster as described for bidding, so that beneficiaries in high-cost areas do not face large increases in out-of-pocket payments. At a minimum, national schedule should include a substantial transition period.                                                                                                                                                                                                                                                                                                                                                                                                |

| Issue                                                        | Breux Plan 1/26/99                                                                           | Preferred Outcome / Options                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Risk Adjustment of Premiums and Government Payments          | Says only that government contribution "will be adjusted for health risk and other factors." | <p>Need more details on general principles. Can't appeal to FEHB experience, since FEHB premiums are not adjusted for beneficiary characteristics. Potential for risk selection is much greater in Medicare. Example: AAPCC "premium" payment in Medicare+Choice for 85+ year-old is over 50% higher than payment for 65-74 year-old. Issues include:</p> <p>(1) Beneficiaries should make similar premium contributions regardless of premium adjustment - 85-year old should not pay much more than 65-year old.</p> <p>(2) Risk adjustment method should be considered in context of other incentives / options to switch plans (i.e., open enrollment, financial incentives in premium support, allowed benefit variation). Goal is to minimize adverse selection pressures without recreating fee-for-service incentives.</p> <p>At this point, probably should (1) encourage further development of risk adjustment systems that do not depend on hospitalization, as HCFA is doing now; and (2) support system for adjusting premiums and government contributions to protect quality and limit out-of-pocket cost of care for higher-cost beneficiaries.</p> |
| Default Choice/ Choice Assistance for Impaired Beneficiaries | Not addressed, except in that option to stay in Medicare FFS will be retained.               | Less serious problem if premium support system guaranteed support for 88% of FFS Medicare premium - assuring that there is a default option that is at least as good as their current insurance. May want to consider a counseling/ assistance system like that for elderly taxpayers, or through AOA offices.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

| Issue                                      | Breau Plan 1/26/99                                                                                                                                                                                                                                                           | Preferred Outcome / Options                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Rural Beneficiaries with No/Limited Choice | Not addressed. Presumably regional bid would be FFS Medicare. Republicans have expressed concerns about HHS operating as unregulated monopoly.                                                                                                                               | Regional premium support might actually make rural beneficiaries worse off, since they generally live in lower-cost areas. Additional steps to assure quality and value of care in areas where traditional FFS Medicare has no competition?                                                                                                                                                                                                                                                                                                                   |
| Oversight Board                            | Similar to FEHB.                                                                                                                                                                                                                                                             | Unclear. HHS has concerns about oversight/ accountability of independent Board, which would be charged with promoting welfare of beneficiaries but which would have no direct ties to them. Additional accountability mechanisms run risk of reducing Board independence from political pressures. Administration has endorsed an independent Board for managing Social Security funds, but the Medicare Board would have a much more complex task and much more discretion.                                                                                  |
| Additional Benefits                        | Plans allowed to offer, with restrictions as in FEHB: oversight board "will be empowered to ensure that all benefit packages do not vary to the point that they produce ineffective or unfair competition." Benefit standardization noted as an "alternative design option." | Unclear. Prohibiting additional benefits would encourage plans to compete on cost and quality, and would reduce opportunities for risk selection. This is done by most private "managed competition" plans, but not by FEHB. If additional benefits are allowed, may want to restrict the types of additional benefits that can be offered - to make choosing among plans less confusing for beneficiaries, and to avoid benefits that create significant risk selection problems. For example, variation in individual Medigap benefits is restricted today. |
| Plan Switching                             | Annual open enrollment period. One member suggested longer lock-in to limit selection.                                                                                                                                                                                       | Annual open enrollment period.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| Issue                                                                      | Breau Plan 1/26/99                                                                                                                                                                                                                                               | Preferred Outcome / Options                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Changes in the "Traditional" Fee-for-Service (FFS) Medicare Program</b> |                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Medicare FFS Option                                                        | Retained as an option in premium support; would continue to be managed by HCFA; could be modernized.                                                                                                                                                             | Must be retained and modernized.                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| HCFA Authority for "Modern" Management of FFS Medicare                     | HCFA would be given "management tools adopted by the private sector," including "enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, elective contracting, and preferred provider arrangements." | Support – both to rationalize benefit package and give HCFA powers needed to compete fairly. Should also allow HCFA to continue to develop quality assurance tools (and using them for payment). Much political opposition to exercising such powers under demonstration authority now – but new context of competition could change dynamic. If HCFA gets greater political independence, may still want mechanism for accountability/review, perhaps through an oversight board. |
| Rationalize FFS Out-of-Pocket Payments                                     | As example, proposes a combined deductible of \$350, with 20% coinsurance for all but inpatient and preventive care, and 10% for home health.                                                                                                                    | Support rationalization. Breau proposal is reasonable (similar to those considered by Administration) but could increase costs. How would deductible be indexed? Would payments for drugs be counted toward deductible? Home health currently has 0 copay.                                                                                                                                                                                                                         |
| Stop-Loss Protection                                                       | Not yet addressed in text – awaiting scoring results? Perhaps trade off \$4,000 stop-loss limit for 20% inpatient coinsurance.                                                                                                                                   | Unclear. Catastrophic protection seems desirable on policy grounds, and may reduce demand for Medigap. But not a priority for most seniors, and much of the catastrophic insurance provided would go to hospitals that currently write off these charges as bad debt (covered by paying patients). If not included in FFS benefits, would it be allowed/prohibited in private plans?                                                                                               |

| Issue                                                                                 | Breux Plan 1/26/99                                                                                                                                                                            | Preferred Outcome / Options                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Medigap<br>(Supplemental Insurance) Reform                                            | No specifics, but states that "Medigap should be reformed to minimize the effects of first-dollar coverage on utilization and so that the price of Medigap policies reflect their true cost." | Need reform to discourage first-dollar coverage and encourage stop-loss protection (some plans today cover copayments and deductibles only). Ideally, benefit rationalization would reduce or eliminate the need for Medigap. Without such rationalization, Breux proposal likely to reduce Medigap takeup, worsening Medigap selection problem and raising out-of-pocket costs for sicker beneficiaries. |
| BBA Extenders<br>(primarily consist of tighter limits on growth of provider payments) | Provider payment rates are noted among "areas that need resolution."                                                                                                                          | Current hospital margins and the magnitude of the proposed payment changes suggest that they could be extended for at least 5 years. (Continuing to reduce payments beyond that might finally reduce provider participation in Medicare.)<br>Could be used to fund some or all of the proposed prescription drug benefit.                                                                                 |

| Issue                                  | Breux Plan 1/26/99                                                                  | Preferred Outcome / Options                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Changes in Medicare Eligibility</b> |                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Increase Eligibility Age               | Proposes to increase to age 67 over 24 years, paralleling Social Security increase. | "Skeptical," especially in the absence of a specified buy-in plan for those approaching Medicare eligibility age.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Medicare Buy-In                        | Suggests buy-in plan may be possible, but offers no details.                        | Administration already supports a two-part buy-in: one for 62-64 year-olds, in which they pay approximately \$300/month premium up front plus \$200-600 annual surcharges on their premiums after age 65 (to account for the fact that higher-cost individuals are likely to sign up); and one for 55-61 year-olds who lose insurance when they lose a job, and who would pay about \$400/month but have no "loan" to repay after 65. Compromise position might be a buy-in for a more limited age group (e.g., starting at 62-65 to match Social Security early eligibility and gradually increasing with NRA). Those buying in would receive no premium support, and because of adverse selection would need to pay an additional premium surcharge to avoid increasing program costs (surcharge could be limited to 62-64 year-olds, but this would reduce savings from raising eligibility age) Analysis of previous Administration proposal suggests those buying in would have expected costs around 133-150% of average. |

| Issue                                                               | Breux Plan 1/26/99                                                                                                                             | Preferred Outcome / Options                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part A Medical Education and Disproportionate Share Payments</b> |                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Direct Medical Education (DME)                                      | Carve out from Medicare Part A and fund as mandatory or discretionary appropriation; would also make available to all residency programs.      | Unclear. Shifting these programs to general revenues would improve Trust Fund solvency (about one year) and progressivity, and medical education payments are probably allocated to hospitals inefficiently. However, they do provide important support to teaching hospitals - which not only provide education but also treat more difficult cases, and (often) large shares of uninsured patients. Making these payments discretionary would probably lead to larger reductions over time. |
| Indirect Medical Education (IME)                                    | Retain but revisit appropriate payment rate.                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Disproportionate Share (DSH)                                        | DSH and other subsidies "should be revisited to ensure that Medicare's support is reasonable and appropriate." Possibility of carve-out noted. | Unclear. Carve-out to discretionary budget would improve Trust Fund solvency (around one year), and improves actuarial balance (by about 0.1 percent of payroll). Payments are probably allocated inefficiently, and financing through payroll tax may not be best policy. But they provide substantial funding for hospitals that treat a many uninsured and Medicaid patients, and they would be more likely to fall over time if they were discretionary.                                  |

| Issue                                 | Breau Plan 1/26/99                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Preferred Outcome / Options                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Addressing Trust Fund Solvency</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Additional Revenues                   | Suggests that financing changes should not be considered until structural reforms are in place. Republicans reluctant to add any new funding.                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Medicare needs infusion of revenues, i.e. transfer of 15% of unified surplus for 15 years as proposed in SOU. Possible further steps: combine HI and SMI Trust Funds, add general revenues as needed to supplement payroll taxes – to improve progressivity and avoid issue of “insolvency”? If not, how would premium contributions be allocated to Parts A and B?                                                                                                                                                                                                                                                                                                                                                  |
| Limiting Medicare Cost Growth         | Unclear how much this will be addressed. No explicit statements recently. Actuarial scoring likely to suggest no significant savings from premium support in Breau plan: it lead to modest reduction in long-term growth rate of Medicare costs, but offsetting impact on Medicare outlays because beneficiaries choose plans with more generous benefits under premium support (traditional FFS Medicare is not a generous benefit package). Modest improvements in solvency (several years) may result from increasing eligibility age and carving out medical education and/or disproportionate share payments. | BBA extenders would have modest positive effect. Unclear how much further extension of Trust Fund solvency is a priority. Pro: Continuing rapid change of health care system suggests that reform should be revisited frequently, so that very long-term solvency is impossible to predict and should not be a high-priority goal – better to make system more rational and efficient so funds are spent wisely whatever their level. Extending Trust Fund solvency to 2020 provides a substantial window to consider whether further reforms are needed. Con: Very likely that health care costs will continue to rise, so deferring further attention to program cost growth may make it tougher to address later. |



|                        |                             |
|------------------------|-----------------------------|
| 12/1/98 # of pages = 2 |                             |
| To: Chris Jennings     | From: Steve McConnell       |
| Co:                    | Co: Alzheimer's Association |
| Dept:                  | Phone #: 202-393-7737       |
| 456-5557               | Fax #: 202-393-2109         |

## MEMORANDUM

*Chris -  
I'll call to  
arrange a time for  
us to meet.  
Steve*

TO: Chris Jennings  
FROM: Steve McConnell and Judy Riggs  
RE: Caregiver Initiatives  
DATE: November 30, 1998

As you continue your work on the President's health care initiatives, we would like to talk with you again about his continuing interest in finding ways to provide meaningful support for family caregivers. We understand that there may be several options under consideration:

1. Grants to States for Alzheimer Caregiver Innovations. This tiny program (\$6 million in fy99) has provided small matching grants to 15 states or jurisdictions to develop new approaches to provide outreach, education, caregiver support and respite to underserved populations (ethnic and cultural minorities and rural). The emphasis is on working within existing systems – community agencies, primary care, and managed care – and it has had a major impact on changing those systems. As you know, administration of the program is shifting this year from HRSA to the Assistant Secretary for Aging. This is an opportune time to consider an expansion of the program, to encourage replications and further innovations in additional states. It has considerable support in Congress – which finally reauthorized the program this year and removed statutory limits on the amounts that can be appropriated and the number of states that can participate. The Alzheimer's Association will be encouraging Congress to double (at least) funding for the program for fy2000.
2. Tax Credits. As you know from our earlier discussions, there is considerable ambivalence about this approach. Enthusiasm among advocates depends on the size of the credit and how it would be targeted to reach those who most need help paying for long term care. You will recall that there was little interest in the \$500 tax credit that was part of the Contract with America. If it can be at least \$1,000 and refundable, we probably can generate support, though some groups (e.g. Families, USA) are adamantly opposed to the tax approach altogether. If we achieve the \$1,000 threshold but are not able to make it refundable, I suspect support, especially from labor, will be lukewarm.
3. Medicare Home Health – the Homebound Issue. This continues to be a very significant problem. Fiscal intermediaries are taking (and HCFA is supporting) a very strict construction of the term homebound, denying the home health benefit to otherwise eligible beneficiaries on the sole ground that they are attending adult day care; no consideration is given to the "considerable and taxing effort" required to participate in day care nor to the treatment that the beneficiary receives at the day center. This is a particular problem for people with Alzheimer's disease, as adult day care is recognized increasingly as a beneficial

treatment for them. We believe that there is ample room in the current statute to make clear that beneficiaries with Alzheimer's disease who attend day care for treatment of their dementia do not lose their homebound status. Further, we believe this can be done without significant financial impact to Medicare, because families forced to make a choice between adult day care (which Medicare does not cover) and Medicare home health benefits must necessarily choose home health.

4. Medicare Home Health – the Larger Issue. The real issue, of course, with the home health benefit -- and one that has been largely sidestepped in the discussion over the interim payment system and PPS -- is what role Medicare should play in addressing the home care needs of beneficiaries who are living with chronic illnesses and disabilities. We can continue to try to deal with brush fires, like the homebound definition or IPS. Or we can confront the issue head on. Some of us are beginning to explore a new approach to home health that would make more sense in terms of the way beneficiaries will be living in the community and receiving treatment in the 21<sup>st</sup> century. We intend to try to make this part of the debate about the future of Medicare that will likely continue over the next several years. It would be wonderful to work with you on this.
5. New Caregiver Support Initiatives. We have heard, indirectly, that there are proposals within the Administration for a new caregiver support initiative. In the past, advocates for long term care (particularly for the frail elderly) have enthusiastically supported caregiver support initiatives, most notably Senator Bradley's legislation (which, while much more modest in the size and nature of the benefit, was quite similar in design to what became the long term care provisions of the Health Security Act.)

From the type of issues outlined above, we think it would be possible to put together a package which, while modest, could generate real enthusiasm. Support for family caregivers is an issue that resonates with the American people. We are just completing work on a new study that will document again the size of the job that caregivers of people with Alzheimer's disease are doing, and the physical, emotional, and financial cost of that caregiving role. (While we have not yet scheduled a release date, we hope to make the information public early in the new year.)

We also want to bring you up-to-date on proposed activities by the LTC Campaign, a nursing home industry financed campaign headed up by Sen. Durenberger, and some other things that are in the works which might affect the above proposals.

We would welcome an opportunity to explore these issues with you and will call to see when we might be able to get together.

1-11-99

**THE BUREAU OF NATIONAL AFFAIRS, INC.  
HEALTH CARE INFORMATION DIVISION**

**1231 25<sup>TH</sup> Street, N.W., Third Floor North  
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**FAX TRANSMISSION COVER PAGE**

**Please send the following page(s):**

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***Office of the House Majority Leader***

**For immediate release -  
January 11, 1999**

**Contact: Michele Davis**  
**(202) 225-6007**

## Army Calls for Tax Credit to Reduce Number of Uninsured

House Majority Leader Dick Arney sent the attached memo, calling for a new phase in the health-care debate, to his Republican colleagues on Friday, January 8, 1999. Arney's memo outlines his vision of how we can expand access to affordable care and maintain our nation's standard of providing the highest quality health care in the world.

In the memo, Arney highlights the growing number of uninsured Americans, and places the blame on rising costs and a distorted market. "Layers of red tape, mandates, and price controls deny consumers the right to buy affordable insurance that best meets their needs," he writes.

The solution: end the market distortion caused by a quirk in the tax code. Arney calls for extending the existing tax exclusion for employer-provided insurance to people who aren't eligible for an employer health plan — through a refundable tax credit. Arney writes "While not the complete answer, this would provide greater equity, access, portability and choice than today's system, with little if any disruption. It would get people covered and begin creating a true marketplace."

Armedy concludes, "We face a choice: we can remain passive as the political dynamic drives us toward an increasingly bureaucratic, government-controlled medical system or we can take decisive action to create a consumer-driven health-care market that responds to patients' real needs. I say the time has come to create the market."

# Memo

**To:** Republican Colleagues  
**From:** Dick Arney  
**Date:** January 8, 1999  
**Re:** Affordable health care for the uninsured: the time is now

The time has come to launch a new phase of the health-care debate. We who are dedicated to advancing freedom need to seize the initiative. We need to pass legislation that protects patients from genuine HMO abuses and ensures their access to timely medical care. We need to offer better solutions for giving the uninsured access to affordable health care. And we need to preserve the high quality of American health care from creeping mandates and socialized medicine. I believe we can achieve all of these goals – and in the process win the hearts and minds of the American people on the health-care issue. Here, for your consideration, are some of my thoughts on how we can do this.

## **The liberals' goal**

We know the liberals' ultimate goal is government control. We also know that a bureaucratic, government-run system means lower-quality medical care for all of us in the long run. And we know that, while ClintonCare may have been rejected in 1994, the liberals are driving the country toward it, step by step. The Clinton Administration's recent, massive proposal to regulate every aspect of managed care is only the latest of these steps. The political problem for Members of Congress is that such regulatory proposals are fueled by voters' legitimate dissatisfaction with today's employment-based health-benefits system, with its lack of access, affordability, portability, and choice. Patients are not in the driver's seat; employers and insurers are. So it's no surprise to me that patients aggrieved by their HMO turn to government for redress: what other options do they have?

Giving trial lawyers new rights to sue health plans, as the President's allies want, would not address any of the real problems of today's system, and would in some ways make them worse. In the long run, only reforms that liberate people to choose their health plans and doctors – and to take their business elsewhere when dissatisfied – can make the health system better and more satisfying for all of us.

Wisely, Congress recognized this truth when it rejected the Clinton plan last year. Instead, as you know, the House passed the Patient Protection Act (HR 4250), a bill that would impose tough accountability for HMOs, give employees more choices, and lower costs. While Senate Democrats succeeded in stopping the Patient Protection Act last fall, hoping to blame its demise on Republicans in an election year, I believe conditions are now ripe to produce a good bipartisan bill the President can sign. I hope and expect to call up such legislation in 1999, following due committee consideration.

### **The crisis of the uninsured**

The current "patients' rights" debate is too narrow. It focuses only on how much new regulation and legal liability to impose on doctors, employers, and health plans. It misses the damage inevitably done by these sorts of intrusions, in the form of higher premium costs and lost coverage. To really help patients, we need to expand the discussion to include the growing crisis of the uninsured. After all, access to affordable health coverage is the first patient protection. Consider:

- At some point during the coming year, 43.4 million Americans will be without health coverage.
- A decade from now, that figure could be 53 million, or as many as 60 million if the economy softens.<sup>1</sup>
- The number of the uninsured has grown by 10 million over the past ten years.
- Where 11 percent of the population was uninsured in 1980, today it's 16 percent, and ten years from now it could be 20 percent or higher.
- In my own state of Texas, 25 percent of the population is uninsured.
- More than 80 percent of the uninsured hold jobs and work year-round, mostly in small businesses. They make too much to qualify for Medicaid, and their employers offer them either no coverage or coverage they can't afford.

While the uninsured are not a monolithic mass – many go uncovered only briefly, others voluntarily for various legitimate reasons – the hard fact is this: the percentage of the population going without insurance involuntarily is growing year after year, in good times and bad. This is clearly a structural problem we ignore at our peril.

What's causing the problem? The immediate cause is clear: Health costs have been rising dramatically, despite a brief slowdown in the mid-'90s. From 1988 to 1996, the cost of the average family health plan more than doubled, from \$2,500 to \$5,350.<sup>2</sup> The next few years are expected to bring further double-digit increases.

But the deeper cause is the lack of a true consumer-driven market. Government policy has distorted the market practically out of existence. Layers of red tape, mandates, and price controls deny consumers the right to buy affordable insurance that best meets their needs. And as I try to explain below, a basic inequity in the tax code has caused third-party payment to become the norm. Since somebody else is paying the bill, people don't shop for the best prices and products.

The uninsured are victims of a classic vicious circle: Each new government intervention increases costs, which in turn swells the ranks of the uninsured, which in turn causes the public to call for yet more interventions, and so on. The way to break out of this cycle is to get more individual Americans into a true health-insurance market, where as consumers they'll demand lower prices and fewer interventions. And the only way to create that market is to go to the real root of the problem: the tax code.

### **Diagnosis: broken tax code**

Big problems often have simple causes. The crisis of the uninsured flows ultimately from a single provision of the Internal Revenue Code: the method by which individuals obtain tax-favored health insurance. Under today's code, the only way an individual can obtain a tax benefit for health insurance is through the workplace. Health benefits provided by employers are excluded from income, that is, they are treated as if they are not really part of the individual's compensation. But health insurance purchased directly by the individual is not. This exclusion is both wasteful and unfair. It is wasteful because:

- Health care becomes an invisible benefit, seemingly free to employees.

<sup>1</sup> Source: Health Insurance Association of America study based on federal health data, 12/98.

<sup>2</sup> Source: July 1997 GAO report.

- Employees become less cost-conscious.
- They demand unnecessary coverage and services.
- The whole medical system becomes wasteful and inefficient.
- Insurance becomes more costly than necessary.

At the same time, the exclusion is unfair because:

- People without access to job-based coverage get no tax benefit, and are thus more likely to be uninsured.
- Higher-paid people get a bigger subsidy than those with lower incomes. Uncle Sam gives the wealthy CEO a more generous subsidy than the waitress at the corner diner – and if the diner can't afford to offer health benefits, she gets nothing at all. That's wrong.
- The majority of employees have little or no choice of plans or doctors, fueling frustration and anger and calls to Congress for relief.

#### **Prescriptions: tax fairness**

How can we fix these problems? Perhaps no one in Congress has spent more time thinking about that very question than Bill Thomas, in his capacity as chairman of the health subcommittee at Ways & Means. Bill advocates an elegantly simple solution: Replace the existing tax exclusion with a refundable Universal Tax Credit for insurance purchased by individuals, with very few if any strings attached. Give consumers a voucher of a fixed-dollar amount and let them shop in the marketplace for the coverage that best suits their needs. If they want richer coverage, they are free to pay for it with after-tax dollars.

I strongly support this idea. It would give all Americans access to at least a minimum level of private health coverage. It would make health insurance truly portable between jobs. It would give people a real choice of plans and doctors. It would let dissatisfied patients "fire" their HMO. Indeed, it would take the steam out of the current movement to put managed care in shackles. And it would stop cold the liberals' endless efforts to expand government-run programs like Medicare and Medicaid to cover the entire U.S. population. It provides justice between rich and poor. It is, in short, the answer to the Health Question.

But a solution so simple and sweeping could also be politically challenging. We haven't the luxury of starting from a blank slate. And frankly we would be deluding ourselves if we thought we could achieve this major reform without causing at least some unease among folks who feel they're served well by the current system, mainly people with stable jobs at large companies.

An alternative, incremental approach would be to leave the existing exclusion untouched, but extend similar tax benefits – either a credit or a deduction; my own preference is for a refundable credit – to people who aren't eligible for an employer health plan. While not the complete answer, this would provide greater equity, access, portability, and choice than today's system, with little if any disruption. It would get people covered and begin creating a true marketplace.

In any event, the amount of the credit or deduction should be large enough to get millions of Americans covered. It should be substantial. If that seems "costly," in Washington terms, let's remember that the current federal surplus – or more accurately, the tax over-payment – is already being squandered by President Clinton and his liberal allies on Washington spending programs; it will soon all be spent, if we don't return it to the people in the form of tax cuts. Why not return some of it in a way that also helps alleviate the crisis of the uninsured? The American tax burden is now at its highest level in history. If we can't cut taxes now, when can we?

To paraphrase my political antipode, Senator Kennedy: Some say we can't afford to cover the uninsured; I say we can't afford not to. If the CEO is going to receive government-subsidized health care, then so should the waitress earning the minimum wage. Period.

### **My dream bill**

At the risk of presumption, I'd like to go one step further here. I would like to suggest a possible consumer-protection package that I believe could win bipartisan support and a presidential signature. My dream bill would include none of the costly mandates of the liberals' plan:

- No body-part mandates.
- No any-willing-provider mandates.
- No sue-your-health-plan provision.

But it would include the Patient Protection Act's tough Talent-Norwood accountability provision, which provides for a mandatory review of disputed HMO treatment decisions by external, independent medical specialists. This offers a better approach than the sue-your-health-plan scheme: sick people need to be in a hospital room, not a courtroom – receiving health care up-front to prevent injuries, not seeking damages for injuries already incurred.

At the same time, my dream bill would address the growing crisis of the uninsured through such exciting and innovative ideas as:

- Medical Savings Accounts for all, to give people more control of their health dollars.
- HealthMarts and HealthUnions,<sup>3</sup> to enable small businesses to pool together to give their workers more affordable choices and a more generous menu of plans and doctors – akin to the Federal Employees Health Benefit Program enjoyed by Members of Congress.
- Medical malpractice reform, to reduce wasteful defensive-medicine costs.
- And most importantly, tax fairness for the uninsured, as discussed above.

### **Conclusion**

We face a choice: we can remain passive as the political dynamic drives us toward an increasingly bureaucratic, government-controlled medical system; or we can take decisive action to create a consumer-driven health-care market that responds to patients' real needs. I say the time has come to create the market. We should pass legislation that addresses in one bold stroke all of the basic problems generating today's frustrations with managed care and the employer-based system: the lack of access, affordability, portability, and choice. We should equalize the tax treatment of health benefits and thus liberate consumers to shop freely for affordable health care for their families. Whether we do this through a Universal Tax Credit that replaces the existing tax exclusion, or some new tax benefit for the uninsured, we still come out winners. We win the health debate – and the hearts and minds of voters – for generations to come.

• • •

<sup>3</sup> "HealthUnions" is my short-hand term for association health plans. I am indebted for it to Ralph Hellmann, policy director for Speaker Hastert.

**DEMOCRATIC POLICY COMMITTEE**

Tom Daschle, Chairman • Byron Dorgan, Co-Chairman  
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# Facsimile

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Office.

# of pages including cover: 3

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## **The Health Protection and Assistance for Older Americans Act**

The *Health Protection and Assistance for Older Americans Act* is the Democrats' principal initiative to improve health care and support services for older Americans. The three central initiatives in this bill are to:

- Improve access to health insurance for 55 to 65 year olds;
- Support Americans who have long term care needs and their caregivers; and
- Reauthorize the Older Americans Act.

### **Expanding Access to Medicare**

The *Health Protection and Assistance for Older Americans Act* includes three provisions to improve access to health insurance for 55 to 64 year olds:

- Individuals ages 62 to 64 without access to group insurance may buy into Medicare.
- Workers ages 55 to 61 and their spouses who lose their health insurance when their firm closes or they are laid off may buy into Medicare.
- Retirees ages 55 to 64 whose employers drop their retiree health coverage after they have retired may buy into the employer's health plan through COBRA coverage.

### **Long-Term Care Initiative**

Those who require long-term care – and their caregivers – face significant costs for their care, but few people have insurance to cover those costs. The *Health Protection and Assistance for Older Americans Act* includes four provisions to support those with long-term care needs and their caregivers:

- People who require assistance with three or more activities of daily living or a comparable cognitive impairment, or the caregivers of those individuals, would be eligible for a \$1,000 tax credit.
- A nationwide program would provide respite care and other caregiver support services.
- An education campaign would inform Medicare beneficiaries about the limitations of Medicare's long-term care coverage and how to evaluate alternative options for meeting their long-term care needs.
- The Federal government would offer quality private long-term care insurance to Federal employees, to set a national example regarding the ability to make available long-term care insurance at more affordable negotiated group rates. (Senator Mikulski initiative)

### **Reauthorization of the Older Americans Act**

The *Older Americans Act* is the main legislative vehicle for delivering social and nutritional services to the elderly, and has not been reauthorized since Republicans took control of Congress. The services funded by the Act include meals on wheels, counseling, elder abuse prevention programs, and a long-term care ombudsman program to investigate the complaints of nursing home residents. In FY 1996, the Act's Title III nutrition program provided 238 million meals to more than 3 million older Americans. A national evaluation of the nutrition program showed that its participants are older, more likely to be poor, to live alone, and to be members of minority groups (CRS).

## **Patients' Bill of Rights Act of 1999**

### **The Problem: Crisis of Confidence in American Health Care**

- Over the past decade, the number of Americans in managed care plans has grown dramatically. It is estimated that by 1996, 75 percent of employees with employer-provided health insurance were covered by managed care.
- As the number of Americans in HMOs and managed care plans has grown dramatically over the past decade, so have concerns about some of their practices. These concerns have led to growing public support for patient protection legislation. A September 1998 survey showed that 65 percent of consumers supported managed care reform legislation compared with 52 percent in September 1997.
- Consumers report widespread problems with their health plans including denial of access to specialists, refusal to pay for emergency room visits, lack of information about plan policies and procedures, and arbitrary limits on medical care.
- Health plans play "doctor" and interfere with medical decision-making with no legal accountability, even when they harm patients.

### **The Solution: The Patients' Bill of Rights Act of 1999**

The Patients' Bill of Rights will provide consumers with enforceable patient protections:

- Access to necessary care covered under the plan: ensures access to specialists; provides direct access to a specialist for patients with serious ongoing conditions; allows women to see their OB/GYN without prior authorization; requires access to and payment for emergency room services; allows continued care when a plan or provider is terminated.
- Fair and timely appeals processes when health plans deny care, both within the plan and to an independent external body.
- Protections for the doctor-patient relationship: bans gag clauses and limits bonuses and limits other financial incentives to deny care; protects providers who advocate on behalf of their patients; prevents plans from interfering with doctors' judgments. HMOs cannot mandate "drive-through" procedures or set arbitrary limits on hospital lengths of stay.
- Understandable information about plan policies and procedures to help patients choose their plan and know their rights.
- Accountability for health plans: plans that make medical decisions which result in harm will be held accountable just as doctors and hospitals are today.