FY 1994 BUDGET: MEDICARE AND MEDICAID SAVINGS PROPOSALS

(Dollars in Millions)

15-Feb-93
05:35 PM

Proposals	1994	1995	1996	1997	1998	1994-1998
Part A:						
10% Capital Reduction, Inpatient	0	0	300	380	420	1,100
Reduce Hospital Update by MB Minus 1% in FY 94 & FY 95	550	1,380	1,560	1,700	1,860	7,050
Put Hospitals on CY Update	1,000	1,140	1,180	1,290	1,420	6,030
Reduce IME	0	0	580	1,360	1,600	3,540
Direct Medical Education	350	340	340	330	320	1,680
Eliminate Add-On for Hospital-Based HHAs	160	200	230	250	280	1,120
Eliminate SNF ROE Payments	110	140	150	160	170	730
HI Interaction	-190	-230	-60	-70	-100	-650
Part B:						
Maintain SMI Premium at 1995 Percent	0	0	0	2,052	4,298	6,350
10% Capital Reduction, OPD	0	0	110	150	170	430
Hospital Outpatient Rate Changes	0	0	740	900	1,025	2,665
Lab Rate Changes	420	800	1,110	1,500	1,960	5,790
Reduce Doctor Fees in 1994 Except Primary Care	200	300	350	400	425	1,675
Resource-Based Practice Expense Phase-In	100	350	700	875	950	2,975
Reduce Default MVPS & Update	0	0	200	650	1,225	2,075
Bundle RAP Payments	0	80	150	160	180	570
Single Fee for Surgery	50	100	110	120	130	510
Ban Physician Referrals	0	50	100	100	100	350
Electronic Billing Initiative	0	0	90	175	175	440
DME Options	75	125	150	160	175	685
Set EPO at Non-U.S. Market Rates ($10 per 1000 units)	30	40	40	50	50	210
SMI Interaction	0	-40	-70	-80	-90	-280
Parts A & B:						
IRS/SSA/HCFA Data Match	0	0	45	120	205	370
MSP for Disabled	0	0	650	960	1,085	2,695
MSP for ESRD for 18 Months	0	0	35	35	35	105
MSP Reforms	127	240	275	305	345	1,292
Medicaid:						
Eliminate Mandatory Medicaid Personal Care	0	1,190	1,355	1,540	1,760	5,845
Reduce Medicaid Match to 50%	310	360	410	450	495	2,025
Remove Prohibition on Drug Formularies	10	15	20	25	30	100
Tighten Estate/Asset Rules	25	80	135	155	170	565
Medicaid Offset	30	70	60	-90	-240	-170
Medicare/Medicaid:						
Third Party Liability	0	150	250	400	450	1,250
TOTAL, ALL PROPOSALS	3,357	6,880	11,295	16,512	21,078	59,122

Proposals	1994	1995	1996	1997	1998	1994-1998
Part A:						
Extenders						
10% Capital Reduction, Inpatient	0	0	300	380	420	1,100
Other						
Reduce Hospital Update by MB Minus 1% in FY 94 & FY 95	850	1,170	1,550	1,690	1,840	6,800
Put Hospitals on CY Update	1,000	1,140	1,180	1,290	1,420	6,030
Reduce IME	0	0	880	1,330	1,560	3,450
Direct Medical Education	350	340	340	330	320	1,680
Eliminate Add-On for Hospital-Based HHAs	180	200	230	280	280	1,180
Eliminate SNF ROE Payments	110	140	150	180	170	730
HI Interaction	-190	-20	-30	-30	-40	-310
Part B:						
Extenders						
Maintain SMI Premium at 1995 Percent	0	0	1,450	4,340	7,120	12,910
10% Capital Reduction, OPD	0	0	110	150	170	430
Continue 5.8% Hospital Outpatient Cut	0	0	425	525	600	1,550
2% Lab Fee Update	30	110	220	380	570	1,310
Other						
Reduce Doctor Fees in 1994 Except Primary Care	200	300	350	400	425	1,675
Resource-Based Practice Expense Phase-in	100	350	700	875	950	2,975
Reduce Default MVPS & Update	0	0	200	650	1,225	2,075
Bundle RAP Payments	0	80	150	160	180	570
Single Fee for Surgery	50	100	110	120	130	510
Ban Physician Referrals	0	50	100	100	100	350
Electronic Billing Initiative	0	0	90	175	175	440
OPD Cut at 10% (above 5.8% cut)	0	0	315	375	425	1,115
Set Lab Rates at Market Levels	390	690	890	1,120	1,390	4,480
DME Options	75	125	150	160	175	685
Set EPO at Non-U.S. Market Rates ($10 per 1000 units)	30	40	40	50	50	210
Interaction of Premium Proposal	0	0	-420	-700	-980	-2,100
SMI Interaction	0	-40	-70	-80	-90	-280
Parts A & B:						
Extenders						
IRS/SSA/HCFA Data Match	0	0	45	120	205	370
MSP for Disabled	0	0	650	880	1,085	2,695
MSP for ESRD for 18 Months	0	0	35	35	35	105
Other						
MSP Reforms	127	240	275	305	345	1,292
Medicaid:						
Eliminate Mandatory Medicaid Personal Care	0	1,190	1,355	1,540	1,760	5,845
Reduce Medicaid Match to 50%	310	360	410	450	495	2,025
Remove Prohibition on Drug Formularies	10	15	20	25	30	100
Tighten Estate/Asset Rules liens + recoveries	25	60	135	155	170	585
Medicaid Offset	30	70	90	-90	-240	-170
Medicare/Medicaid:						
Third Party Liability - clearing house	--	--	--	400	--	400
TOTAL, ALL PROPOSALS	3,357	6,730	12,075	18,100	22,470	62,732

Memorandum

To: Hillary Rodham Clinton and other interested parties
Fr: Chris Jennings, Ken Thorpe
Re: Nature of Medicare/Medicaid Budget Cuts
Dt: February 15, 1993

1. Overview

As you know, the current draft of the President's budget proposal makes a number of cuts in the Medicare and, to a lesser extent, the Medicaid program. These cuts were developed in response to a desire to achieve $18 billion in cuts in FY 1997. The current budget draft now assumes Medicare/Medicaid cuts of approximately $16 billion in FY 1997 and approximately $59.1 billion over 5 years. (The two billion shortfall is due to the fact we have moderated the Medicare Part B premium increase to beneficiaries).

To achieve the savings, the following rationale was used: (1) we avoided cuts that could be construed as systematic changes that will be pursued separately during the health reform process, (2) we minimized any beneficiary impact, and (3) we tried to avoid any public savings that could be used in the context of health reform.

Under these constraints, and because there are limited extenders (continuation of current Medicare policy) available, approximately only one-fourth of the currently assumed cuts come from extenders. The remaining three-fourths of the cuts are made up of recommended policy changes. Most of these proposed cuts have been previously advanced by OMB and considered by Congress.

2. Highlights of Proposed Cuts

A. **Beneficiary Cuts.** Assumes an increase in the Part B premium over and above current law starting in FY 1997. This is an extender and totals $6.745 billion over 5 years and represents 11.4% of the Medicare/Medicaid cuts.

B. **Hospital Cuts.** Assumes approximately $23.6 billion cuts in reimbursement to hospitals over 5 years. This amounts to approximately 40 percent of the $59.1 billion Medicare/Medicaid cut.

C. **Physicians and Lab Cuts.** Assumes a $13.7 billion cut in reimbursement to physicians and labs. This represents approximately 23% of all of the proposed Medicare/Medicaid cut.

D. **States.** Assumes a $2 billion cut in the Federal match for States' administrative expenses. This represents approximately 3.4 percent of the total proposed Medicare/Medicaid cut.

3. Expected Reaction

* **Providers.** Health care providers will strenuously object to these cuts because (1) the public programs will be, once again, cost shifting to the private sector, and (2) because cuts will not be offset by any increase in health insurance coverage.

* **Governors.** State Executives will be displeased because of the proposed shifting of administrative costs under Medicaid to the States.

* **Congress and Consumers.** Advocates for health reform can be expected to become disgruntled because this round of cuts in Medicare are going to deficit reduction rather than to expand coverage. As a result, they will focus on the need to raise additional revenue through increased taxes, making it more politically problematic to pass national health insurance reform this year. In other words, they fear they will be asked twice to vote for cuts and tax increases.

  In addition, many of these cuts are extremely similar to those proposed and opposed by Democratically controlled Congresses. Many Democrats will feel extremely uncomfortable about defending. Lastly, a number of Members particularly sympathetic to health reform will (and do) feel that such an approach is inconsistent with previous statements made by the President with regard to this issue. Moreover, they feel that they have not been adaquately consulted in switching directions.

TALKING POINTS

Q: If the Administration is planning to apply the Medicare savings to deficit reduction, where does that leave health care reform? Will you cut Medicare further? Will you raise taxes to pay for access?

A: First, let me emphasize that health care reform continues to be one the President's top priorities. The Medicare cost controls in the budget are aimed at things like cutting hospital charges and the high fees that medical specialists charge. We believe that controlling these costs is simply the first step in controlling everyone's health costs, so that we can provide quality affordable health care for all.

I can assure you that the President's health reform proposal -- which we have promised in May -- will include mechanisms to control costs in the private sector, in addition to the Medicare cost control measures. It is very important to put the Medicare cuts in the context of the broader effort to squeeze excess out of ALL aspects of the health care system.

Second, let me say that as we reform the health care system, we expect that we can maintain quality and realize other public sector savings. For example, when we move to a system that emphasizes preventive and primary care, the public sector should save money. More importantly, as we put people back to work and get the economy moving again fewer people will be relying on Medicaid to provide coverage. Likewise, as we extend coverage to all workers, Medicaid costs should be reduced.

So the bottom line, is that we think that we can maintain high quality and make the system more efficient, and so we are looking for some further savings down the road. But not of the type that we have seen before; these would be savings that result from overhauling the system.

As to your specific question with regard to revenue, it is premature to discuss financing a proposal that is still being designed.

Q: Isn't this budget a big set-back for advocates of health care reform?

A: Definitely not. Getting the economy going, putting people back to work, and controlling health care costs are consistent with our plans to reform the health care system. The President continues to consider health reform a top priority.

TO: MELANNE VERVEER
BOB BOORSTIN

FROM: ANNE LEWIS

RE: TALKING POINTS FOR CONGRESSIONAL MEETING:
DEALING WITH THE IMPLICATIONS OF MEDICARE CUTS FOR THE FUTURE OF HEALTH CARE REFORM

DATE: FEB.

The Problem:

The President's budget is expected to include approximately $16 billion in Medicare cuts which are to be applied to deficit reduction. The problem this causes for health care is that the President has said in the past that we would use the public sector [primarily Medicare] health care cost savings to pay for universal access. If we are applying $16 billion of Medicare cuts to deficit reduction, how will we pay for access?

Discussion:

If we point to further Medicare cuts we risk serious opposition in Congress. Many Congressional Democrats spent the last 12 years fighting Medicare cuts [and cost-shifting], and are likely to find $16 billion in cuts difficult enough to swallow -- without adding further cuts to pay for access. Conversely, if we say we won't cut Medicare any further, then we have a difficult time explaining how we intend to pay for access without a substantial tax increase.

Answer:

First and foremost, Mrs. Clinton should emphasize that we need to deal with the deficit problem and that putting the Medicare cuts towards deficit reduction is the right thing to do. Make the economic case.

Second, the First Lady should make her point that it is impossible to have a detailed discussion about how to pay for the reform plan given that we haven't designed the plan yet and therefore don't know the price tag.

Third, with regard to Medicare, the First Lady must emphasize that Wednesday's Medicare cuts are part of our larger cost control mission, and that although this week's budget package contains only public sector health care cost

control, we will include private sector health care cost control in our reform package, which is due out soon. In fact, we hope that the health care plan and the budget will be linked [by using reconciliation as the legislative vehicle for health reform] and we will be imposing cost controls system-wide, not just on the public sector. This is important because the Congress will be leery of further cost-shifting.

Fourth, Mrs. Clinton should explain that the Medicare cuts in the budget are based on the current health care system and that there is potential for broader savings from policy changes under health reform. And, these savings can and should be applied to pay for universal access. [Be careful not to over-promise. The argument should be that there are some further public sector savings to be applied, not that there are certain to be sufficient public sector savings to pay for access.]

For example, as we extend coverage to all workers, Medicaid will save money now spent providing coverage to the working poor. Moreover, to the extent that everyone has coverage,we can promote better use of health care and emphasize primary and preventive care, which saves money in the long run.

In addition, as part of health reform we hope to be able to make Medicare a more efficient and effective health care provider by promoting better use of services in ways that will save money -- without further cost-shifting. For example, we may reform the outpatient reimbursement system to encourage better and more efficient care.

Finally, Mrs. Clinton should point out that one of advantages of linking the economic package and the health reform package is that doing so enables us to offer benefits, such as insurance reforms, at the same time that we legislate the financing/cost cutting.

To: Ira, Melanne

From: John Hart

Re: Phone Conversation with Governor Dean

cc: Carol Rasco

Governor Dean called this afternoon to register his serious concern with the direction of the economic plan as conveyed in this morning's New York Times. In particular, he expressed concern about the approach taken for health care system savings. As one of the four Governors appointed as a point-person to our Task Force, he felt he was speaking on behalf of the NGA, and had spoken to a number of other Governors (including Governor Roemer) and seemed to imply that they feel similiarly.

He feels, in a nutshell, that **imposing caps and costs restraints on public system programs, and not on the entire health care system, will lead to cost-shifting to the states and will not effectively control health care spending.** He said he feels that this is, in short, a reiteration of Republican policies traditionally opposed by Democrats.

Consistent with the NGA's position, he supports national caps on health care spending. He recognizes the need to constrain costs, but feels that capping fees alone, particularly just public sector fees, will only result in volume increases and little appreciable savings. He is concerned that in the end, states will once again bear the brunt of cost-shifting.

While our briefing with the Washington representatives of Governor's staffs scheduled for tomorrow is technically about the Health Care Reform effort and the working group process, questions about health care and the budget may be raised. I plan to reiterate that we are not in a position to discuss the plan before the President releases it on Wednesday. Obviously, the sooner the budget staff can appraise us of how planned cuts will affect states, the better prepared we can be to plan a strategy of response.

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Put Hospitals on CY Update	1,000	1,140	1,180	1,290	1,420	6,030
Reduce IME	0	0	560	1,330	1,560	3,450
Direct Medical Education			340	330	320	1,590
Elim Add-On for Hospital-Based HHAs			220	280	280	1,180
SNF ROE Payments	110	140	130	160	170	730
HI Interaction	-30		-70	-30	-40	-210
Part B:						
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Maintain SMI Premium @ 1995 Percent	0	0	1,450	4,350	7,110	12,910
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Medicaid:						
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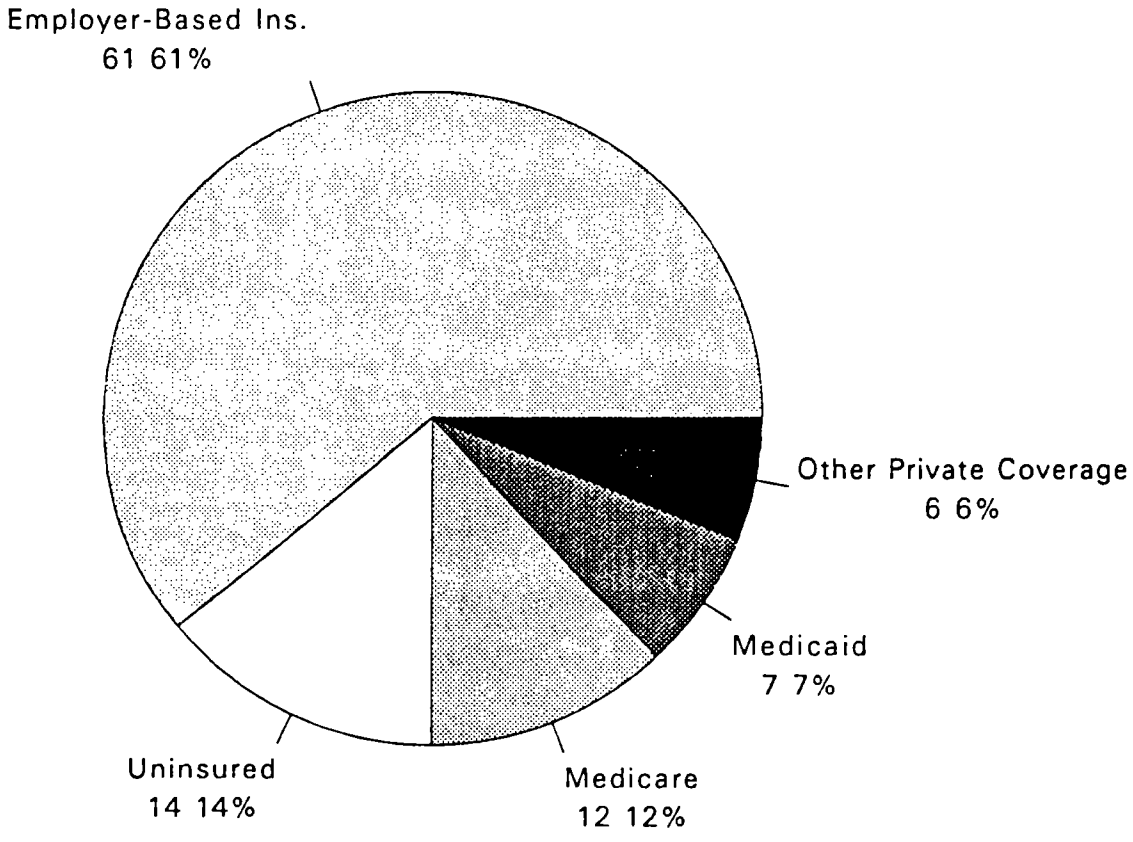
Re Medicaid Match to 50%	310	350	410	430	495	2,025
Remove Prohibition on Drug Formularies	10	15	20	25	30	100
Tighten Estate/Asset Rules	20	60	135	155	170	540
Medicaid Offset	-30	-70	-80	-90	-240	-170
Medicare/Medicaid:						
Third Party Liability	--	--	--	400	--	400
TOTAL, ALL PROPOSALS	3,357	6,730	12,075	18,100	22,470	62,732

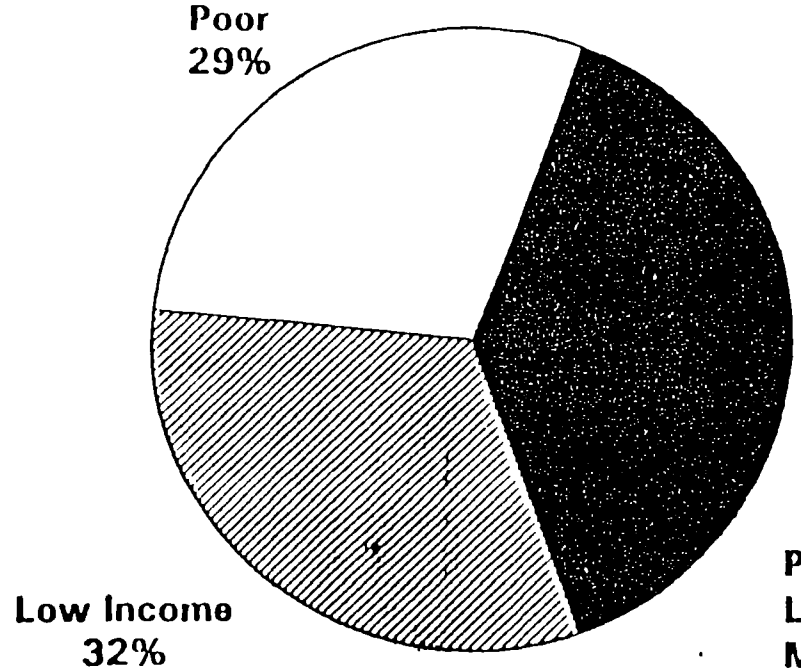
34 Million Americans Were Without Health Insurance in 1990



Population by Source of Health Insurance (249 million)

Source: CPS, 1991

Two-Thirds of the Uninsured Are Above the Federal Poverty Level*



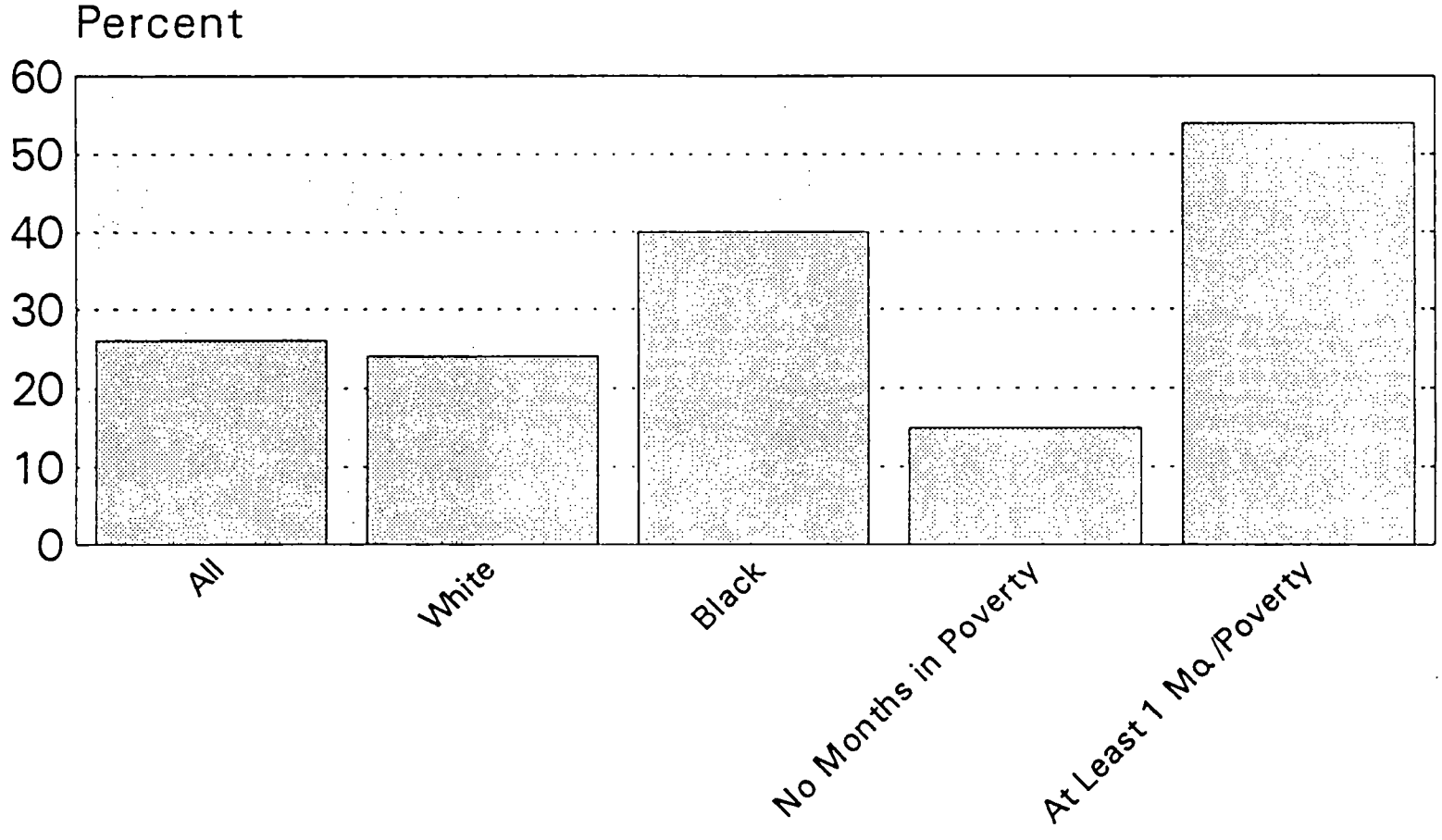
Poor = < 100% poverty level
Low Income = 100%-199%
Moderate to High = > 200%

Uninsured by Income, 1990

Source: Karen Davis
Johns Hopkins University, 1992

*Federal poverty level for a family of four in 1990 was $13,360

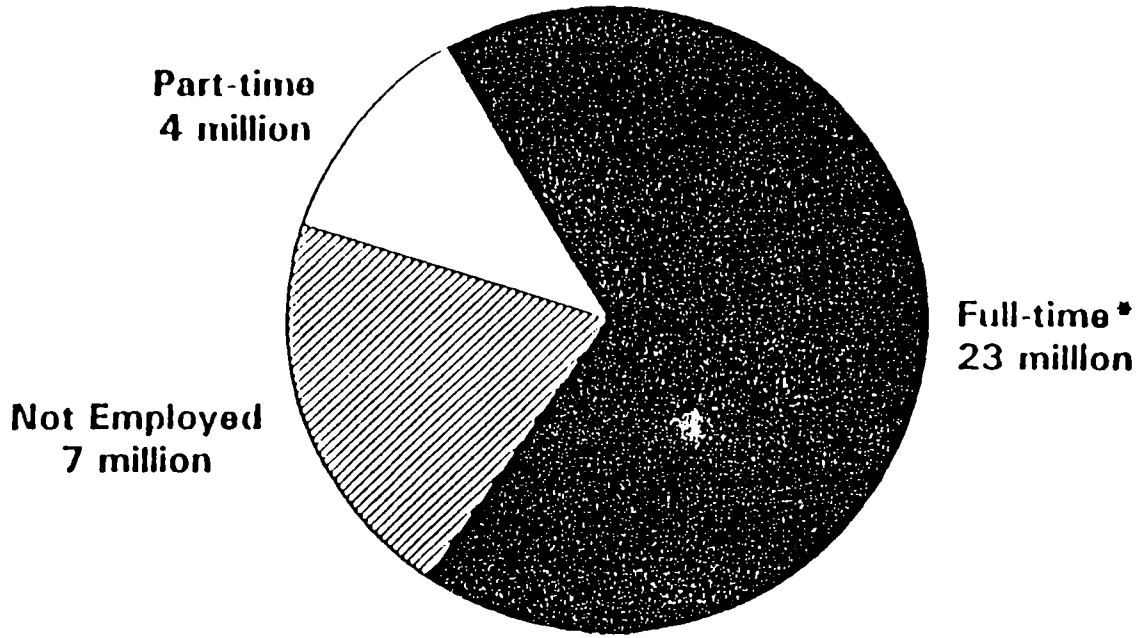
Over 1 in 4 Americans Had Lapse in Health Insurance between 1987 and 1989



Percent without insurance for at least 1 month

Source: Bureau of the Census, 1992

The Majority of Uninsured Americans Are Employed Full-Time

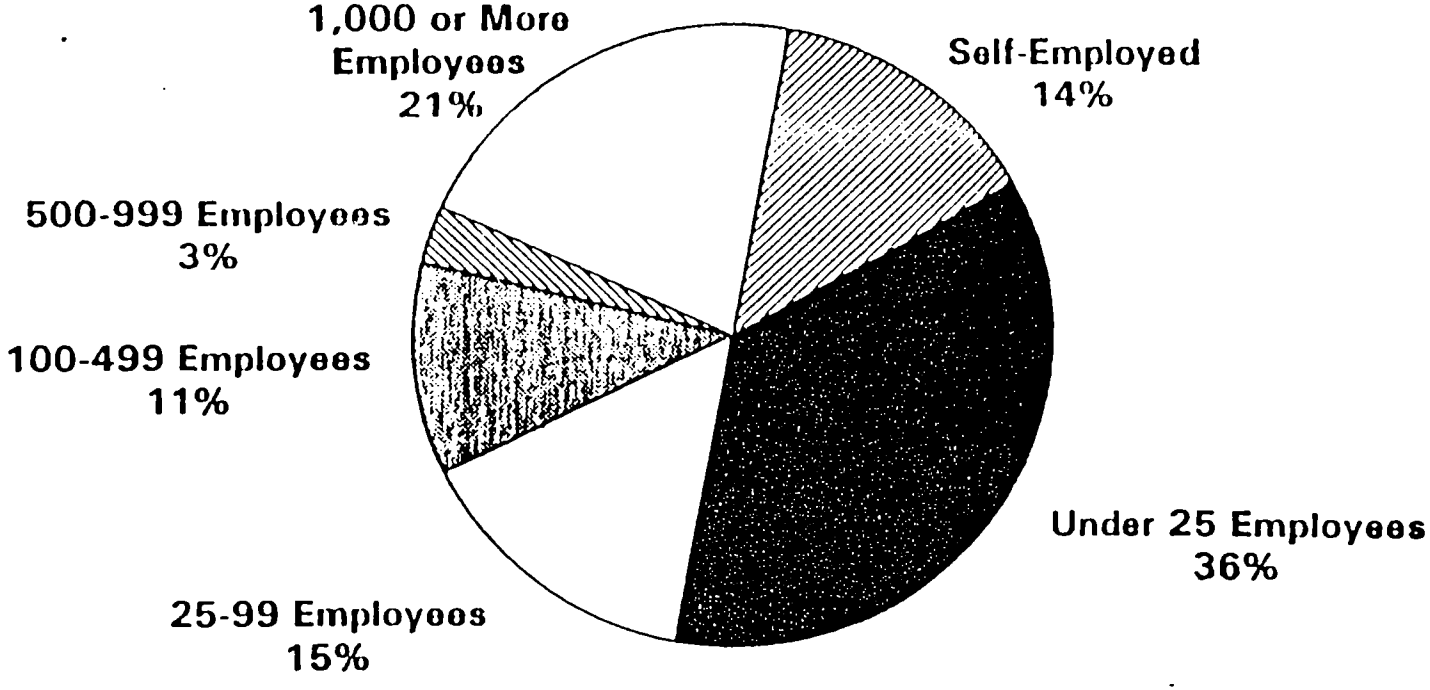


Uninsured by Employment Status, 1990
(34 million)

Source: Karen Davis
Johns Hopkins University, 1992

*Full time = 35 hours per week

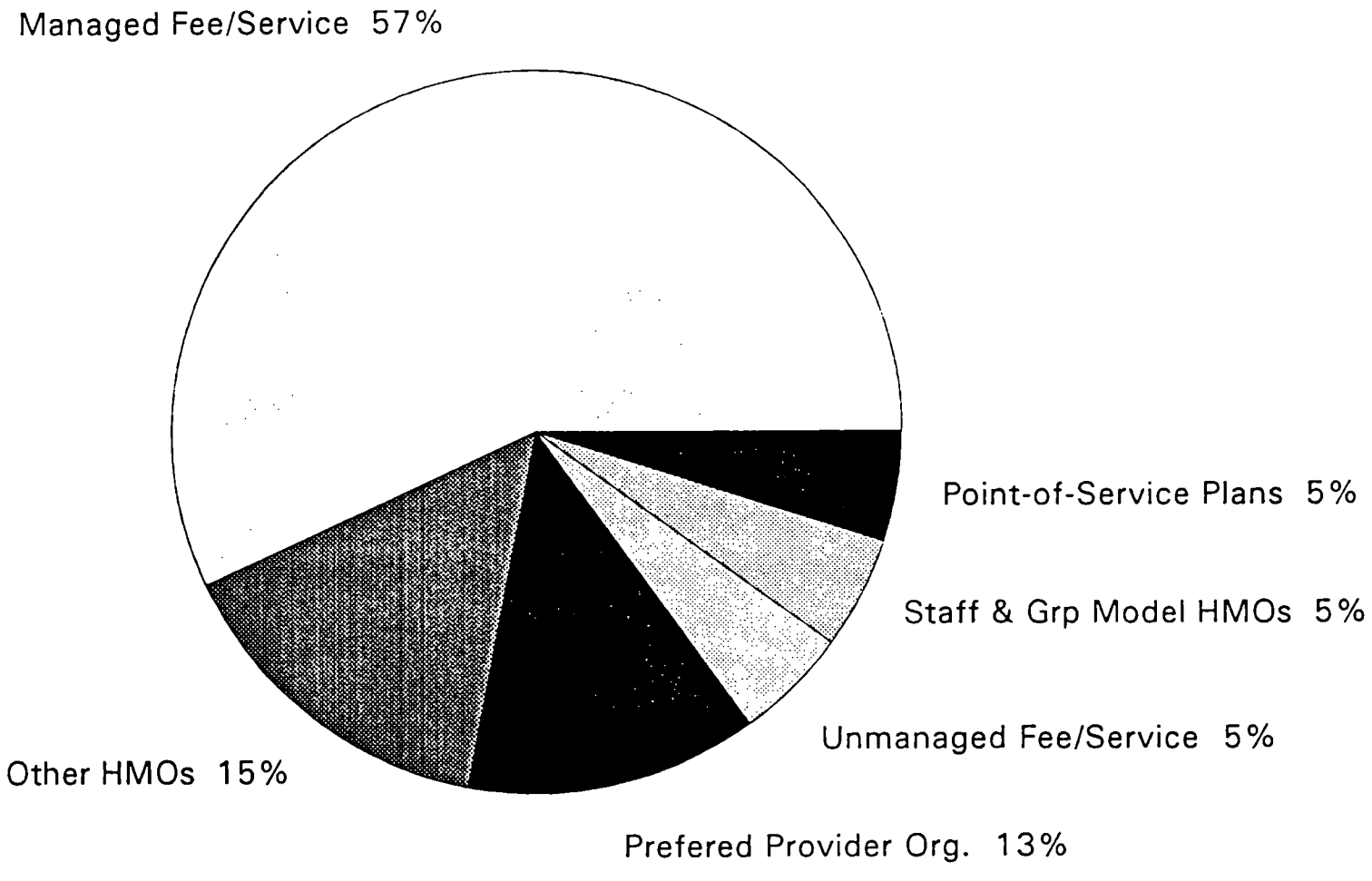
Smaller Firms are Less Likely to Provide Health Insurance



Distribution of Uninsured Workers by Size of Firm, 1990

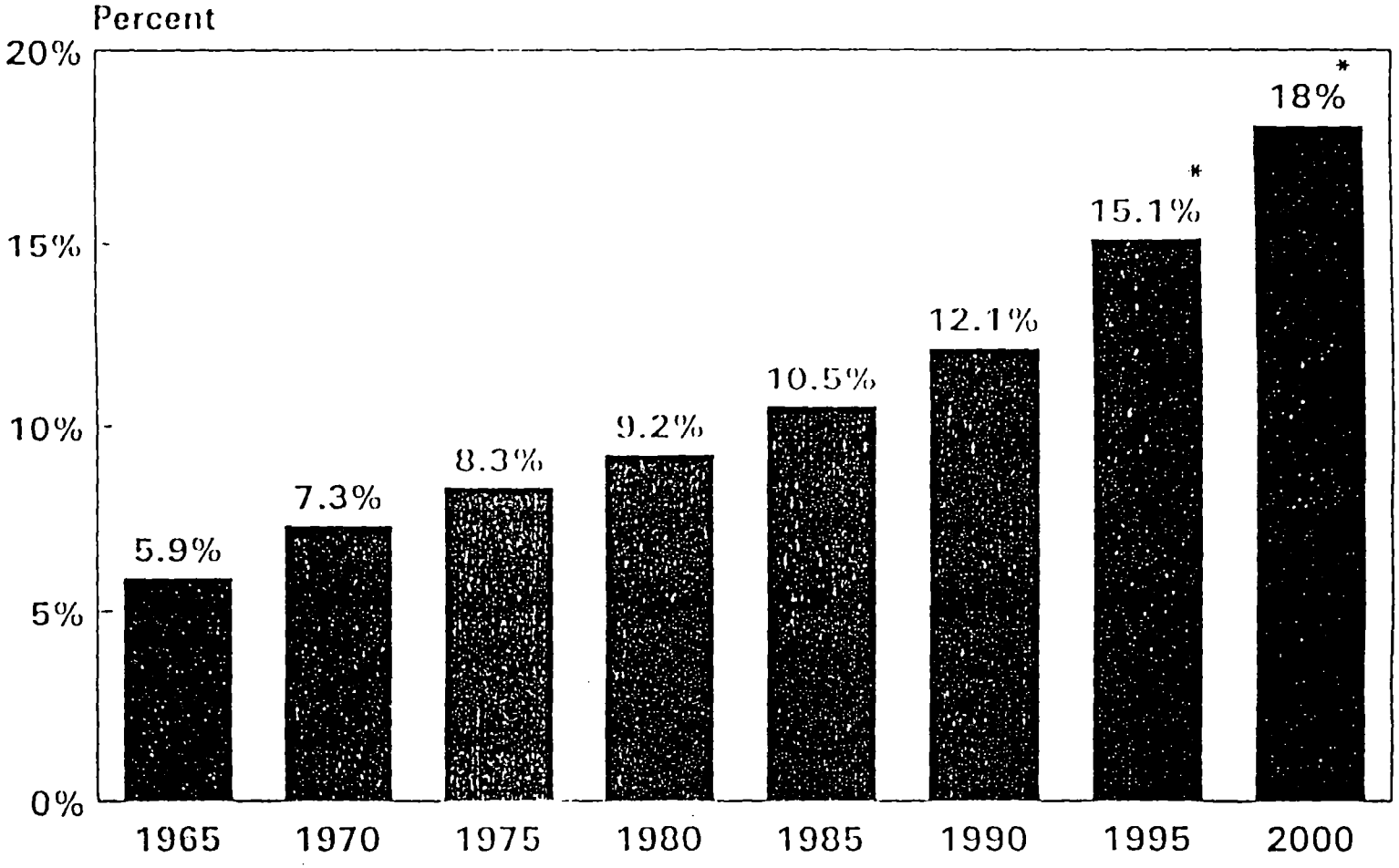
Source: EBRI, based on 1990 CPS

Health Benefit Plan
Enrollment of Workers, 1990



Source: CBO, based on data from Elizabeth W. Hoy, Richard E. Curtis, and Thomas Rice "Change and Growth in Managed Care," Health Affairs, vol. 10, no. 4 (Winter 1991), pp. 18-36.

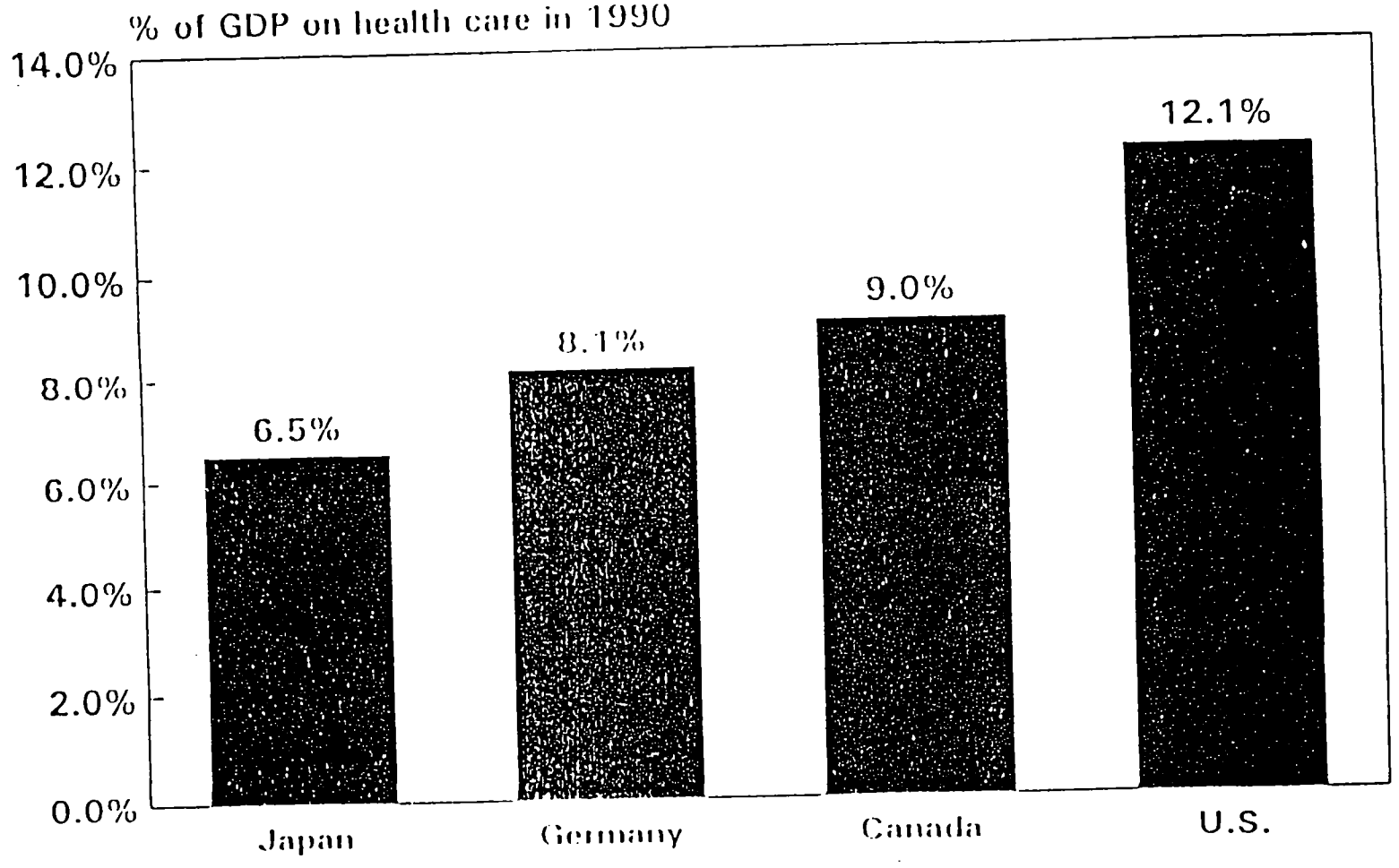
Health Expenditures as a Percent of GNP 1965-2000



Source: CBO, 1992.

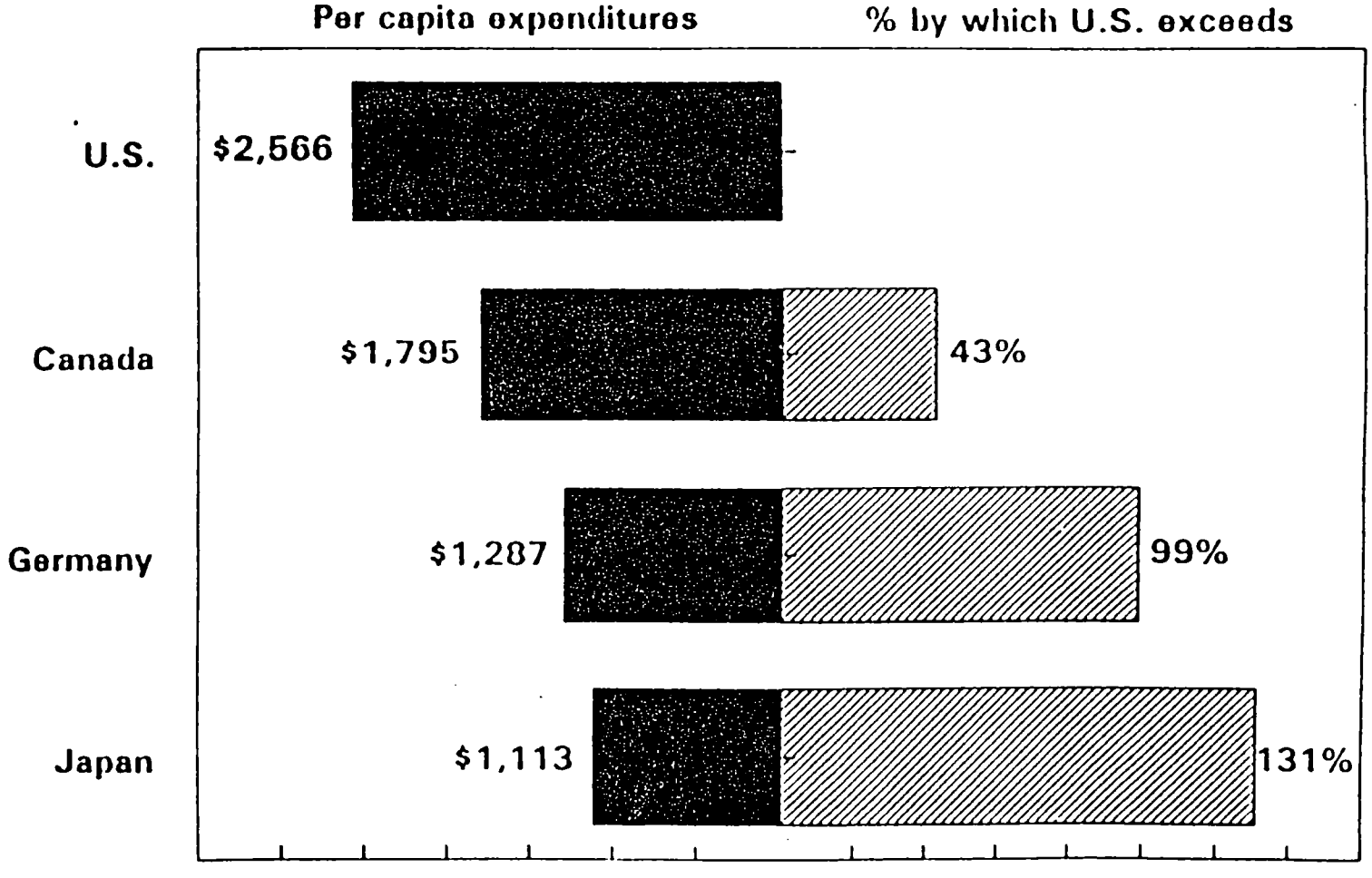
* = projected

The U.S. Spends More on Health Care Than Any Other Country



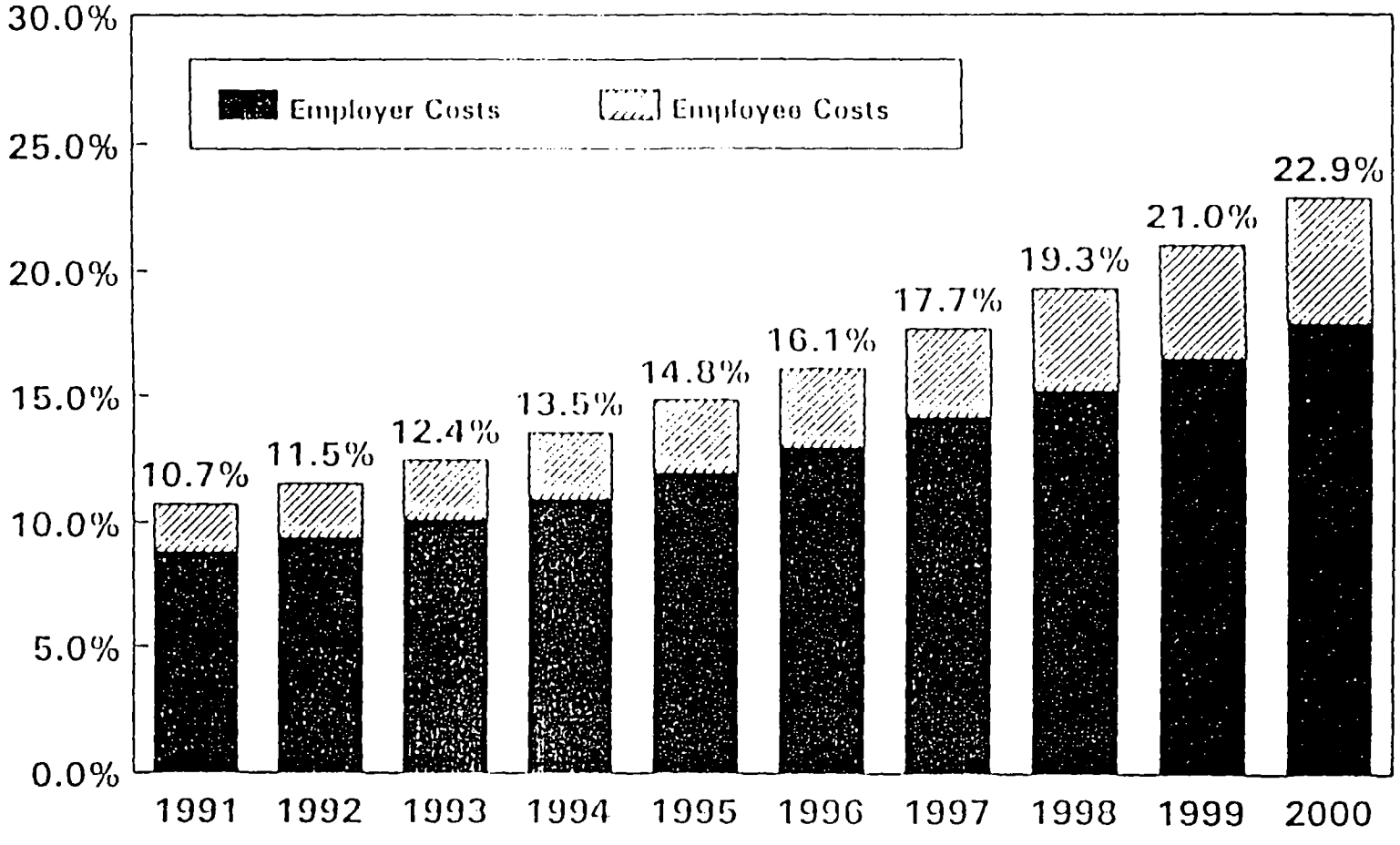
Source: OECD, 1991

Per Capita Health Spending in Selected Countries, 1990



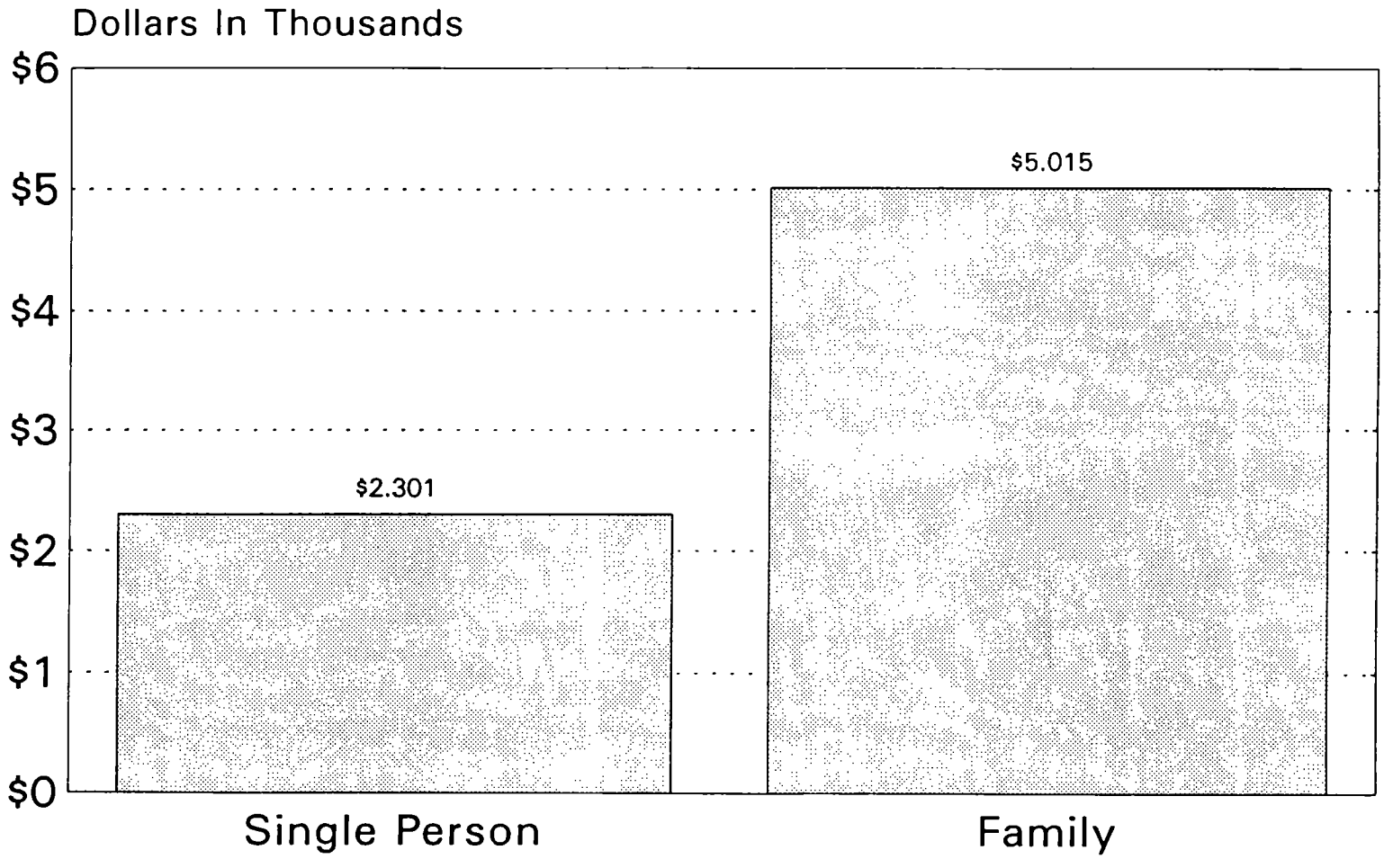
Source: OECD, 1991

Health Insurance Premiums as a Percent of Payroll are Rising



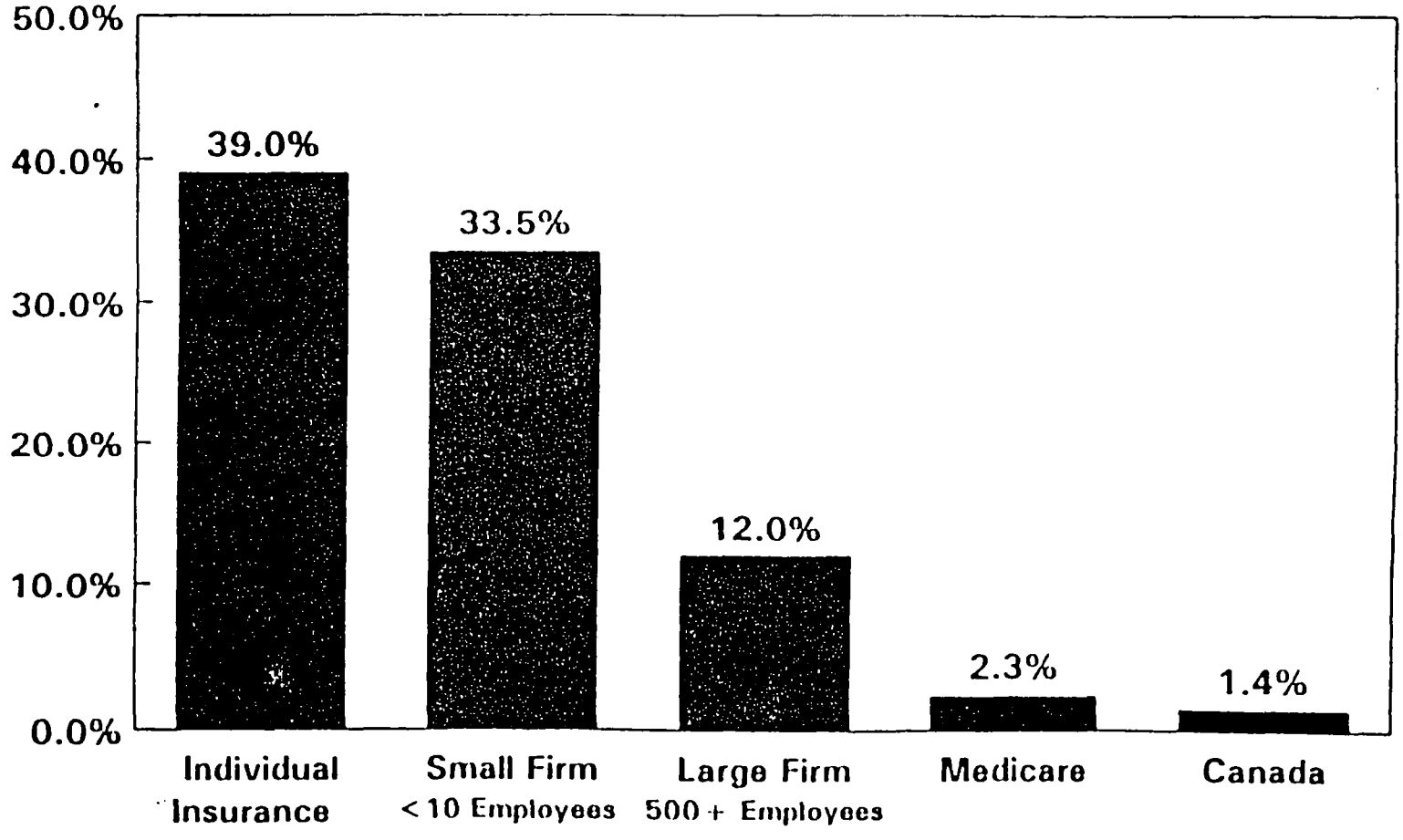
Source: Karen Davis,
Johns Hopkins University, 1992

Annual Group Health Insurance Premiums Single Person and Family, 1992



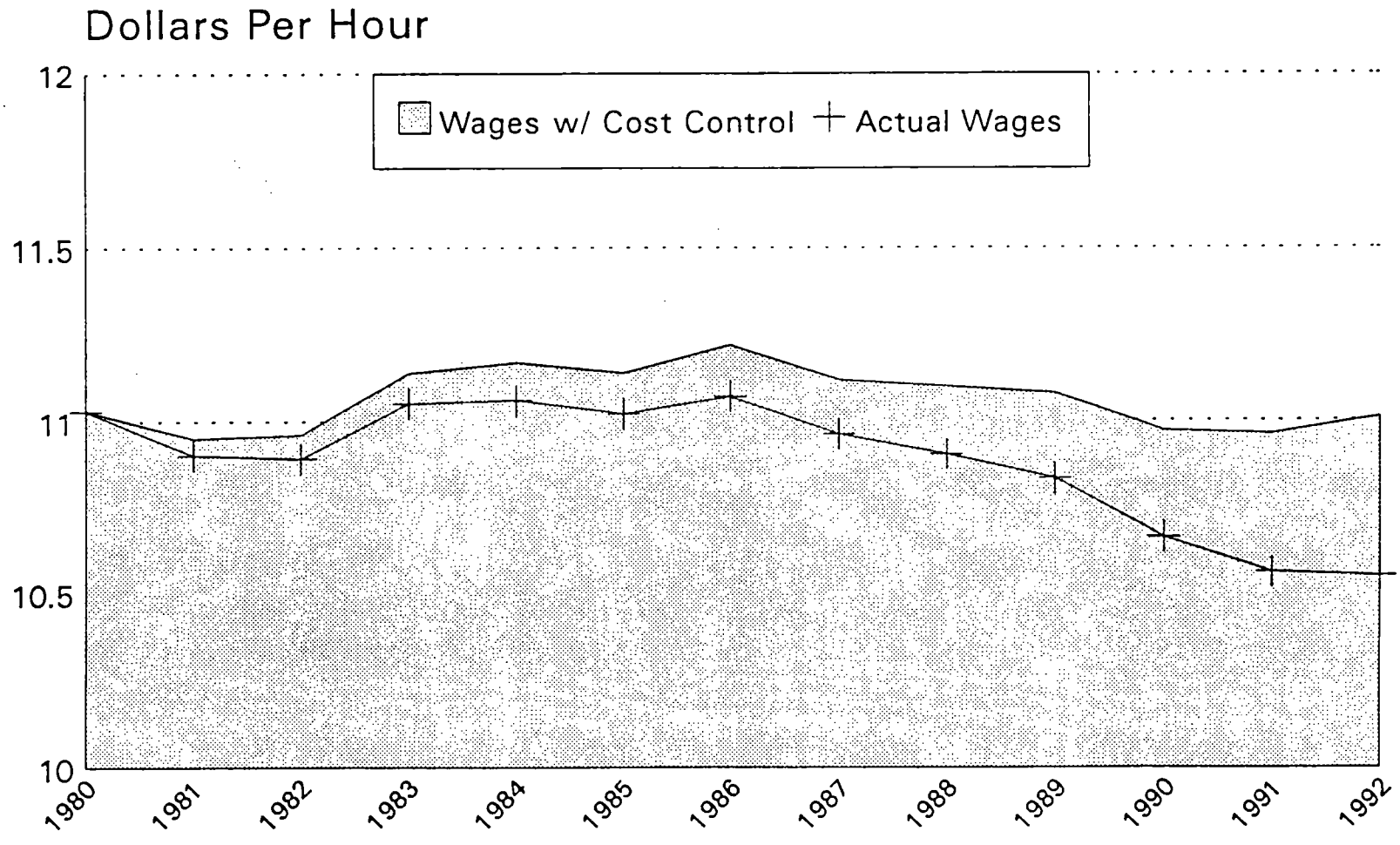
Source: Karen Davis, 1992

Administrative Expenses as a Percent of Health Benefits, 1987



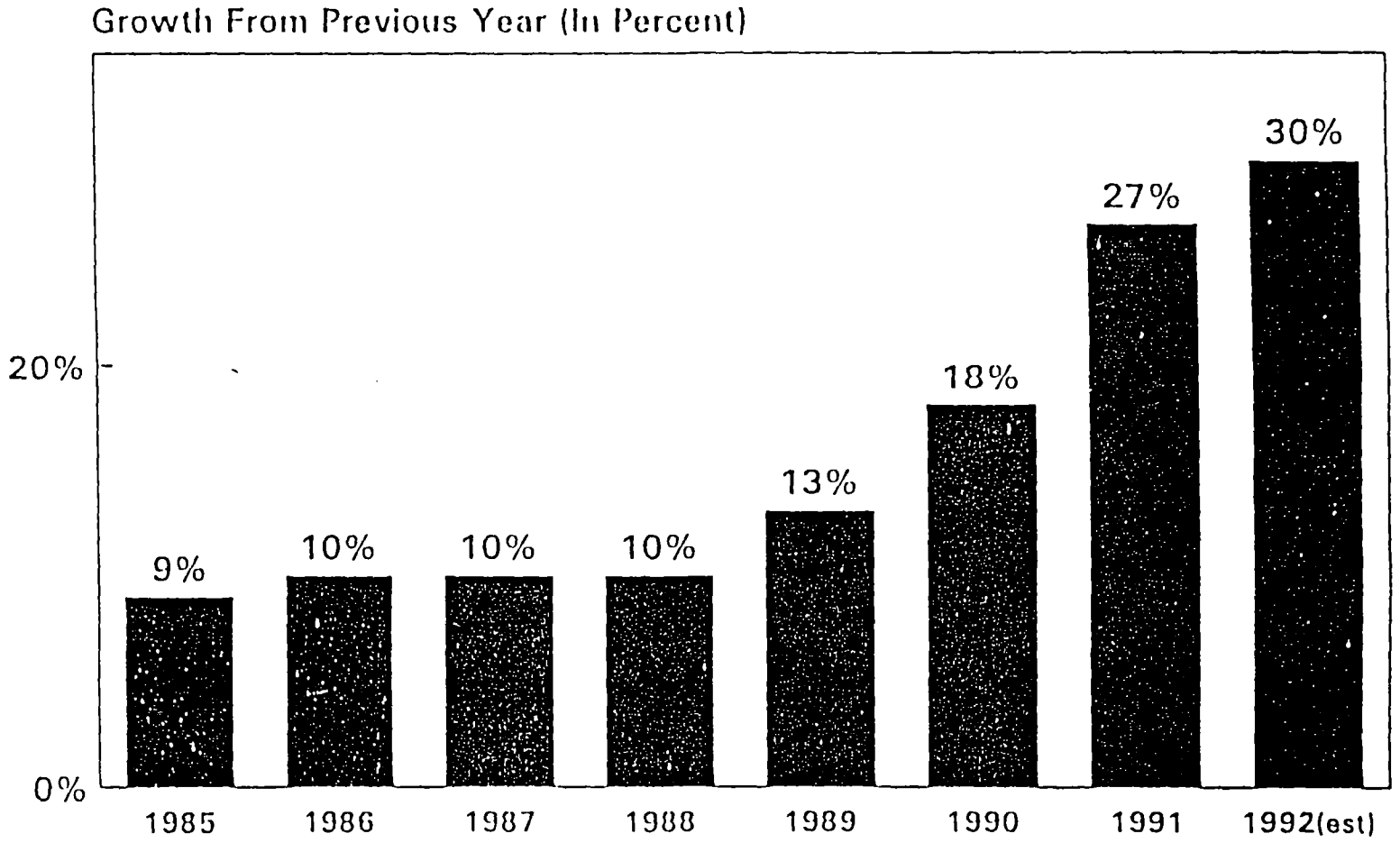
Source: Karen Davis,
Johns Hopkins University, 1992

Real Wages, Actual And Had Cost Controls Been Enacted In 1980, 1980 - 1992



Source: SEIU 1992 (Lewin-ICF analysis using BLS data)

Annual Percent Growth in Medicaid Spending, 1985-1992



Source: Long, 1992.

Kaiser Commission on the Future of Medicaid

HEALTH CARE REFORM: PROBLEMS, ISSUES AND OPTIONS

HHS BRIEFING FOR HILLARY RODHAM CLINTON

FEBRUARY 12, 1993

Health Care Reform
Major Issues and Options

- Coverage
  - Expanding coverage to individuals
  - Employer-based coverage
  - Government financed

credits to individuals
+ require them to
buy health insurance

- Cost Containment
  - Regulatory approach
  - Managed competition
  - Blended approach

EXPANDING COVERAGE TO INDIVIDUALS

- APPROACHES:
  TAX CREDITS TO
    INDIVIDUALS
    SMALL BUSINESSES
  MANDATE FOR INDIVIDUALS

- PROS: MINIMAL GOVERNMENT INTERFERENCE

- CONS: FAILS TO ACHIEVE UNIVERSAL COVERAGE
    LEAVES MILLIONS UNCOVERED
    IMPOSES SUBSTANTIAL PUBLIC COSTS OR PRIVATE BURDENS

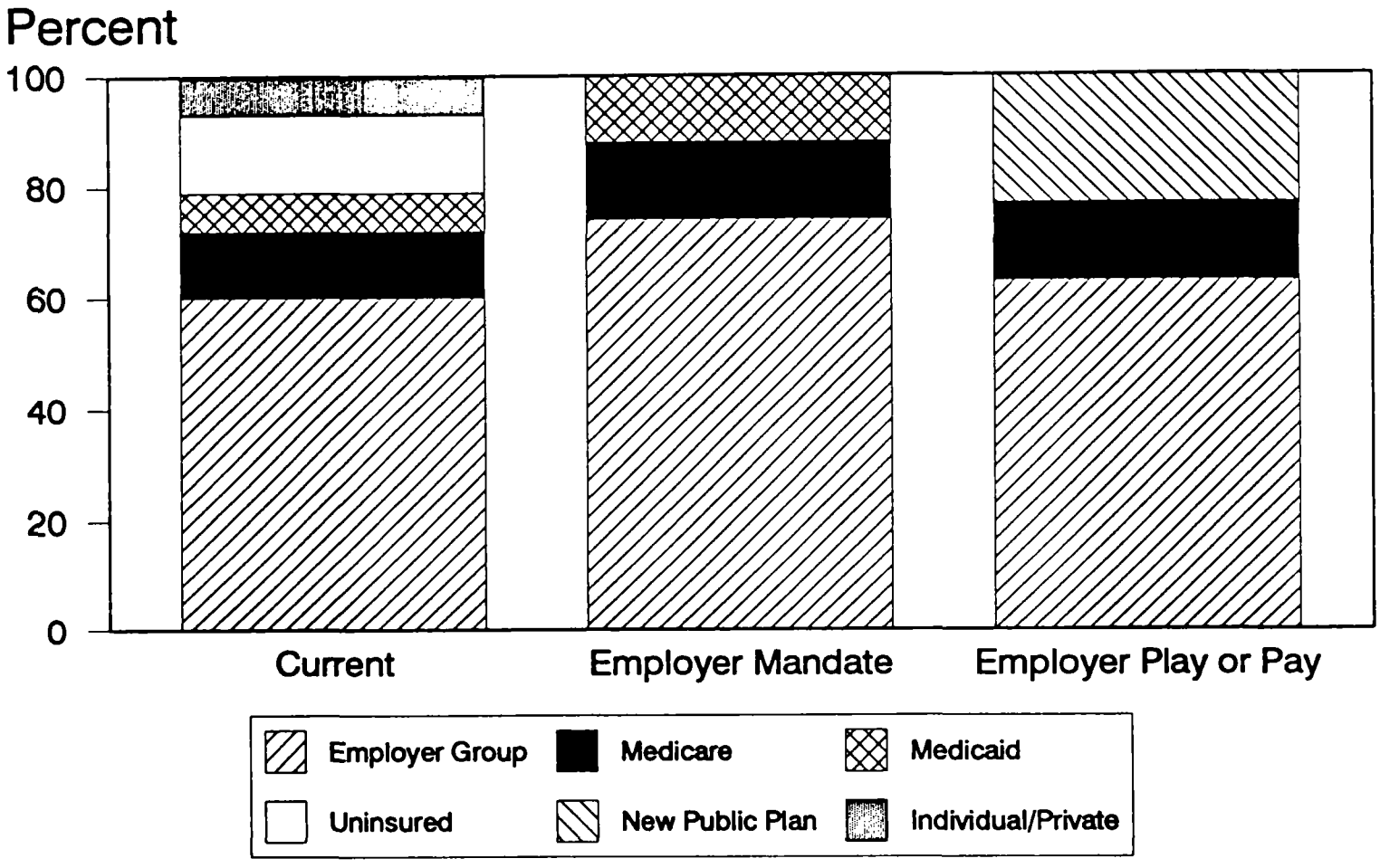
EMPLOYER-BASED COVERAGE

- APPROACHES:
  - EMPLOYER MANDATE
    - EMPLOYERS PURCHASE PRIVATE COVERAGE FOR WORKERS
    - SUBSIDIZED PRIVATE COVERAGE FOR NONWORKERS
  - PLAY OR PAY
    - EMPLOYERS PURCHASE PRIVATE COVERAGE OR PAY TAX
    - SUBSIDIZED PUBLIC COVERAGE FOR NONWORKERS

- PROS:
  - ACHIEVES UNIVERSAL COVERAGE
  - AVOIDS DISRUPTION
  - MINIMIZES TAX FINANCING
  - RETAINS PRIVATE SECTOR ROLE

- CONS:
  - ADMINISTRATIVELY COMPLEX but less than under current system
  - INEQUITABLE FINANCING
  - BURDENS ON SMALL BUSINESS

Private/Public Insurance Mix In Employment-Based Reform Plan



Source: Karen Davis, 1993

A34/ASPE212a

GOVERNMENT-FINANCED COVERAGE

APPROACHES:

- TAX-BASED FINANCING:
  - SINGLE GOVERNMENT PLAN
  - CHOICE OF PRIVATE PLANS

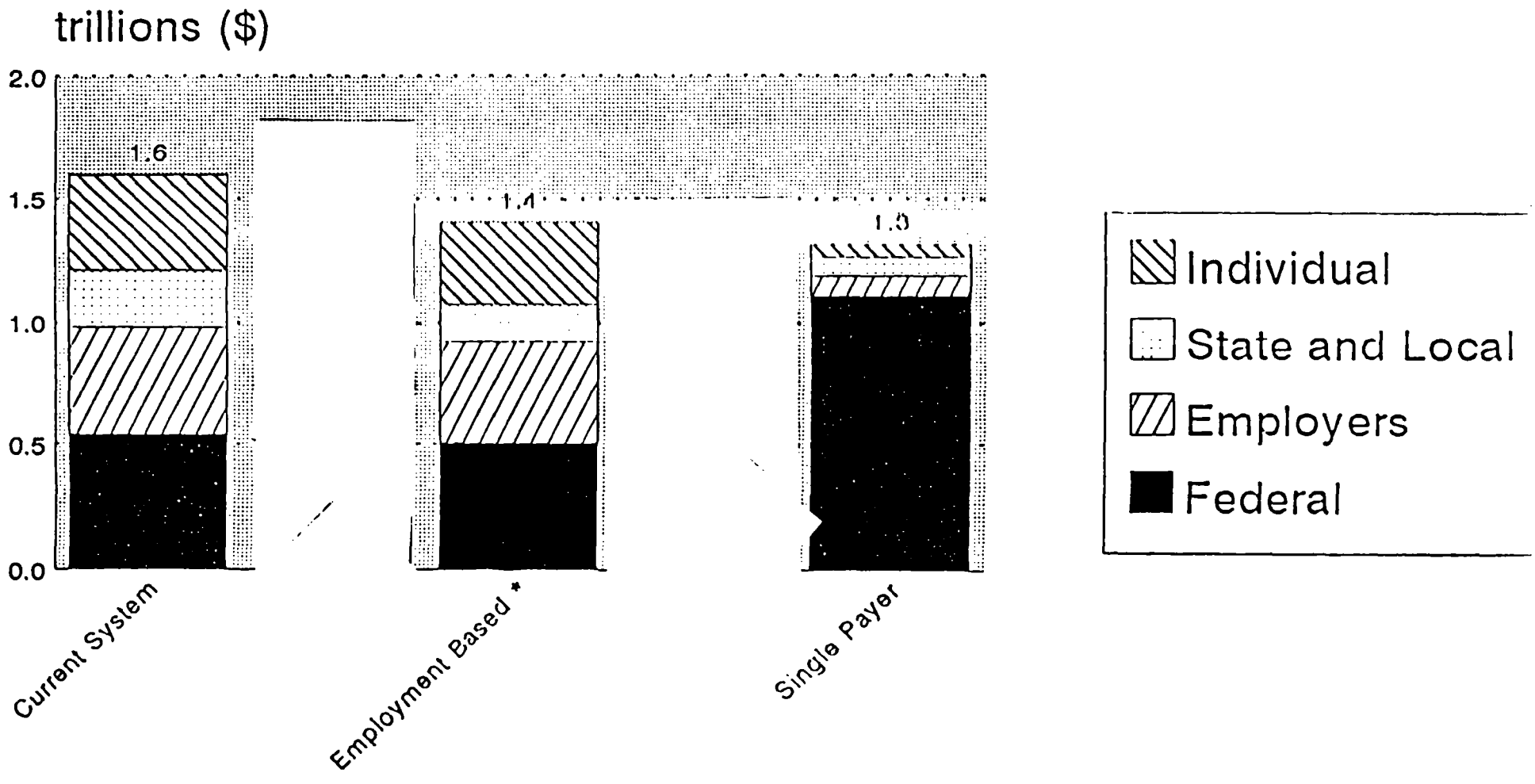
PROS:

- ACHIEVES UNIVERSAL COVERAGE
- MORE EQUITABLE FINANCING
- CAN BE ADMINISTRATIVELY SIMPLE; NO CRACKS

CONS:

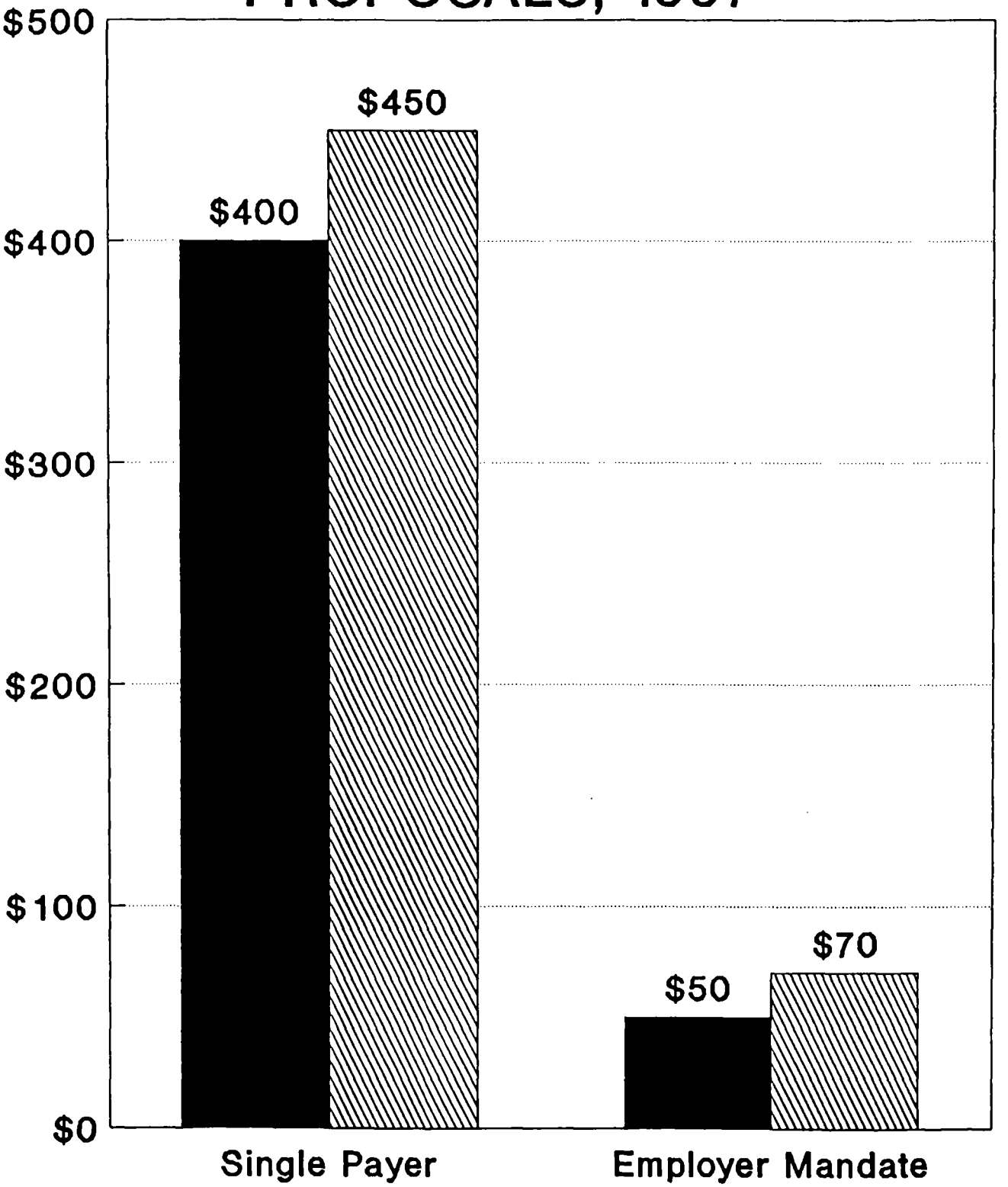
- SUBSTANTIAL TAX COSTS (WINNERS, LOSERS)
- GOVERNMENT ROLE

Financing Implications of Health Care Reform
Health Expenditures by Source, 2000



Source: Karen Davis, 1992
+ w/o Cost Controls
* w/ Expenditure Limits

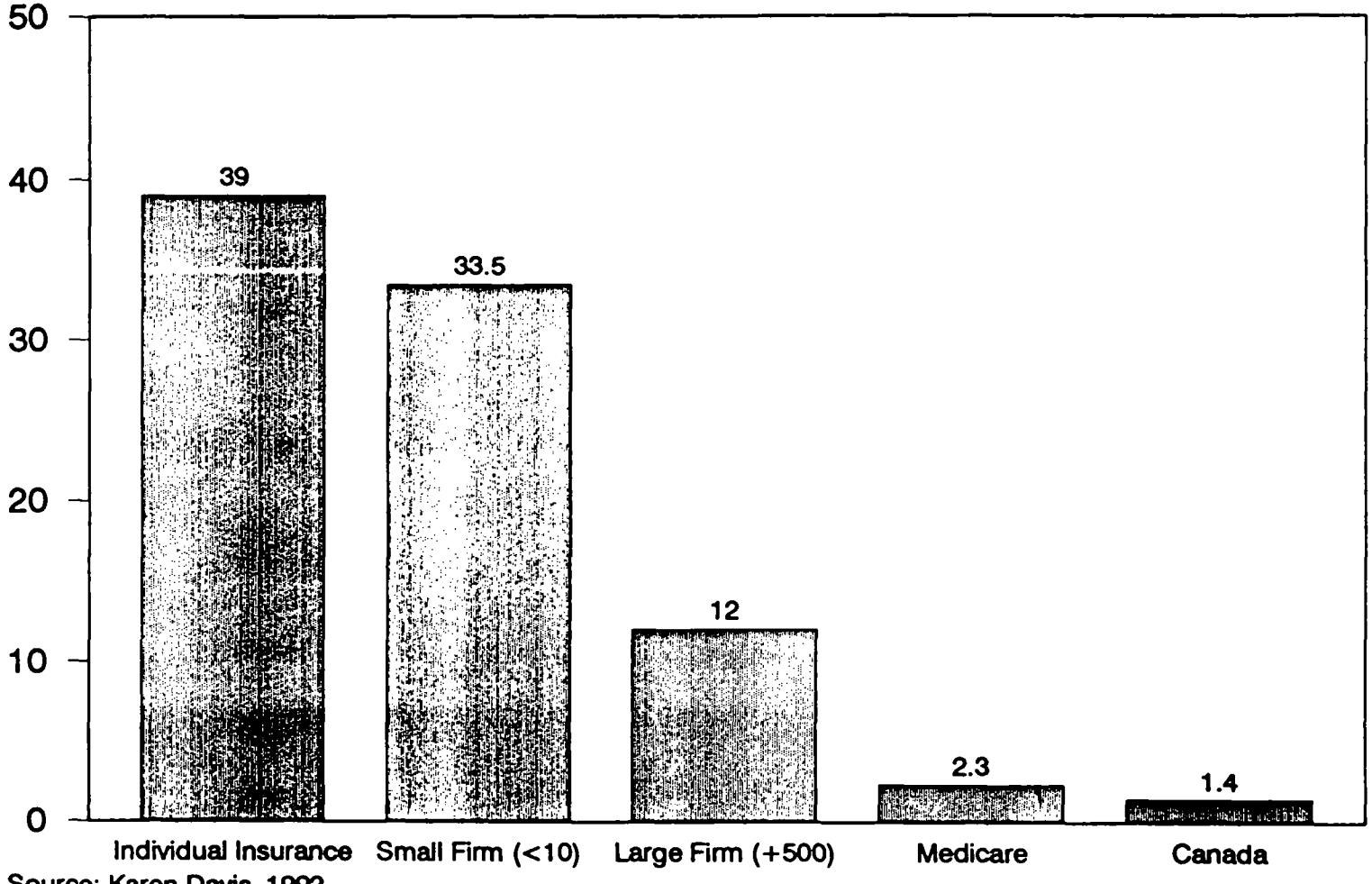
NEW FEDERAL COSTS OF SINGLE PAYER AND EMPLOYER MANDATE PROPOSALS, 1997



What's the target?

- Administrative costs
- Service costs
  - Price
  - Volume

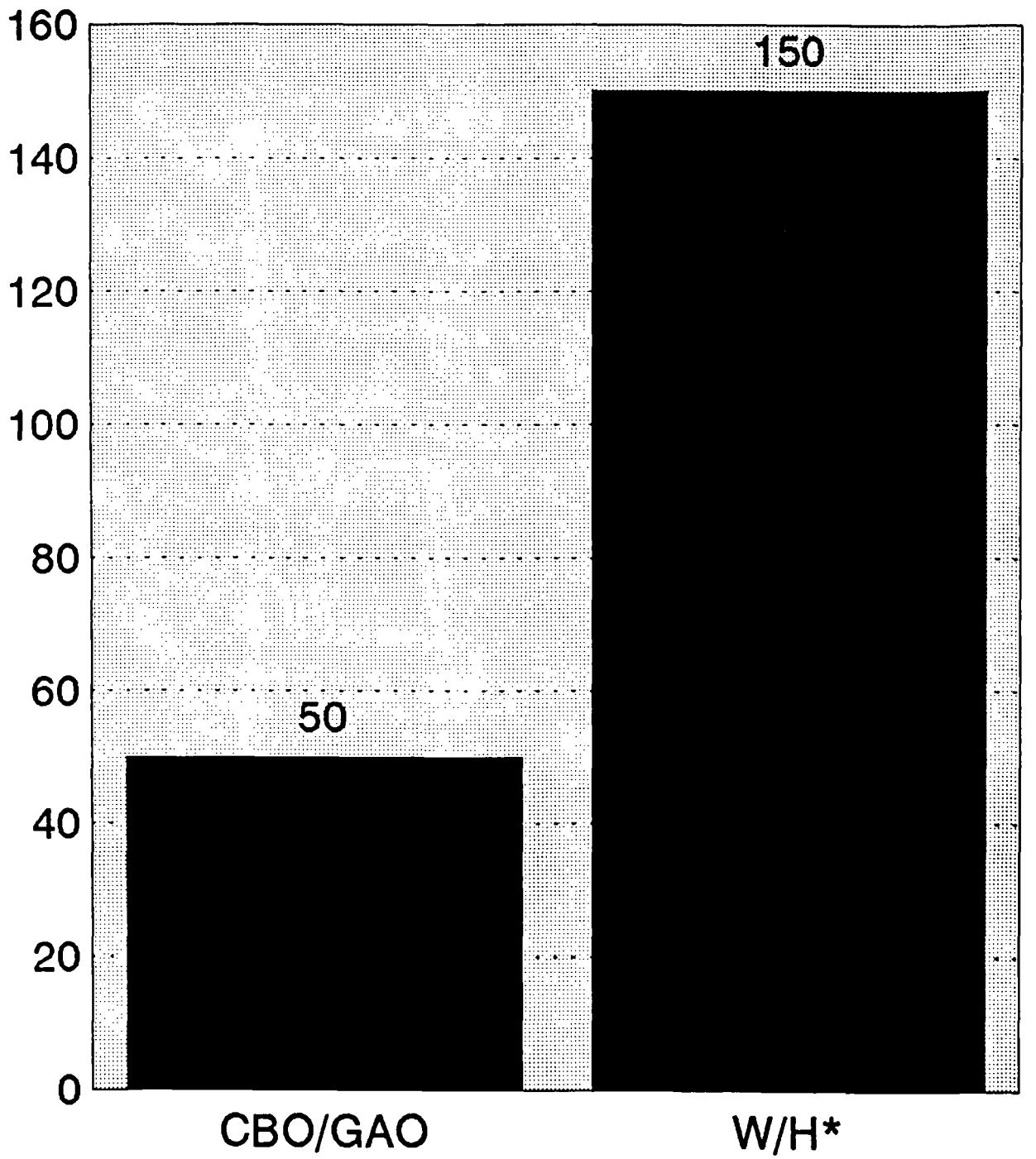
Administrative Expenses as a Percent of Health Benefits, 1987



Source: Karen Davis, 1992

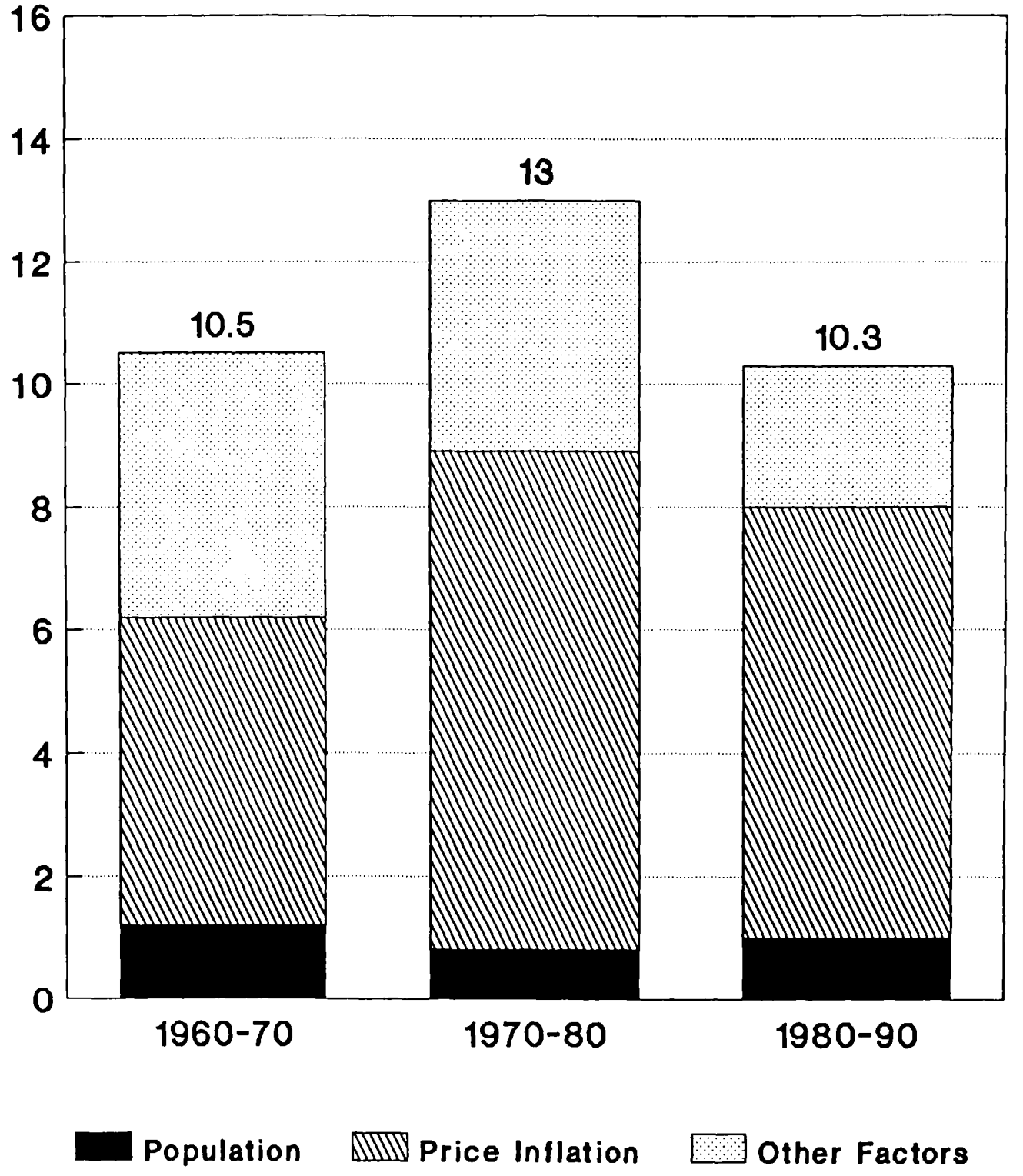
A34/ASPE.212c

POTENTIAL SAVINGS IN ADMINISTRATIVE COSTS UNDER A SINGLE PAYER SYSTEM, BILLIONS OF 1992 DOLLARS



*WOOLHANDLER/HIMMELSTEIN

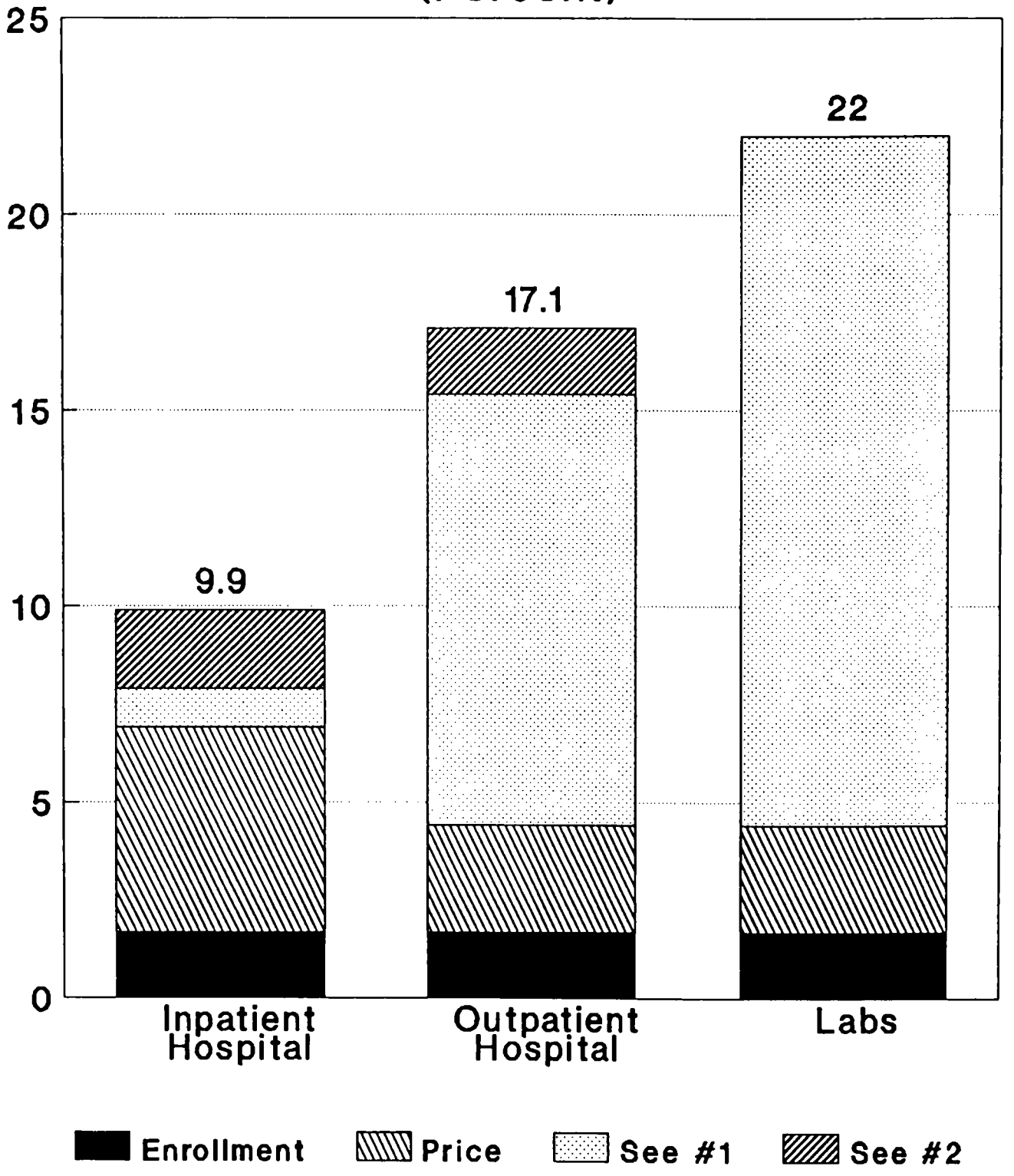
FACTORS AFFECTING GROWTH IN PERSONAL HEALTH CARE EXPENDITURES
(Percent)



SOURCE: HCFA/OACT

SOURCES OF YEARLY MEDICARE HEALTH CARE COST GROWTH

(Percent)



1: Admissions (Inpatient), Volume/Intensity (Outpatient/Labs
2: Case Mix (Inpatient), Other (Outpatient)

Price/Expenditure Limit Approach

- Limit prices to providers
- Global budgets

Pros:

- Has been successful in lowering costs
- Can build on Medicare experience

Cons:

- Exacerbates increases in volume of services
- No improvements in quality, management of care

Pure Managed Competition Approach

- Pool purchasers into cooperatives
- Manage choice among capitated insurance plans
- Increase consumer sensitivity to price

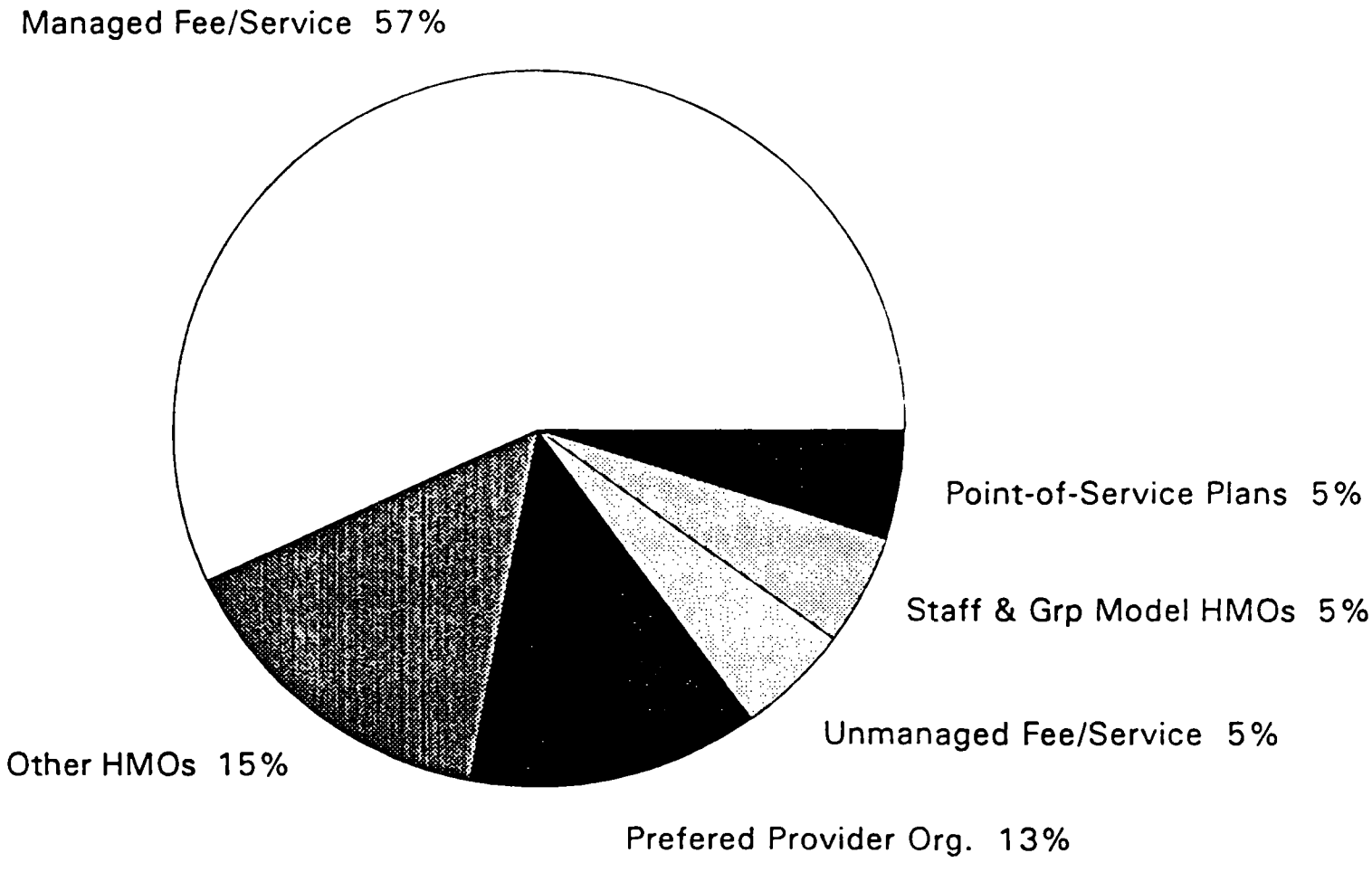
Pros:

- Changes incentives to control volume as well as price;
- Has potential to improve quality of care

Cons:

- Little or no evidence of effectiveness
- Potential deterioration of access; quality
- Incentive to avoid sick or disabled
- May burden families
- Little choice in rural areas

Health Benefit Plan
Enrollment of Workers, 1990



Source: CBO, based on data from Elizabeth W. Hoy, Richard E. Curtis, and Thomas Rice "Change and Growth in Managed Care," Health Affairs, vol. 10, no. 4 (Winter 1991), pp. 18-36.

Blended Approach

- Pool purchasers; manage choice (as above)
- Emphasize accountability of plans to ensure quality, access
- Place managed competition in broader context that allows a controlled fee-for-service option
- Establish budget as maximum on premium costs ("insurance" for enforceable cost containment)
- Promote state flexibility to achieve budget goals
- Support development of high-quality HMO's in undeserved areas

Pros:

- Guarantees cost control/delivery reform

Con:

- Administrative challenge

Sources of Financing Expanded Coverage

Federal Budget Cost Containment Savings

Recapture Private Sector Health
System Savings
-- Tax on Insurance Coverage
-- Tax on Health Care Providers
-- Tax on Employers

New taxes
-- Alcohol, Cigarette, and other "Sin" Taxes
-- Payroll tax or Social Security
Inter-Fund Borrowing
-- Value-Added Tax
-- Other

Benefits

Dental

TYPICAL benefits Plus Preventive Services for Children and Pregnant Women

Deductibles, Co-Insurance, Ceilings on Out-of-Pocket Expenses

Prescription Drugs

Mental Health

Special Low-Income Provisions

Medicaid

-- Expanded to Include All Low-Income
-- Replaced with New Public Plan Modelled on Medicare
-- Replaced with Private Coverage

Reduced Cost-Sharing/Premiums for Low Income

-- Full Subsidies up to 100% of Poverty
-- Partial Subsidies up to 150% to 200% of Poverty --

Role of States

State-Based System Subject to Broad Federal Guidelines and Shared Federal-State Financing

States Operate Own Program on a Waiver Basis

States have Administrative Role within National Plan

States have On-Going Financial Contribution

-- State Medicaid Outlays Indexed Over Time
-- New formula Based on Per Capita Income or Other Basis
-- States Fully Responsible for Low-Income Long-Term Care Portion of Medicaid

Health Care Delivery Reform

Prevention and Outreach

Quality Assurance

Malpractice Reform

Primary Care

Rural Health

Development of Staff and Group Model HMOs

Phasing

Children and Mothers First

By Size of Firm

By Income Level
(e.g. Less than 100% of Poverty)

Cost Controls before Expanded Coverage

GENERAL TALKING POINTS

HEALTH CARE: COMPLEX AND CHALLENGING ISSUE

- Health care reform is one of the most complex and controversial issues that the President and Congress face. I am under no illusion that achieving success will be easy.

- Democrats were elected in the last election to lead on this issue and I am committed to helping the President and the Congress enact a law that comprehensively reforms the system.

OPTIMISTIC ABOUT CHANCES FOR SUCCESS

- I am optimistic that by working together, we can develop, pass and enact a comprehensive health care initiative this year. There are two primary reasons for my optimism:

- First, you individually and collectively have been working on health reform and related elements of this issue for years, if not decades. You have accumulated a vast array of knowledge and experience that we can and expect to draw upon over the next weeks and months.

- Second, I'm encouraged by the constructive and productive transition effort that was undertaken over the last two and half months. It enables us to start from a strong position of understanding where the key players and resources are.

PROCESS DISCUSSION

- Discuss different roles of Interagency Task Force and working groups (it may be appropriate here to reiterate your role)

- Explain that Task Force involves all departments with interest and expertise in health issues (list attached)

- Emphasize policy development roles and responsibilities of Ira and Judy, and their collaborative working relationship

- Briefly discuss how working groups will operate and that they will draw upon recognized, broad-based experts, including members of Congress and their staffs.

- Describe outreach process: constituency outreach, communications plan, etc. Emphasize your intention to avoid the failed public and the media education strategies of previous administrations on this issue.

SPECIFIC TALKING POINTS ON CLINTON PLAN

The Clinton Plan will build on what's best in our system -- private health care the choice of the world's finest doctors, nurses and hospitals. We need new rules to protect consumers and give Americans security and peace of mind.

- For controlling costs and reforming the insurance market:

  Bring health care inflation under control through an entirely new insurance system.

  - Provide a disciplined budget which limits insurance premiums and medical bills.

  - Empower consumers to choose among competing health care plans so that insurers will finally face real competition.

  - Ban pre-existing condition exclusions that block citizens out of the health coverage they need.

  - Establish a comprehensive benefit package that guarantees that the coverage you need is there when you need it.

- For assuring security of coverage:

  Expand coverage by building on, extending and reforming the employer-based system, so that everyone is covered.

  - Call on employers, individuals and providers to contribute to the cost of health care and to work to keep costs under control.

  - Provide subsidies to assist the system's most vulnerable contributors-- small businesses and low-income Americans.

- For assuring and promoting flexibility:

  Where special needs and circumstances dictate a tailored and flexible approach, insure that flexibility is provided for state and local communities to address their unique concerns in an appropriate manner within the overall context of national reform.

  -Assure that rural areas are adequately addressed, both in terms of access and cost containment

WHAT NOT TO TALK ABOUT

Don't Talk About:

Limiting what consumers spend.	(Do talk about controlling the cost of insurance and medical bills.)
Germany or Canada.	(Do talk about success changes seen across the country -- from Hawaii to Rochester, NY.)
Managed Care.	(If necessary, talk about "health networks.")

Limiting choice of doctors or hospitals.

"Mandating" employers.

Technical terminology, to extent possible. For example:
- "Global budgets"
- "Managed competition"

Issues to avoid discussing:

Tax caps or limiting tax deductibility.

Using health care savings for deficit reduction. (Can talk about generating major savings in the overall system.)

Wage or price controls.

Taxes.

TESTIMONY OF LANE KIRKLAND, PRESIDENT **92-20**
AMERICAN FEDERATION OF LABOR AND CONGRESS
OF INDUSTRIAL ORGANIZATIONS
BEFORE THE SENATE FINANCE COMMITTEE

May 7, 1992

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues for working people and their families.

At long last, this nation has reached an important milestone in the century-long debate over health care reform.

The AFL-CIO has long been on record in calling for federal legislation to assure all Americans access to essential health care services at a price they can afford. In this effort, we are now being joined by organized medicine and many in the business community who are offering their proposals for national health reform. This represents true progress toward resolution of the nation's health care crisis.

We believe that the time is right for Congress to take advantage of this growing consensus and to take the lead in fashioning an approach that will reduce health care inflation, expand access and improve the efficiency of the system.

It is crucial that you achieve these objectives before this crisis does further damage to American families, who have been called upon to absorb a major share of cost increases; American businesses that are attempting to do their fair share by providing health care coverage; and health care

THE ECONOMIC IMPACT OF THE HEALTH CARE CRISIS

Increasingly, union members are concerned about preserving their negotiated health benefits. This concern is warranted. In recent years, the majority of labor-management disputes have been caused by the nation's health care crisis. When these disputes could not be settled at the bargaining table, all too often the workers found themselves permanently replaced when exercising their legal right to strike.

A recent study by the AFL-CIO Employee Benefits Department found that in 1990, health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job loss in a strike over health care. Last year a shocking 69 percent of all permanently replaced workers struck over health care benefits as the major issue.

This turmoil is not confined to organized labor. During the 1980s, the health care crisis further exacerbated the economic decline of the middle class. The average hourly wage, adjusted for inflation, dropped from $10.56 in 1980 to $10.03 in 1990. During the same period, health costs as a percent of payroll nearly doubled and expenditures for households increased from six percent to nine percent of gross earnings.

Health care costs are depleting the family income necessary for working Americans to maintain their homes, educate their children and achieve income security in retirement. If current trends continue, by the year 2000 one-third of total compensation will go to pay for health care at the expense of wages and other benefit improvements.

A similar trend is occurring nationally, as health care consumes a growing share of our economic resources. In 1980, health care programs accounted for 17 percent of

domestic spending. Now that figure is 22 percent and by the middle of the decade, it will be 30 percent. Health care inflation is siphoning off valuable economic resources necessary for other national priorities, including education, infrastructure and research and development.

While public expenditures grow, beneficiaries of public programs continue to lose ground. Senior citizens pay more for health care than they did prior to passage of Medicare and 60 percent of those with incomes below the federal poverty level do not qualify for Medicaid.

In short, we are paying more for less. A nation that seeks to be competitive in the 21st century can no longer continue down this road. On a per capita basis, we spend 40 percent more than Canada, 90 percent more than Germany and 125 percent more than Japan. Rather than become mired in esoteric debates about competition vs. regulation, this committee and the Congress should recognize that the most costly solution would be to do nothing at all.

THE CASE FOR COMPREHENSIVE REFORM

Last Fall, the AFL-CIO commissioned a study by Lewin-ICF, Inc. to determine how much could be saved if Congress established a single cost containment program for all payers. They estimated that just a two percent reduction in the projected rate of growth in health inflation will save $165 billion (in 1990 dollars) by the end of the decade. Recently, the Prospective Payment Review Commission (PROPAC) issued a study that supported these conclusions. PROPAC estimated that if the Medicare payment rates were extended

to private payers, there will be an immediate cost savings of $16 to $21 billion annually.

As part of its deliberative process, we would urge the Committee to compare the cost and performance of the U.S. health care system to those of our industrial partners. While these systems have unique structures and differ on numbers of payers, all of these countries have achieved universal access to health care benefits and effectively controlled costs by setting budget targets and paying providers uniform rates.

We urge the committee not to be distracted by the myths of rationing, excessive government bureaucracy and inferior quality that have long been advanced by those who oppose reform. Taken together, the health care systems throughout the industrial world provide conclusive evidence that it is possible to provide coverage to all Americans far more effectively and at an affordable cost.

The burden is on those that advocate market-based mechanisms to explain why we should continue with "voluntary efforts".

In comparison to our industrialized partners, the U.S. health care system fails the tests of fairness and equity. We also fail the test of efficiency, which is apparent to both consumers and providers who are frustrated with red tape and paperwork. Even those who support the current system can no longer defend the excessive overhead and administrative costs associated with our fragmented system.

In pursuing a "competitive" health care market, the U. S. has ended up with a system that operates on the principle of Social Darwinism. It punishes employers who provide health insurance to their workers by forcing them to, in effect, subsidize the health care of those who are employed by firms that seek a competitive advantage by refusing to provide

such coverage. The system rewards purchasers with large groups or relatively young workers with short-term discounts, and it penalizes small employers and those with older, more experienced workers by forcing them to pay more for coverage. The system is replete with inefficiencies that have forced costs to rise sharply, and millions of Americans who are fortunate enough to be covered by health insurance have, as a result, suffered the financial burden of increased cost-shifting and reductions in benefits.

The view has long been held that, notwithstanding these structural flaws, the U.S. system provides better quality of care. But this too has proved to be another myth advanced by those who oppose change. While we do have more technology than other industrial countries, it is virtually impossible to defend the high rates of surgery and diagnostic tests, the relatively small attention paid to preventive care, including the immunization of our children, the lack of coordinated technology assessment and the duplication of equipment in our current system.

In short, our health care problems are urgent -- and they are being exacerbated by our delay in acting on them.

AFL-CIO POLICY PROPOSAL

The labor movement is united in its pursuit of fundamental restructuring of the system and we have three essential goals: to contain health care inflation; to provide all Americans access to care; and to improve the quality of services.

All of the unions within the AFL-CIO support these goals. Attached to this testimony is a copy of our recent Convention resolution on health, which describes our

prescription for reform. Some of our affiliates support the implementation as soon as possible of a single payer approach. But all of the unions believe that we need Congressional action now to address the health care crisis, and they support the Federation's efforts to get legislation that conforms to our principles enacted as soon as possible.

As a nation, we cannot hope to expand access or improve quality without controlling health care costs. The AFL-CIO has proposed a comprehensive strategy to bring health care inflation under control.

To achieve this objective, we have urged Congress to establish a national Commission composed of stakeholders in the system -- labor, consumers, management, government and providers -- to administer a single national cost containment program. The primary functions of such a Commission would be to conduct negotiations between health providers and purchasers of care on payment rates and other necessary measures to achieve these targets and to establish controls on capital costs.

Once payment rates are negotiated, they must apply to all payers, including government programs, to prevent cost-shifting. The Commission should use the methodology that has been implemented successfully under Medicare. Payments to hospitals should be on a DRG basis, with adjustments for facilities with special needs. Payments to physicians should be on the basis of a resource-based relative value schedule (RBRVS), with geographic adjustments as necessary.

We believe it is time to overhaul our costly administrative structure by establishing requirements for administrative intermediaries that would standardize claim forms, develop a uniform health care information system and simplify paperwork. That means that

Congress must establish federal regulations for insurers and managed care providers if we seek to improve the efficiency of the system.

Between those that argue government can not do anything and those that say government must do everything , there is considerable running room. The task before this Committee is to define the combination of public and private strategies that will make our system live up to its reputation as "the best in the world".

SMALL MARKET REFORM

In this Congress, I have testified before each of the House and Senate Committees that have jurisdiction over health care. I have stated repeatedly that the AFL-CIO is prepared to consider each and every proposal that meets our principles. We are not committed to any one plan. The one proposal that we reject out-of-hand is small market reform. No amount of political spin control will convince our members that this proposal moves us forward.

In our view, the term "small market reform" is <u>not</u> synonymous with health care reform, which must encompass comprehensive reforms in the organization of the health care system, payment of providers and delivery of care. The lessons of proposals already in place within certain states, is that small group market reform will not make health insurance accessible and affordable unless it is enacted as part of comprehensive package that controls costs and guarantees coverage.

There are important limitations in many of the small group market reform proposals:

- The reforms neither stop nor reduce the rising cost of health care, the major reason small businesses give for not providing health benefits.

- Reforms will raise costs for the majority of small employers and will not reduce overall premiums.
- The reform proposals would do nothing to guarantee that all individuals have coverage.
- Recent studies on subsidizing employment-based health insurance indicate that these subsidies have induced few small businesses to provide health benefits to their employees.
- During this time of budget cutbacks, state insurance departments may not have adequate resources to assure regulatory compliance with a comprehensive small business reform proposal.

OTHER PENDING LEGISLATION

The AFL-CIO is encouraged by the sheer numbers of bills that have been introduced to reform the health care system and the commitment on the part of Members of Congress to enact legislation in this Congress that will offer relief to families caught in the middle of the health care crisis.

The AFL-CIO has long advocated enactment of a social insurance national health insurance plan. S.1446 introduced by Senator Kerrey and S. 2320 introduced by Senator Wellstone both call for restructuring the present system so that revenues are collected and then distributed through a single payment source. Working men and women are united in their belief that a single payer approach would be the most efficient mechanism for the systemic restructuring necessary to move us forward.

The legislation introduced recently by Senator Daschle, S. 2513, also is designed to capture the efficiency of a single collection mechanisms, but also to provide competition on the delivery side. This bill takes a fresh approach to the challenge of balancing the role of government and the private sector. While we believe that this proposal deserves an in-depth

look, we are concerned about how much of the key decision making about the fundamental structure of the system is left to a Commission and the states. While we ourselves have advocated a Commission to develop reimbursement methodology, establish a strategic planning process for the system, and monitor the effect of systemic changes on Americans of all ages, we believe that the Congress cannot delegate the authority for defining basic benefits and establishing the financing arrangements.

We applaud the leadership offered by Senator Mitchell and his colleagues who introduced S.1227 and we strongly support the amendments offered by the Labor and Human Resources Committee, making the cost containment provisions in that bill mandatory. The legislation also contains a unique feature to bring together supporters of single payer and limited payer approaches, allowing each state, within specific state budget targets, to determine how it desires to establish its cost containment system, including the option to adopt single payer.

In our view, it is imperative that any type of system, whether it be single or multiple payer, have the stability and uniformity of a national program. We are dubious of initiatives, which place the burden of developing, financing, and monitoring the system on the already hard-pressed states. Medicaid has taught us this important lesson.

We must also deflect attempts to delay national reform by encouraging state-based demonstrations. It seems ludicrous for the United States to take the position that demonstration projects are needed to help rally the public behind national reform. We can build on the vast experience that our country has acquired in running programs, such as Social Security and Medicare, that have been hugely successful in contributing to the well-

being of the society as a whole.

CONCLUSION

We can reform the health care system - now - if we commit ourselves to get on with the job. To advocate anything less is to accept the inevitable chaos in which the nation's resources continue to be misapplied and drawn into the black hole of uncontrollable costs.

No combination of voluntary efforts will be enough to solve the deep-rooted problems of rising costs, diminishing access and uneven quality. It is time for all members of Congress to exercise the type of leadership the American people deserve from their elected officials. It is time for Congress to take a hard look at the effects of the health care crisis on their constituents and time to develop and enact the comprehensive health care reforms that working men and women so desperately need.

TESTIMONY OF KAREN IGNAGNI, DIRECTOR EMPLOYEE BENEFITS DEPARTMENT AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS BEFORE THE SENATE FINANCE COMMITTEE ON STATE CARE ACT OF 1992

September 9, 1992

The AFL-CIO appreciates the opportunity to share with the Committee its views on S. 3180, the State Care Act of 1992. We commend the sponsors of this legislation for their commitment to the goals, which we share, of expanding access to health care services and bringing health care inflation under control.

This testimony addresses the fundamental question that underlies this legislation: Should Congress give states waivers to develop their own programs while the debate about health care reform strategies continues at the national level. The members of this Committee and the entire Congress are being called upon to make key decisions about the direction and shape of health care reform. As you fashion the appropriate blend of federal and state responsibilities, there are some key issues that merit discussion:

1. Would state demonstration programs postpone enactment of a national health care reform plan until the results of the demonstrations are known? If so, can we afford to wait?
2. Given that many states are facing severe fiscal crises, can they be expected to move forward on health care reform without additional federal financial support?
3. If the Congress chooses to develop health care reform solutions at the state level will the result be a patchwork quilt of coverage, eligibility and performance across states?

4. Based on the health care bills that already have been passed in states, can it be concluded that state legislatures are in a better position than Congress to balance varied constituent interests and design fair and equitable health system reform plans?

As you consider these questions, we urge you to evaluate the performance of current state-based programs, from Workers' Compensation to Medicaid, to separate the promise of state health care reform legislation from its reality and to weigh whether the goals of S. 3180 can be achieved at the state level.

The men and women of the AFL-CIO have long believed that the most efficient and effective approach to the health care crisis involves a national solution, as opposed to 50 state plans. We believe that an opportunity for consensus on this issue is fast approaching and that the key goals embodied in this proposed legislation can be achieved nationally. Nonetheless, in the context of a broad national program, we support giving implementation flexibility to the states.

During consideration of the Employee Retirement Income Security Act (ERISA), the AFL-CIO strongly supported the principle that states should not regulate employee welfare plans. In the words of Senator Javits upon passage of ERISA in 1974:

> "Although the desirability of further regulation -- at either the state or federal level -- undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive federal interest and the interests of uniformity with respect to interstate plans required . . . the displacement of state action in the field of private employee benefit programs."

Given the significant time, effort and resources that would have been devoted to complying with various state laws, union members supported the enactment of a uniform federal health care program. Now, almost 20 years later as we evaluate the rationale for

this position, we have concluded that the concerns articulated in the 1970s are even more relevant today. They are: the need for federal action, the precarious financial condition of states and the uneven performance of a variety of existing state-administered programs. In addition, in reviewing the state health plans that already have been passed, we are concerned that the goals set out in S. 3180 will not be met.

URGENT NEED FOR FEDERAL ACTION

Nearly a third of Americans have no health insurance or are under-insured. The vast majority of them are people who work hard, who do their level-best to provide for their families, and yet they are only an illness or injury away from financial ruin. What we need is fundamental change of the health care system. That change should be based on the premise that all Americans should have access to basic medical services at a price they can afford.

From labor's perspective, we've seen the issue of health care nearly consume the collective bargaining process in this country. In every industry, employers have moved to cut back on health benefits or have demanded that union members sacrifice wages and other benefits in order to keep their health care.

For more than half of union members who are forced to strike, health care is the number one issue in dispute. As it stands, the free market rewards employers who deny health benefits to their employees. This has created a cross-subsidization in health care that drives costs up even further. We have learned through several years of painful experience that, absent government action, there will be no end to this cycle.

In theory the State Care Act would address this urgent need by giving increased flexibility to states so that they could design their own programs while debate continues at the national level. In practice, however, the Act could well postpone national reform for

several years while the state demonstrations are evaluated.

INCREASED FINANCIAL PRESSURE ON STATES

Many states are currently facing severe fiscal constraints that would limit their ability to initiate comprehensive health care reform. Many of these problems can be traced to the poor condition of the economy over the past two years. With actual revenue falling far below projections, many states have had to endure multiple rounds of budget cuts and tax hikes as they struggle to balance their budgets. The National Association of State Budget Officers (NASBO) recently reported that 29 states were forced to reduce their *enacted* FY 1991 budgets by more than $7.5 billion to remain in balance. For FY 1992, the states have collectively raised taxes by more than $15 billion, following on the heels of a $10 billion increase in FY 1991. On average, state budgets proposed this year contain growth of just 4.8 percent. According to NASBO, this is "the lowest rate of growth since 1983 and represents a reduction of services in many states."[1]

Even without the recession, many states would be facing a number of constraints on their ability to initiate costly new programs. In the early 1980s, the Reagan Administration eliminated a number of federal programs that provided financial assistance to state and local governments. These programs had provided states with over $40 billion of revenue between 1979 and 1981.

A related problem over the past few years has been the underfunding of many key block grant programs. While there has been substantial growth in block grants for anti-drug abuse programs, other grants for preventative health, social services, and community services have not kept pace with inflation, while those for job training, low income home energy

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[1] *Fiscal Survey of the States*, National Association of State Budget Officers, National Governors Association (Washington, D.C., April 1991).

assistance, and education have been cut. States have been forced to use an increasing share of their revenue to make up for lost federal dollars.

Given this situation, it seems unlikely that many states will be able to organize the kind of large scale experiments in health care financing and delivery that are envisioned in the State Care Act. Even if states manage to establish such programs, it seems probable that they will be subject to the same kind of budgetary pressures that are forcing large cuts in state services across the country. This may be one of the central lessons from the Massachusetts experience, where a promising attempt to use employer mandates to provide health insurance to all the state's citizens has been dramatically scaled back due to the budgetary and economic pressures generated by the prolonged economic downturn.

TRACK RECORD OF STATE PROGRAMS MEETING FEDERAL GUIDELINES

Even during periods of economic expansion, the track record of state programs in meeting guidelines established by the federal government is not encouraging. In examining the history of such programs as Occupational Safety and Health, Workers' Compensation, and Medicaid, there is a common thread of states falling short of fulfilling their responsibilities. It is often difficult to determine whether responsibility for this lies with the states, the federal government, or somewhere in-between. Nonetheless, the fact that reality falls far short of past promises should cause us to be much more cautious about claims that states should take the lead in health care reform.

A. Occupational Safety and Health

In 1970, the Occupational Safety and Health Act established federal workplace safety and health regulations. States were permitted to develop their own programs, provided that they met federal standards. To date, only 21 states operate approved occupational safety and health programs and unsafe working conditions continue to exact an enormous toll.

More than 10,000 workers are killed every year, one worker every hour of every day, more than six million workers are injured on the job and sixty thousand are permanently disabled. While states that operate their own safety and health programs tend to conduct more inspections than the federal agency, state inspections tend to be less comprehensive with fewer serious citations issued and significantly lower penalties imposed.

Outraged by the catastrophe in Hamlet, North Carolina, in which a workplace fire unnecessarily claimed the lives of 25 poultry workers, the AFL-CIO called upon federal OSHA to withdraw approval of the North Carolina state plan. Federal OSHA did initiate withdrawal proceedings, but suspended this action, even though North Carolina has yet to correct all the deficiencies in its plan. After the Hamlet fire, federal OSHA also conducted an evaluation of the other 20 state OSHA programs, which centered on the states' ability to operate effectively in 36 performance areas. All of the state plans were found deficient in bringing performance to a level at least as effective as that of federal OSHA.

B. Workers' Compensation

In 1970, as part of the Occupational Safety and Health Act, Congress authorized and the President appointed a national commission to evaluate state workers' compensation programs. In 1972, the national commission issued its report and made 84 recommendations, including 19 criteria considered to be essential to the survival of the state system. The commission suggested mandating federal standards to ensure adequate, prompt, and equitable protection if the 19 recommendations were not incorporated into state programs by 1975. Now, 17 years later many states still do not meet the Commission's criteria in the areas of coverage for occupational diseases, benefit levels, and rehabilitation services. So far, the average compliance rate is only 66 percent. Since 1980, progress toward meeting the criteria has virtually ceased. Three states do not have mandatory

workers' compensation coverage. Of those that do, many do not cover certain types of employees, such as domestic workers, farm workers, and employees of small businesses. Some states waive responsibility for certain employers, such as realtors and taxi cab owners, and a significant number of states limit either the duration or the amount of benefits for different types of disability.

The decision to leave workers' compensation in the hands of states was contingent on compliance with the national commission's findings. Since that time, some states have made strides in improving their programs; however, the overall condition of the workplace has worsened. A recent Bureau of Labor Statistics survey indicates that the incident rate for occupational injury and illness has grown from 7.9 per hundred full-time workers in 1986 to 8.8 per hundred in 1990. Lack of compliance with the national Commission's recommendations has left workers and their employers struggling to improve the various state programs to insure that adequate and fair protection from work-related injury will be implemented.

C. Medicaid

As the Committee evaluates S. 3180, we believe that it will find the Medicaid experience a compelling argument for not moving ahead in this direction. Indeed over the past few years, many of the initiatives of this Committee have been directed toward establishing uniform program standards across states.

While the legislation when enacted contained sweeping promises about establishing a health care safety net for the poor, the reality of the program has been a jumble of eligibility, reimbursement and benefit policies across states. In California, a family with an income below 79 percent of the federal poverty level qualifies for coverage. The average for all states is 47 percent, and in Alabama eligibility is set at 13 percent of poverty.

This experience raises substantial questions in our minds about states' financial ability to assume broader responsibilities without the benefit of federal resources.

ERISA: IMPEDIMENT TO REFORM OR PROTECTION AGAINST INEQUITABLE STATE FINANCING PROPOSALS?

The AFL-CIO is concerned that the State Care Act would allow states to obtain waivers from the Employee Retirement Income Security Act (ERISA) for the purposes of regulating and taxing existing employee welfare plans. It is our belief that states will use these waivers to levy extremely regressive taxes to finance their health care reform plans. Recent evidence suggests that the costs of state health care reform will be disproportionately borne by union workers and their employers.

ERISA, which was enacted in 1974, provides a single set of federal standards for the regulation of pension plans. The legislative history indicates that it was the intention of the original sponsors of the legislation that Congress would also develop a set of federal standards for the regulation of health and welfare plans, to avoid passage of 50 state laws. Congress preempted states from regulating welfare benefit plans. The only exception was a waiver granted to Hawaii to preserve its comprehensive health care system that mandates that all employers provide health care protection. Despite pressure from trade unionists, no further progress has been made toward national health care reform. In the meantime, several states have sought waivers from ERISA allowing them to regulate health plans.

Through our state bodies, trade unionists have been working in a variety of coalitions to advocate policies that are consistent with our pursuit of national reform. At the state level, unions have advocated cost containment legislation designed to stem the tide of health care inflation. We also have advocated universal access proposals that depend on broad-based and equitable financing imposing requirements on all employers to contribute to the

cost of health care services.

To date, state legislation has fallen far short of these goals. Moreover, not one of the state bills that already have been passed would meet the standards specified under S. 3180. (In consulting with our local bodies, it appears that states that have enacted legislation, as well as those that are evaluating proposals to go forward, are encountering the same problems that Congress has faced, particularly with respect to the issue of whether employers should be required to contribute to the cost of health care coverage and the difficult task of designing fair and equitable financing systems.) Florida is a voluntary system until 1994 and it is unclear what will happen after that. Minnesota finances uncompensated care by imposing surtaxes on health care services, thereby disproportionately penalizing those that already are providing health care protection. Thus far, Vermont is in the study phase of developing legislative alternatives.

Not only have most of the state initiatives been inadequate to address the full scale of the health care crisis, the means by which states have proposed to finance these initiatives have been, in our view, inequitable.

In New Jersey, the state government placed a surcharge amounting to 19.4 percent on all hospital bills in order to pay for the provision of uncompensated care for the state's nearly one million uninsured. New Jersey's labor leaders opposed the plan, arguing that the tax forces unions and employers who are paying their fair share to subsidize their competitors, employers who refuse to provide health care protection to their workers. The state AFL-CIO and 14 other labor organizations and unions filed suit against the plan. On May 27, 1992, the U.S. District Court issued a landmark decision in United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital concurring with the labor movement's reasoning.

Prior to the enactment of the state surcharge, union representatives in New Jersey

made a strong case for passage of legislation requiring all employers to do their fair share and financing any gaps in coverage equitably across the entire population. Union representatives in Florida and Minnesota made similar arguments when health care legislation was being considered in their respective states. In all cases, these principles were rejected in favor of more expedient political compromises. With health care costs skyrocketing all over the country and dramatic increases in the number of uninsured individuals, our members fear that other states will seek ERISA waivers to pursue regressive approaches to finance uncompensated care without being able to address the larger issues that underlie the health care crisis.

CONCLUSION

In our view, health care reform is the responsibility of government, employers and individuals and we are committed to the following principles:

- All Americans must be entitled as a right to a core benefit package,
- All employers must contribute fairly to the cost of care, and
- Financing must be based on an equitable and progressive basis.

While we are supportive of the goals that motivated the sponsors of the State Care Act, we feel that past experience argues for a national, rather than a state-based approach to national health care reform. While the goal of expanding access is one that we have long advocated, we are concerned that there is nothing in the legislation requiring all employers to do their fair share, thereby eliminating the competitive advantage of not providing health care coverage. We also are concerned that by establishing goals for coverage that are less than 100 percent, we will postpone longer than necessary the achievement of universal access.

We are prepared to join with the sponsors of the legislation and the other members

of this Committee to continue discussions about how to achieve the goals set out in the legislation.

Health Care Policy

Options for a Clinton/Gore Administration

Presentation by the Clinton/Gore Health Care Transition Team

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HEALTH POLICY

In this health care briefing book, we are presenting to you basic options with financial implications for national health care reform and the other key areas in which the campaign pledged action -- long term care, AIDS, women's health, public health. For each topic, we present a range of scenarios with the cost implications and a political analysis.

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Background

During the campaign, we pledged to submit a comprehensive health care proposal to Congress within the first one hundred days of a Clinton administration. The proposal we put forward called for cost control through managed competition within the discipline of a national health budget. Universal coverage would be achieved through employer mandates to cover workers and subsidies to nonworkers.

In the appendix to this memo we present a first cut at a detailed outline of a reform proposal which builds on the plan put forward during the campaign. Controversial matters are highlighted and analyzed there. The specifics are illustrative, not definitive and will change with your advice as we work with Congress and others. However, it is not our intent that you resolve specific issues of long term design. We will produce an options memo based on the products of our expert working groups providing you with choices on key technical (but politically controversial) details for your review later.

The key budgetary decisions you face now are not about the details of your campaign plan for long term cost control. Rather, they are about the rate at which the costs of expanding coverage to all Americans are phased in and the extent to which you employ short term price controls while managed competition gets up and running.

The major budgetary expenses for health reform come from the costs of expanding coverage. Specifically, the costs are subsidies to unemployed individuals, subsidies to businesses offsetting a portion of mandate costs, adding prescription drug coverage to Medicare benefits, and federal enhancements in Medicaid payments to relieve state burdens. As shown in Appendix A, if universal coverage is phased in over four years, these costs could reach $91 billion for 1998. Different phase-in schedules will result in different annual costs.

The major savings from health reform comes from cost control. However, even if your plan is passed at the end of 1993, the earliest that significant Medicare and private sector savings will be realized from competition within global budgets is probably 1997. Most experts agree that health insurance purchasing cooperatives (HIPCs) -- the structures for managing competition -- would require at least two to three years to set up across the country. Only temporary all-payer price controls would free up large amounts of public and private funds for financing health care reform/deficit reduction and private investment.

We have developed three short-term options for expanding coverage and dealing with federal health care spending during the transition between 1993 and 1997. In order of increasing budget expense they are:

a) Delay phase-in of coverage until 1997 when managed competition and a national budget limitation begin generating savings. Reduce Medicare provider payments on the margin, but avoid across-the-board price controls.

b) Begin phase-in of coverage immediately and complete by 1997. Implement temporary tough controls on physician and hospital fees, either for both the public and private sectors or for Medicare only.

c) Begin phase-in of coverage immediately and complete by 1997. No tight short-term price controls.

Under all three options (with four to six year phase-ins to universal coverage), new revenues are required to cover all Americans. Following the options we therefore provide some health care specific revenue options.

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Options - Health Reform Investment (coverage expansion and short-term cost control)

As mentioned in the introduction, if we win passage of our health reform plan, cost containment through managed competition and a national health budget will generate savings no sooner than 1997. Three options are presented below for implementing expansions in coverage and addressing rising health costs in the short term. All assume our comprehensive cost containment plan will be implemented as quickly as possible.

Option 1 - Low Cost - Coverage expansion does not begin until 1997.

Scenario:
> Phase in managed competition with national budget enforced in 1997.
> Delay mandates and nonworker coverage until 1997; universality in 2000.
> In short term, reduce Medicare spending 1% over 4 years.

	94	95	96	97	98
Costs of coverage	0	0	0	16	39
Savings[1]	-.2	-1	-3	-9	-20
Net deficit ($ billion)	**-.2**	**-1**	**-3**	**7**	**19**

Without action to generate savings during the transition to a reformed system, one option to limit new costs over the next five years is simply to delay the first expansions in coverage to 1997, when budgets enforceable through competition are in place. Universality would not be achieved until at least the year 2000. Even limited expansions in coverage before 1997 would require new revenue.

This option establishes a comprehensive cost containment program for the longer term and in the short run only attempts increased tightening of Medicare spending alone (through cuts in the rate of growth in physician payments and hospital outpatient care by 1.5 percent). This option would reduce growth in overall Medicare costs by one percentage point over four years.

[1]Larger savings shown elsewhere reflect substitution of employer coverage for Medicaid coverage and other such offsets.

Policy Analysis:

This scenario presents a general investment strategy of enacting long term cost control and delaying the phase-in of universal coverage to generate no or very small increments in the deficit in the near term. By pushing these costs toward the end of the decade, however, it would delay our ability to reduce the deficit into the next century.

Under this option, the private sector would experience continued growth in health care costs. In fact, increases in private spending would be accelerated, as providers shifted the costs Medicare did not pay. At the limits proposed, however, reduction in access would not be expected for the elderly.

Insurance reforms, such as the elimination of pre-existing conditions exclusions, the establishment of a core benefits package, and the introduction of community rating for insurance policies would be in place by the end of 1996. However, on their own, these changes could increase premiums for many of those already insured.

To create more near-term deficit reduction, tougher Medicare limits could be implemented, such as making deeper cuts in annual hospital payments, freezing physician payment increases at current levels, eliminating the disproportionate share payments to hospitals, and other steps. These steps would lower Medicare payments even further below actual costs. However, this would shift more costs to the private sector and, if aggressive, could jeopardize access for Medicare beneficiaries.

An alternative general investment strategy would enact long term cost control and begin phasing in universal access early but only incrementally (e.g., by expanding coverage to just pregnant women and children during the first four years). This would increase the deficit by a small amount if at all, but would delay any longer term deficit reduction (and universal access) until 2000 or beyond.

Political Analysis:

IMMEDIATE PUBLIC AND MEDIA RESPONSE:

The public will view option 1 to be a moderately delayed cost containment and universal coverage package. As with all three options, however, the press and general public response will be fiercely divided. The public will welcome the relatively immediate positive elements of the package (e.g. the insurance market reforms, the insurance portability provisions, and the administrative simplifications) and will be pleased that real cost containment is eventually assured in the proposal.

Having said the above, there is no question that there will be influential and visible critics who will charge that you have pushed off addressing the toughest problems, and by doing so,

you are increasing the likelihood for the future repeal or delay of the "meat" of your package. They will charge that your approach is totally inconsistent with your repeated statements that health care costs represent a crisis that must be addressed immediately. In making this criticism, they may well suggest that you have given in to the special interests by giving them more time to "milk" the system.

One final note: Regardless of which option you choose, if a prescription drug benefit and some steps toward a substantive long term care benefit is not included, influential aging advocates will adamantly oppose the proposal.

1996 ELECTION POLITICS:

By reforming the insurance market (e.g., eliminating discriminatory insurance underwriting practices and guaranteeing insurance portability from job to job) and establishing a system which assures administrative simplification (e.g., adopting a single claims form and standardized billing arrangements), you will have addressed some of the most visible and threatening problems that people with insurance -- the great majority of the voting public -- have with the current system. However, because you will have not been able to slow health inflation, out of pocket costs for the average consumer will have gone up significantly. Moreover, more people are likely to be uninsured than even today. Lastly, because enforceable cost containment and revenue raisers come into place in 1997, rationing and taxes will likely be major election year issues.

Advantages:

- **Universal Coverage and Cost Containment is Achieved with Less Immediate Pain**
  Although delayed, you achieve your campaign promise without an immediate financial impact on politically influential health care providers and insurers.

- **May be Easiest Option for Congress to Pass**
  This option represents what some in Congress believe is the middle ground between the managed competition advocates and the universal coverage, global budget supporters. It allows us to avoid a fight over short term price controls. Moreover, by putting off the employer mandate to a time in the relatively distant future, it probably will be an easier pill to swallow.

- **New and Politically/Economically Difficult Taxes are Delayed**
  By delaying access (and, hence, the cost of providing tax subsidies for small businesses and individuals), you will not have to ask Congress to pass a tax increase that will hit their constituents before the 1996 election.

- **Fear of Immediate Economic and Health System Disruption is Diminished**
  The fear that an employer mandate will hurt the economy in terms of job loss will be

assuaged to some extent. It will allay fears of a sudden cost containment jolt to the health delivery system that will create more problems than it solves.

- **Most Influential Interest Groups Will Hate It Less**
  The delay in cost controls and mandates may make it easier to sell not only to the Congress, but to some of the most influential interest groups, (e.g. most small & large businesses, most health care providers, and most insurers).

- **Conservative Democrats May Grudgingly Accept**
  Because this approach avoids drastic price controls, it is possible that many of these managed competition advocates will grudgingly accept this option.

Disadvantages:

- **Delay Undermines Confidence that Promise Will Be Fulfilled**
  Many consumer groups and some in the media are will conclude that the delay in implementation of the hard choices will significantly increase the likelihood that the politically difficult elements of this package (tough cost containment and mandates) will be more vulnerable to further delays or even eventual repeal.

- **Key Clinton Supporters will be Dismayed**
  Most unions and consumer advocates will be dismayed that you took this action. Most of the advocates have consistently taken the position that it is imperative to achieve strong cost-containment and universal access as rapidly as possible.

- **States Cannot Afford to Wait for Cost Savings**
  In the absence of quick cost containment savings and access expansions, you can count on receiving numerous requests for financially and politically expensive waivers that will enable states to develop and implement their own state-specific initiatives. These may be very difficult to pass the Congress and, regardless of their outcome, the funds allocated to the few states ready to implement comprehensive reforms will reduce the pool of dollars available to the other states.

- **Great Potential for Increase in Insurance Premiums**
  Insurance market reforms, absent strong cost containment and movement towards universal coverage, are likely to result in higher insurance premiums for those who are currently covered.

- **Numbers of Uninsured Continues to Expand**
  In the absence of strong cost containment (in the early years of this plan), it is highly likely that the number of uninsured will increase. This fact will be no doubt documented and portrayed by the media and political opponents, particularly during the 1996 election cycle.

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Option 2 - Moderate Cost - Begin immediate coverage expansion and create temporary, tight cost controls.

We will present two options under this heading: (2a) Temporary, tight price controls on both the public and the private sectors; (2b) Tight controls on Medicare alone. The first option is shown using tighter controls than the other.

Scenario 2a: Immediate all payer price controls and four year phase in.

Scenario: > Phase in managed competition with national budget enforced in 1997.
> Phase in universal coverage by 1997.
> Institute temporary price controls on physician and hospital fees, insurance premiums and drug prices for all payers, limiting health expenditures to GNP and population growth in advance of the competitive system.

	94	95	96	97	98
Costs of coverage					
w/ Rx drug coverage	14	37	54	74	91
w/o Rx drug coverage	11	26	45	63	77
Savings	-6	-11	-21	-32	-49
Net deficit ($ billion)					
w/ Rx drug coverage	8	22	33	42	42
w/o Rx drug coverage	**5**	**15**	**24**	**31**	**28**
Net private sector savings ($ billion)[2]	**-7**	**-18**	**-51**	**-87**	**-110**

Under this scenario, you would seek legislation that would put in place your long term comprehensive reform as quickly as possible -- managed competition with a national health budget enforced in 1997, coverage of uninsured women and children by 1994, employer mandates and subsidies for nonworkers phased in between 1995 and 1997. The legislation would also grant you power to declare a national emergency and bring in across-the-board price controls on health care costs. Physicians, hospitals, insurers, drug manufacturers and other providers would face short-term price limits which make it illegal for them to raise their rates in the public and private sectors faster than CPI or some other determined figure.

[2]Accounts for new costs of employer mandate, reductions in administrative costs, and reduced out-of-pocket payments.

The scenario shown above phases down total expenditures to the growth in GNP over four years (which would require limiting prices to much lower than GNP, since some sectors will respond by increasing the volume of services or goods sold).

To reduce annual spending further, one must phase in the coverage expansions over six years or longer. Alternatively, one could substitute an immediate GNP growth limit, instead of a gradual phase-down to GNP, for a short period (e.g., two years) and then let up on prices as managed competition gets underway. If you chose this shock treatment, immediate federal savings would be larger, leaving no deficit in 1994 and a $6 billion deficit in 1995, although costs are higher in later years. Private savings would be $16 billion and $35 billion in 1994 and 1995, respectively.

All the options presented in this memo have included costs of implementing coverage of prescription drugs for the elderly, as pledged during the campaign. However, to lower costs, we have presented here figures for expansions in coverage which do not include the drug benefit.

Policy Analysis:

This scenario presents an altogether different investment strategy from those discussed under Option 1. Here you would phase in universal insurance in the near term (four or at most six years) and couple it with very tight cost controls. This would increase the deficit substantially in the near term, but would set the stage for substantial reductions in the deficit in the longer term. Under this option, comprehensive health reform would be fully in place in 1997, and the short term price control strategy would have begun controlling health care spending from early in your Administration.

Price controls are the fastest way to achieve savings throughout the health care system. You could use a crude technique like that used during the Economic Stabilization Program in 1971-74, limiting the increase of existing prices, which would emphasize the temporary nature of the price controls. Such controls would put strict caps on prices for physician and hospital services, prescription drugs, and insurance premiums. Alternatively, you could expand the Medicare system of DRG hospital payments and RBRVS fees for physicians fees and various outpatient care rates to all the payers for health care -- public and private. This option would establish uniform payment schedules, reducing fees for many overpriced procedures and increasing primary care rates.

While these aggressive cost containment options and the phase-in schedule would still increase the federal deficit, they would produce substantantial savings for the private sector and state and local governments. By 1998, these savings would reach $110 billion annually in the private sector -- freeing up this amount for more productive investments and increased wages -- and could exceed $20 billion in reduced state and local health care spending. These private sector savings could make a fundamentally important contribution to the success of overall economic policy.

There is deep disagreement about the effect of shock price controls on the health care system. Some argue that profit margins for doctors, hospitals, drug companies and others are high and the controls would have little effect on quality and delivery of services. Others (such as Henry Aaron of Brookings) argue that it would produce severe reductions in quality and delivery of services, even producing rationing. If you are interested in this option, considerably more staff work would be required (which we are more than willing to do).

Political analysis:

IMMEDIATE PUBLIC AND MEDIA RESPONSE:

The public will view this as an aggressive approach to controlling costs as well as a fast timetable for achieving universal access. Several polls indicate that the general public believes there are enormous amounts of fraud, abuse and waste in our health care system. This means that aggressive cost-containment aimed at all health care providers and manufacturers in order to slow health inflation will be popular with the general public. On the other hand, provider groups such as the AMA, PMA, AHA will oppose this option claiming that it will produce rationing, substandard levels of care, waiting lines, and any other limitations to access. These providers can also be counted on to take actions to make sure that some of these claims are realized.

Finally, this cost containment strategy creates a potential new revenue source through recapturing savings although it is not without political risks.

1996 ELECTION POLITICS:

By 1996, you will have completely reformed the health care system. As with Option 1, insurance reform and administrative simplifications will be achieved. In addition, by 1996 you will be well on your way to universal coverage. A comprehensive cost containment system would come into place in the next year. And the massive private capital freed up by cost control could spur economic growth and be seen as a major gain.

However, there are problems that could develop. If the economy is bad, changes to the health care system could be blamed. The general public may perceive the sudden cutbacks in health industry growth -- and the construction and jobs that go with it -- as an economic loss. Blame for this will likely be placed on the Administration and government rather than various segments of the private sector as it is now. Another important potential problem is that while prices will be controlled by this option, Americans will still inevitably see increases in their health care costs which they already find to be too high. Though experts will applaud the cost containment achievements, the public may not, especially if people believe that their choice under a managed competition has been significantly curtailed.

Advantages:

- **Health Inflation Controlled**
  Consistent with the pledge to stop spiraling health care inflation, you will achieve scorable cost containment. It also enhances the likelihood of obtaining support of more sensitive groups such as small business and insurance groups. Serious cost-containment strategy is critical to obtaining labor support.

- **Universal Access Nearly Achieved**
  By 1996, most of the population will have insurance coverage, and everyone will in the next year.

- **Strong Cost Containment Reduces Need for New Revenues**
  Savings achieved from cost containment will significantly reduce the amount of politically difficult-to-raise revenue needed to underwrite the cost of universal coverage. In fact, raising any revenue will be extremely difficult without it as many will fear throwing good money after bad. Revenue raised will increase your ability to alleviate the burden of the mandate on small businesses.

- **States Protected from Bankruptcy Due to Medicaid Growth**
  Access and cost containment will protect the States from expected future growth in Medicaid obligations.

- **Show Strength Against Special Interest Groups**
  By taking this option, you will illustrate your willingness to stand up to the multitudes of special interests, e.g. providers, manufacturers, etc., who can be expected to oppose this option.

Disadvantages:

- **Strong Opposition from Well-Financed, Organized Special Interest Groups**
  The best financed and represented health care interests are likely to vehemently oppose this option. They will likely join forces with more sympathetic representatives of the health care equation, such as some within the small business community, as well as with inefficient providers, insurers and agents who will feel a disproportionate impact from cost containment to oppose this approach.

- **Potential Decrease in Access and Some Services**
  Providers may react to stringent cost controls by cutting valued or needed services, certainly charity care. The public will react negatively to any real or perceived loss of care. Provider groups will call this "Rationing" and will manipulate cuts to achieve this perception, while claiming that there hand was forced by the draconian cost containment strategy imposed. This reaction from providers and a resulting

backlash from consumers will put legislators under considerable pressure to modify the plan.

- **Costs Still Rise**
  This is tough cost containment, but it only reduces the size of cost increases. Though analysts may see the reductions as remarkable, people will still feel they are paying too much for premiums that continue to rise, though not as quickly. Some will also have to pay even more through higher taxes and community rating.

- **Price Controls Difficult to Pass**
  Price controls will be strongly opposed in Congress and pressure to do so can undermine your ability to achieve your long-term cost containment strategy. Even if passed, provider animosity could undermine creation of stable long term system.

- **Shifts Blame for Problems from Market to President**
  The public perceives that the problems with our current system are the fault of greedy providers and insurers taking advantage of a flawed market. If you move aggressively to address this issue as you pledged to do during the campaign, blame for both new and ongoing problems will be focused on the Government and the new President rather than the market.

Scenario 2b. Tight limits on Medicare alone and six year phase in.

Scenario: > Phase in managed competition with national budget enforced in 1997.
> Phase in universal coverage by 1999.
> In the short term, put tough growth limits on physician and hospital payments for Medicare alone.

	94	95	96	97	98
Costs of coverage					
w/ Rx drug coverage	14	27	45	62	84
w/o Rx drug coverage	11	20	36	51	70
Savings	- 6	- 9	-17	-25	-39
Net deficit ($ billion)					
w/ Rx drug coverage	8	18	28	37	45
w/o Rx drug coverage	**5**	**11**	**19**	**26**	**31**

This scenario differs from the all-payer price control scenario of Option 2a in stretching out the phase in of coverage from four to six years and by putting controls on Medicare only. These controls are less rigorous than under the all-payer scenario, as well.

Specifically, this option assures coverage for all uninsured pregnant women and children in poverty by 1995 and all Americans by 1999 through phase in of employer mandates (and tax credits to businesses). Universal coverage could be phased in by 1997, however, costs would be higher. Managed competition would be geared up as quickly as possible with a national health budget being applied in 1997. Until then, we would make tough reductions in Medicare payment growth while avoiding a fight for immediate across-the-board controls.

The figures shown above reduce Medicare annual growth by 2 percentage points over four years. These limits would include a 2% cut in annual hospital payment increases, a freeze on physician payment increases at current levels, cutting subsidies to teaching hospitals, reducing annual growth in hospital outpatient payments to 12% (currently 19% a year), and other steps. Even tighter controls could be effected.

Policy analysis:

Under this option, the expansions on coverage would produce substantial savings for states and localities overburdened with the costs of the uninsured on public hospitals and public programs. Until the comprehensive cost control program is in place in 1997, however, little will be done to control private health costs for businesses and individuals.

It will be much easier technically to undertake this option than putting controls on all

payers. In the absence of comprehensive limits on health costs, however, Medicare payment reductions will likely result in further shifting of costs to the private sector rather than overall reduction in national health costs. This would increase further the difference between public and private payments to providers, potentially leading some providers to avoid serving Medicare beneficiaries. Businesses would see costs increase even faster than currently until the competitive system and national health budget are in place. Their obligations for coverage would also come in before costs were controlled.

Political analysis:

IMMEDIATE PUBLIC AND MEDIA RESPONSE:

The public will see this option as a slow expansion in coverage with no cost controls until 1997. Controlling only Medicare prices leaves providers the chance to shift costs, reducing the intensity of their opposition to reform. In addition, you do achieve federal savings which can finance expansion of coverage.

On the other hand, by failing to include the private sector in your cost containment strategy, you are open to criticism on several fronts. Consumers will face continued super-inflationary prices which increase even faster because of the cost shift. Small businesses, in particular, will be apoplectic over mandates requiring that they cover their workers going into effect without any private sector cost controls in place. In addition, there will be an outcry from the aging groups claiming they are bearing a disproportionate burden for the reform effort. The elderly will also become angry that Medicare payments may reduce their access to good care and that money taken from Medicare will go to the under-65 population. Congress is likely to have serious reservations about this approach given their experience with the "Catastrophic" legislation. The aging groups may be assuaged somewhat by the inclusion of a prescription drug benefit. Finally, you could face criticism for not living up to your campaign pledge to reign in health care costs and addressing this issue with urgency.

1996 ELECTION POLITICS

By 1996, you will have made a strong down payment toward comprehensive health care reform. As with the previous options you will have implemented insurance reform and achieve administrative simplification. In addition, you have improved access, although not as dramatically as Option 2A. But no private sector cost controls are in place. People will face higher premiums than ever before (cost-shift) and the elderly and small businesses will be up in arms.

Advantages:

- **Access to Health Care Improved**
  By 1996, you will have made a significant down payment toward universal coverage,

all children and pregnant women will have access to health care. This not only puts expansion to universal coverage within the general time frame outlined by campaign, but it also provides a tangible demonstration of your commitment to full reform to the general public and consumer advocates.

- **Federal Cost Containment Reduces Need for New Revenues**
  Savings achieved from Medicare payment controls will reduce the amount of politically difficult-to-raise revenue needed to underwrite the cost of universal coverage.

- **Avoids Fight for System-wide Cost Controls**
  By focusing on public sector savings, you control federal costs while avoiding a bloody fight with well organized and financed special interest over a short term savings plan inconsistent with your long term strategy for controlling costs.

Disadvantages:

- **Private Sector Health Costs Not Controlled**
  Lack of private sector cost controls may be viewed by the general public and the media as a betrayal of your campaign promise to move aggressively to control costs.

- **Elderly and Small Businesses Outraged**
  This option will be opposed by the elderly not only because they are bearing the burden of cost containment without receiving any new benefits. In addition, it will feed their fear that access and quality will be diminished under Medicare and that it will become a second tier delivery system. Small businesses will be vehemently oppose to your plan because they are being asked to cover their workers without any effort to control private sector costs.

- **Six Year Phase-in Disappointing**
  Drawing out the phase-in period may be disappointing to the general public anticipating more aggressive action on controlling costs and phasing in access.

- **Contradicts Clinton and Democratic Leaders Stated Position on Medicare only Cost Containment**
  This Option contradicts your own statements that this approach is insufficient, inequitable and inflationary to the private sector.

- **Congress Unlikely to Support**
  Given the statements of the Democratic Leadership against this approach and significant opposition they will face from such potent political forces as the elderly and small businesses, Congress is unlikely to support this option.

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Option 3 - High Cost - Universal coverage in first term without tight short term controls.

Scenario: > Phase in managed competition with national budget enforced in 1997.
> Phase in employer mandates and nonworker coverage by 1997.
> In short term, produce limited reductions in Medicare provider payments. (as in Option 1).

	94	95	96	97	98
Costs of coverage	14	33	54	74	91
Savings	- 4	- 5	-10	-13	-20
Net deficit ($ billion)	**10**	**28**	**44**	**61**	**71**

Under this option, we would phase in the employer mandates and subsidies for individuals over four years, but we would choose to avoid the fight for comprehensive across-the-board controls in the short run. Instead we would wait for fully implemented managed competition and national health care budgeting to constrain costs throughout the health system beginning in 1997. In the meantime, we would rely on the same practices as in Option 1 to constrain Medicare cost growth -- reducing physician and hospital outpatient payment increases by 1.5%. The result would be enormous new revenue requirements.

Policy analysis:

Under this scenario, all Americans would have coverage by the end of 1997. A comprehensive cost control system will be fully in place in 1997, as well. States and localities would see a tremendous windfall from coverage of the uninsured. However, while universal coverage will reduce insurance costs for insured Americans and businesses covering their workers, the limited Medicare reductions while shift enough costs to the private sector to counterbalance the savings. The current super-inflationary trend in health costs will continue in the short term and business obligations, especially for the smallest businesses, would increase through the employer mandates.

The effects on delivery and quality of care would be minimal and access for the elderly at these levels of reductions should not be adversely affected.

Political analysis:

IMMEDIATE PUBLIC AND MEDIA RESPONSE

The public will view this option as a plan that achieves rapid universal coverage and eventual cost containment, but at an enormous price.

Many citizens will be pleased that there will be universal coverage and delayed but significant cost containment. They will also be pleased with the administrative simplications and some aspects of the insurance market reforms. Some, although far from a majority, will accept significant revenue increases as the price they have to pay for comprehensive reform. Without question, however, the majority will find this approach to be fiscally irresponsible.

1996 ELECTION POLITICS:

By 1996, everyone has coverage but the cost of achieving this will be extremely high. Critics of the plan will charge that this approach simply added fuel to an already out-of-control health care inflation fire. Supporters will be criticized that there first inclination was to raise taxes, rather than deal with the issue driving the debate -- health care costs. Most important, the majority of those who had insurance prior to enactment will feel the costs of this package are not worth the benefits. This may create a backlash similar to the one resulting during the Medicare Catastrophic Coverage Act. In addition, there will be a sympathetic audience responding to the business complaint that they have been forced to pay for health care in an environment that does not contain costs. Having said all of this, the health care providers generally positive reaction to this approach mean that the likelihood of acceptance of your long term strategy (including global budgets) is greater.

Advantages

- **Universal Access Achieved**
  By 1997, everyone will be covered.

- **Deliberate Cost Control Strategy**
  This option allows for the deliberate implementation of a long-term cost containment strategy without the shock of price controls.

- **Avoids Fight for System-wide Cost Controls**
  In time, you control costs while avoiding a bloody fight with well organized and financed special interest over a short term savings plan, inconsistent with your long term strategy for controlling costs.

Disadvantages

- **Small Businesses Outraged**
  Small businesses will balk at requirements that they cover their workers without any concurrent effort to control health care costs.

- **Throwing Good Money After Bad**
  Critics will argue that you are throwing more taxpayer money into a bloated and inefficient system.

- **Congress Highly Unlikely to Swallow**
  After making cost containment the highest priority to address, the Congress will strongly resist the possibility of raising revenue and mandating coverage in the absence of visible cost containment.

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OPTIONS -- HEALTH CARE REVENUE ESTIMATES (billions)

Option 1- Windfall taxes to recover a portion of private savings under health reform.

	94	95	96	97	98
3% Hospital Revenue Tax.	11	12	14	15	17
3% Insurance Premium Surcharge.	9	10	10	11	12

These measures would recover a portion of the savings accruing to the private sector from tight across-the-board price controls and to all hospitals due to the elimination of uncompensated care under universal insurance. One would apply a 3 percent surcharge to health insurance premiums and health benefit payments made by self-insured firms and/or a similar surcharge to all hospital revenues.

Across-the-board price controls will generate the largest savings for upper-income workers and big businesses while the mandates increase financial pressure on small businesses and low wage workers. The rationale for these taxes then is to recover part of the savings to subsidize the smaller businesses and poorer workers from the windfall rather than pay for subsidies entirely from savings from programs for the elderly.

Option 2- Limit tax deductibility of insurance premiums.

	94	95	96	97	98
Limit deductibility to lowest cost core package of benefits	10	17	21	26	33
Eliminate deductibility of health benefits	32	35	40	45	51

Option (a) treats employer contributions to premiums for the lowest cost basic health plan as tax free income for employees (as under current law), estimated to be sheltering $185 per month for individuals and $385 per month for families. Employer contributions above this amount would be treated as taxable income. Proponents of managed competition

contend the tax cap is required to promote cost consciousness among consumers.

Option (b) eliminates the tax free status of employer contributions for worker health benefits. Whatever the employer contribution is will be counted as fully taxable income for employees. This option leaves a tax credit for 20 percent premiums for a basic package of benefits.

(For additional analysis of this revenue option see page 11.)

Option 3- Eliminate Wage Cap for Medicare Hospital Insurance Fund

	94	95	96	97	98
Scenario:	3	6	7	7	8

Part A of Medicare is financed by employer and employee payroll tax (combined 2.9%) applied to the first $130,200 in income. This option would apply the 2.9% payroll tax to all earned wages. Additional revenue will eventually have to be found for the HI trust fund, as the Social Security Actuaries have estimated the fund will run a deficit starting in 2002.

The tax increase is limited to high income individuals, ending its regressiveness. Because earners already have this tax deducted from the first $130,000 in income, this tax increase is relatively "hidden." For that reason, it would not generate as much opposition as other measures. However, although in many cases where there is dual income, family income of taxed individuals will be over $200,000, this tax will inevitably reach families earning less than $200,000.

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Appendix A
Federal Costs of Universal Health Insurance Plan

A fully phased-in universal insurance plan will be expensive. A critical policy issue is the extent to which these costs are financed through federal tax revenues or direct payments by individuals and employers. Four key elements comprise the costs of the health plan outlined above. For illustration, we present the federal costs of these components of a universal insurance plan phased-in over 4 years. As discussed below, the federal costs could either be lower or higher depending on the following policy choices. Figure 1 shows annual costs for each element of your plan under a given set of assumptions.

- **Medicaid Payments to Hospitals and Providers.**
  Medicaid currently pays hospitals and physicians about 10 percent less than Medicare. Mainstreaming the program will, over time, require an alignment of these payments. At issue is the timing of this alignment and whether the states would share in any new costs.

- **Subsidies to Low-Income Americans.**
  The proposal subsidizes the costs of health insurance individuals and families with incomes below 200% of the federal poverty line. At issue is the extent of the subsidy (e.g. premiums, cost sharing, limits on out of pocket spending) and which individuals are eligible (e.g. those under 150%, 200%, 250% of poverty).

- **Subsidies to Low-Wage, Small Firms.**
  Approximately 27 million previously uninsured Americans will now receive coverage through their employer. Many of these employers are smaller firms that employ low wage workers. We have talked about providing tax credits, or other subsidies to employers to mitigate the economic impact on these firms. At issue is the extent and availability of these subsidies.

- **Medicare Drug Benefit.**
  The basic benefit package offered to Americans under the plan would, in all likelihood, contain a prescription drug benefit. Medicare does not cover outpatient prescription drugs, although 40 percent of Medicare beneficiaries do have such coverage through retiree health plans, or those receiving full Medicaid benefits (all state Medicaid programs cover drugs). At issue is the timing of the Medicare drug benefit, and the extent of cost sharing (e.g. deductible level and coinsurance).

Figure 1. Federal Costs of Universal Coverage, Phased-in 1994-1997 ($ Billions)[3]

	94	95	96	97	98
Medicaid Payment Enhancements*	0	3	5	8	14
Subsidies to Low-Income Individuals**	7	17	25	35	38
Subsidies To Firms***	2	3	9	12	15
Medicare Drug Benefit****	3	7	9	11	14
Other*****	2	4	6	9	10
TOTAL	**$14**	**33**	**54**	**74**	**91**

* Set at 80% of Medicare levels in 94, 85% in 95, 90% in 96 and 100% by 1997. New costs federally financed.

** Those in poverty face no cost sharing or premium requirements. Premium set at 20% of cost at 200% of poverty, 15% at 150% of poverty.

*** Subsidize premium costs above 9% of payroll for firms with fewer than 150 workers.

****Package includes an $850 deductible with a 20% coinsurance requirement..

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[3]Coverage is phased in according to the following schedule:

1994 Coverage for pregnant women and children under 18, all Americans under 50 percent of poverty. Firms with 100 or more worker mandated to provide coverage.

1995 Coverage for all those living in poverty. Mandates for firms with 75 or more workers .

1996 Coverage for all those living under 50 percent of poverty. Mandates for firms with 50 or more workers.

1997 All are covered through subsidized insurance or mandated employer coverage.

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Appendix B
Draft Clinton Plan for a Reformed Health Care System

During the campaign, we put forward a plan that would guarantee all Americans adequate coverage for needed health care services by relying on an employer mandate and government subsidies for those not in the labor force, restructure the health care delivery and insurance systems to make them more efficient, and create sufficient economic constraints through managed competition within the discipline of a national health budget to slow the growth of future health care spending. We also said that this plan would not require payroll taxes.

The following provides details expanding on how such a reformed American health care system would function in the long term when fully implemented.

Health Care Reform Plan When Fully Implemented

Covered Benefits

1. Universal Access to a Guaranteed Benefit Package

a. The federal government would define a guaranteed benefits package to which all Americans would be entitled.

* The core benefits will be broad based including preventive services, limited mental health benefits, and out-patient prescription drugs.

* The core benefit plan will include limited out-of-pocket costs.

* Legislation will specify general types of benefits but leave specification to a National Health Board to develop .

b. The new National Health Board would assess new and existing technologies to determine whether they should be included as part of the guaranteed benefit package.

2. All Employers Provide Coverage for Their Employees

a. The federal government would require that all employers contribute towards health

coverage for their employees.

b. For full-time workers and their families, employers would be required to contribute at least 75-80% of the lowest cost health plan providing the guaranteed benefits in their region. Employees would pay no more than 20-25%, plus any additional amount to enroll in a more expensive plan.

c. For part-time workers, employers could provide coverage or pay a pro rata premium into the area-wide purchasing cooperatives where such individuals would be required to obtain coverage.

3. Making the System Affordable for All Employers and Employees

a. For a limited time period, small employers would receive subsidies for premiums in excess of 8-10% of payroll, with federal subsidies (tax credits) making up the shortfall.

b. The premium and cost-sharing contributions required of working families between 100-200% of the poverty rate would be subsidized. For individuals and families with incomes below 100% of the poverty rate, no premium or cost-sharing contributions would be required.

c. A variety of revenue sources could be used to finance these subsidies, including: capping the tax exemption for employer-sponsored health coverage at the lowest cost plan available in a region; an assessment on health care providers to capture windfall savings resulting from reduced uncompensated care and lower administrative cost.

d. National standards would be set for administrative simplification, including a single claims form and standardized electronic billing arrangement.

4. Covering Part-Time Workers, the Unemployed, and the Self-Employed.

a. All individuals without an attachment to the labor force (i.e. those who are not working and do not have a working spouse) and the self-employed would be entitled to coverage through the purchasing cooperative.

b. Those with little or no income would pay no premium or cost-sharing (less than 100% of poverty). For families between 100 and 200% of the poverty there would be reduced premiums or cost-sharing. The federal government would provide revenue to purchasing cooperatives to pay for those whose contributions fall short of the full premium.

5. Early Retirees

a. All early retirees would be eligible for coverage under the HIPCs. Those not covered by a previous employer would pay an income-related premium. Those covered by a previous employer (or previous employer of spouse) would share the premium depending on the conditions of the employers' plan. In a subsequent memo, we will further discuss this issue. We will examine the extent to which premiums paid by all early retirees should be age and risk adjusted to avoid having the younger and healthier members of the HIPC subsidize them and the degree of fiscal relief given to firms which now incur a large expense for such coverage.

6. Establishing State-Sponsored Health Insurance Purchasing Cooperatives (HIPCs) to Manage Competition

a. Each State would be required to establish one or more regional purchasing cooperatives, or to cede responsibility for operating a cooperative to the federal government.

b. Such purchasing cooperatives would be responsible for approving HMOs and other organized insurance/delivery system plans, as well as fee-for-service insurance systems which would be offered through the cooperatives. They would also be required to insure that all approved plans meet federal guidelines for providing a standard benefit package, eliminating any pre-existing conditions exclusions, and assuring community-rating. All health plans within the cooperative would be required to meet standards for reporting on the cost, utilization, quality and outcomes of care, and consumer satisfaction.

c All employers with fewer than 100 employees -- about 52% of the labor force -- would pay health insurance premiums to area wide purchasing cooperatives. Employer premiums could be defined as 75-80% of the lowest cost health plan offering coverage in the region. If a family chose to enroll in any health plan other than the lowest cost plan, it would have to pay the full difference in cost. This would be a strong stimulus to individuals to select more efficient health-care plans.

d. Purchasing cooperatives would manage competition among private health care plans, e.g. by negotiating with plans, distributing standardized information and marketing materials, and risk-adjusting premiums to prevent adverse selection. Consumers would be offered a choice of plans during an annual open enrollment period.

e. Larger employers (with 100 or more employees) must provide coverage directly to their employees. While they may use plans that are also offered by the purchasing cooperatives in their areas, they would be required to negotiate premiums separately. Such firms would be required to meet all federal standards with respect to the benefits required of all core plans, as well as the exclusion of pre-existing condition clauses,

and guaranteed coverage for all of their workers at the same premium. Spending by large firms would also be subject to the provisions of the state budget limitation.

7. A Global Budget to Control Costs

a. **National Health Board.** An independent National Health Board would be established within the executive branch and charged with the design and implementation of the plan.

b. **Cap on HIPC Budget.** The National Health Board would establish an annual per capita health-care budget for each State based on national cost containment objectives, health care needs and costs of the State. Adjustments to the budget could be made for epidemics or other medical disasters. Each state would allocate budgets to each area purchasing cooperative based on the number of individuals covered in the area and their health care needs. The funds allocated by the federal government for each State would be predetermined each year. Knowing their total budget, the area purchasing cooperatives would then negotiate with approved plans bidding to participate so that total payments do not exceed the area budget.

c. **Global budgets for purchasing cooperatives.** If the rate requested by the lowest price plan is greater than the per capita resources available to a purchasing cooperative, the cooperative could take various steps to bring costs in line with revenues. These steps could include: jawboning with plans; working with plans to discover ways of reducing costs region-wide; or refusing to contract with any plan not willing to accept a defined rate of increase in its premium.

A purchasing cooperative's persistent inability to meet its budget would trigger a review of its activities and circumstances. Ultimately, the State would be held responsible by the National Board for any excess over the allocated State budget.

d. **Extension of budget limits outside HIPC.** The national budget limit will apply to total health care spending for all core services as well as most supplemental coverage for services usually considered as part of health insurance coverage. It will also extend to spending by firms that obtain coverage outside the HIPC (100 employees or more). Such limits on spending would be on a per-capita basis adjusted for the health status of the employee. The standard used to judge the appropriateness of the spending by large firms would be based on the per-capita premium the HIPC negotiated with its approved plans (adjusted for risk).

e. **Optional federal rate system.** The federal government would annually establish hospital and physician rates (perhaps based on current Medicare standards), with adjustments in the rates to reflect excessive increases in the overall volume of services delivered. States could choose whether or not to invoke these rates, across-the-board or selectively, in order to aid them in meeting their budgets.

This rate setting system, however, is intended as a fall-back system. We expect that most states would choose to meet global budgets through managed competition and control over *premium* increases rather than through *price* regulation. Capitation payments to health plans allow them full flexibility for innovation in allocating resources (e.g. between doctors and hospitals) without government interference. Even where a state has invoked price regulation, an insurance company or HMO would be able to choose whether or not to use the regulated rates or negotiate its own rates and reimbursement mechanisms with providers.

8. State Involvement

Flexibility

a. States have the option to reject the baseline managed competition/cost-control system and design options appropriate to their State as long as they assure the Board that they have a reasonable prospect to meet their budget targets and are subject to recapture of overspent federal funds.

b. States may develop alternative plans to provide universal coverage for all citizens so long as they meet federal criteria, i.e. no exclusions for pre-existing conditions, guaranteed insurability of all citizens, and community-rating of any premiums.

c. Even for those States that create a managed competition system, there could be specified conditions (e.g. rural areas, insufficient competing plans, etc.), which would require that the State operate the purchasing cooperatives differently. In these areas, the state, itself, could become the purchasing cooperative and create a single insurance plan or regulate provider prices.

Spending

d. The plan assumes that state spending will not grow faster than the growth in total health-care spending indicated in the national budget plus any additional Medicaid spending mandated in current law. States are, however, expected to save considerable funds because of the substitution of federal funds for all future medically needy recipients.

9. Medicaid and Medicare

a. By a defined date, Medicaid would become a residual program limited to non-covered services, the largest of which is long-term care. Medicaid beneficiaries would be entitled to private coverage through the purchasing cooperative. In operating the cooperatives special attention needs to be paid to providers that have traditionally served disadvantaged populations. Provider payments for Medicaid recipients would be gradually increased up to Medicare levels paid by federal funds.

b. Medicare would continue as a federal program with financial incentives for beneficiaries to join approved plans of the area-wide purchasing cooperatives. Prescription drug coverage would be added to the benefit package. Total spending under Medicare would be subject to inclusion in the national budget and subject to limitations imposed by the National Health Board, and approved by Congress. Spending limits would also apply to Medigap insurance policies.

10. Other Issues

In a subsequent decision memo (to be completed in early January), we will provide additional components of the plan which will focus on:

a. Assuring the availability of primary care, preventive services and the public health needs of the community
b. malpractice reform
c. provisions to improve the quality of medical care
d. changes in the training of health professionals
e. supply and distribution of new technologies and health resources
f. regulation of prescription drug prices
g. lifting of ERISA requirements
h. dealing with retiree health issues
i. a phase-in strategy, including measures to accelerate development of competitive markets

We also will provide a more detailed design for paying for long-term care services than discussed in the long-term care section of this briefing book.

ANALYSIS OF KEY COMPONENTS OF PLAN

The reform plan outlined above includes several components that are controversial but critical to meeting the goals of guaranteed coverage for all, restructuring of our health care system and making health care affordable.

1. Mandated Coverage

a. **Employer Mandate.** In order to create a system that protects all Americans, we require all employers to provide and help pay for a federally determined comprehensive health-care benefit package. While a strong majority of the general public supports such a mandate, this support breaks down if they are told that it could hurt small business.

The mandate will be fiercely opposed by small business, creating difficulties for passing this plan in Congress. However, the use of such an employer mandate is supported by many groups including national physician, nurses, and hospital

organizations. It is also supported by many large employers including the National Leadership Coalition for Health Care which includes several of the large unions and over 55 large companies. Such an approach, however, will be vigorously fought by small business groups, and some large employers which fear it would force them to provide a more expansive benefit package. Most corporations are not likely to take a stand either way.

For small employers our plan does include substantial subsidies for small low-wage firms, but only for premium costs that exceed 9 percent of their payroll for health-care coverage. While close to half of firms with fewer than 50 workers already provide coverage, it will be argued that forcing all firms to pay for such services will lead to a reduction in wages and/or less employment. While there are studies with widely varying conclusions on this issue, the most credible evidence indicates that such effects will be relatively modest. A similar program in Hawaii appears to have had relatively little negative effects and similar requirements exist in Germany, France and Japan, and have broad based public support.

b. **Individual Mandate.** To assure universality, individuals would be required to accept the employer-offered coverage and pay their premium share, and those working in small firms would be required to purchase coverage through the HIPC. If they were not employed, they would be required to obtain coverage through the HIPC where income-related subsidies would be provided. While this assures universality and such a provision will be supported by most health care interest groups, it could be attacked by those who oppose any governmental dictates on the behavior of individuals, e.g. mandatory seat-belt controversy. Depending on how the mandate is structured, constitutional issues may be raised as well.

2. Creation of Managed Competition Market

Managed competition will substantially reform the nation's health insurance industry particulary for small and medium sized firms and create a market system in which the health sector is accountable for efficiency, quality and consumer satisfaction. Purchasing cooperatives will cover at least half of the work force and 80-90% in some states. Substantial advantages would accrue particularly to small employers through reduced administrative costs. Most workers in such firms would also have expanded choice of health plans; community rating; guaranteed coverage; portability. There will be minimal need for government "micro-management" of the health sector.

Growing numbers of groups express at least public support for a "managed competition" strategy. But the proposed changes still face concern and controversy, and there are major tasks ahead to explain the proposals and allay legitimate concerns. Recent polling shows that large segments of the population are strongly averse to joining HMOs and fear that managed competition would restrict their choice of doctors. However, the polls

also showed support for a hybrid approach using managed competition and the guarantees of price controls.

One other major shortcoming of managed competition is that it will not work everywhere, especially in rural areas with small populations and limited numbers of providers providing no prospect for competition among plans.

Clear losers include health insurance agents and many of the 1500+ smaller insurance companies that lack ability to compete in reformed markets. Larger insurance companies, such as Prudential and CIGNA, support the concept because they are well positioned to offer integrated care plans in large numbers of areas throughout the US.

Provider groups strongly dislike insurers' efforts to control costs, particularly intrusions into clinical decisions. They are equally concerned about government fee controls. Employers with favorable deals through multi-employer arrangements that exclude high-expense populations will probably object. A move to "community rating" will involve significant premium increases for those individuals that work in firms with younger and healthier individuals.

The massive and rapid reforms called for by a managed competition strategy for this $800 billion industry face substantial public and private management challenges. Finally, the size of firms required to obtain coverage through the HIPC is controversial. Some plans, such as plans from the Congressional Conservative Democratic Forum (CDF) and John Garamendi, require that firms up to 1,000 employees be required to join the HIPC. Others who support a totally public system are indicating potential support for having all individuals regardless of firm size obtain coverage through the HIPC. Our plan limits the requirement to firms up to 100 employees. We established this cut off primarily because of political concerns that big business prefers to manage their negotiations on their own. Some also argue that leaving larger firms outside the HIPC will provide valuable experimentation that has produced innovation in health care delivery. Garamendi has in fact modified his initial proposal by reducing the firm size required to join from 10,000 to 1,000. Deciding on a final number will be a major issue in the political process.

3. Enforceable National Health Budget

Alongside managed competition, this plan requires all approved health care plans and insurance systems to function under enforceable total budgets. Budgets are applied at the community level but flow from approved national budgets established by a quasi-independent federal Board. This is both one of the most important features of our plan and its most controversial component.

Despite the public's strong support for price controls on doctors' fees and insurance premiums (even 74% of Republicans support it), when asked about a national budget they

fear it means rationing.

The managed competition groups are split over the advisability of global budgets. The CDF plan does not include such a feature (although they have broached the subject of "soft" targets). A global budget is included in the Garamendi plan in California. Many governors are concerned about such budgets if it forces the State to be responsible for enforcement and to be penalized if spending exceeds their allocation. However, the NGA recently indicated support for developing "goals" for growth of national health care expenditures. Insurance companies, while not opposed to the idea, do not want it applied to a cap on insurance premiums or capitation payments. (Many would favor controls on provider prices instead).

On the other hand, a national budget provides a guarantee that savings will be generated under managed competition. The major reason the Bipartisan Panel estimated that our plan would provide significantly more cost-savings than the Bush plan was because of the inclusion of an enforceable national global budget. Also the Congressional Budget Office will not "score" our plan with large savings unless we have such a feature. Global budgets will be vigorously attacked by the AMA; however, this method is supported by the American College of Physicians, the nurses association and the American Academy of Family Physicians.

4. Limitations on Tax Savings

The federal tax code now excludes employers' health insurance premium contributions from the taxable income of their employees; it also allows such contributions to be fully deductible as employer business expenses. Our plan thus far does not include any changes in these tax preferences. There are, however, strong arguments for changing these tax policies which include the $65+ billion of revenue loss from the employee exclusion; the effects of these open-ended, rapidly rising public subsidies in fueling inflation; inequities which channel these subsidies predominantly toward higher income persons, while 35 million persons have no coverage. Proponents of "managed competition" and conservatives usually argue that capping these subsidies, at the cost of an economically provided standard benefit plan, is critical for a market-oriented strategy. The Conservative Democratic Forum (CDF) bill tries to skirt opposition to increasing employee taxes by limiting only the deductibility of employer business expenses and requiring "equal contribution" rules so that employers do not continue their frequent practice of making higher premium contributions for fee-for-service plans than for HMOs and other more economic plans.

We have not included any tax policy changes in your draft proposal because: some could perceive it to be contrary to your campaign pledges of no new taxes on the middle class; it would be vigorously opposed by labor groups; and the price-restraining effects of the tax treatment are likely to be modest, particularly in the short run. Ultimately, this tax policy change may be a "deal maker" in a final compromise, with labor unions willing to

accept limits if guarantees of universal coverage and cost control are in place.

5. Comparison to Other Managed Competition Plans

A number of "managed competition" advocates, e.g. Conservative Democratic Forum (CDF), Jackson Hole Group, John Garamendi, *The New York Times*, have different variants on the campaign plan. They are urging campaign plan modifications toward their versions. There are some fundamental differences in coverage -- the CDF plan, for example, does not include an employer mandate and fails to achieve universal coverage. In cost containment, the "pure" managed competition theories differ in three respects from the campaign plan:

1) No global budget Pure market theorists (such as CDF, Jackson Hole and Professor Alain Enthoven) believe that, if market reforms assure that consumers are well-informed, cost-conscious, and able to exercise effective choice, there is no legitimate basis for government limiting the medical care that individuals can purchase from their own after-tax incomes and what providers can offer.

2) No reliance on premium or rate regulation Market theorists recognize only a limited, specific role for rate regulation, e.g. rate-setting for monopoly providers. They oppose price controls as a general tool to address cost-increases that are symptoms of other problems, e.g. self-dealing providers, lack of consumer information, risk-skimming by insurers. They also view limiting insurer premiums below rates achievable through a competitive market as a tool that may require more of insurers than they can reasonably deliver without compromising their enrollees' welfare and/or risking bankruptcy.

3) Limiting tax deductibility to the lowest price standard plan available in a community For most market reform advocates, the open-ended tax subsidies for health insurance are the primary Federal policy fueling runaway inflation and cost-insulated market behavior. As well, they recognize little policy justification for requiring that employers, individuals, and taxpayers pay more than the cost of an economically-provided standard plan.

6. Federal/state fiscal responsibilities

The draft proposal assumes that states will maintain their current spending levels for Medicaid acute care services, inflated annually by increases in the national budget. This approach would reward states that have had restrictive Medicaid eligibility or low provider payment rates. It is not clear that such an approach is politically feasible.

Furthermore, governors feel that current burdens are too high. Although reform will provide significant relief (by controlling costs and expanding access), additional adjustments may be worth considering. For example, states question the appropriateness of mandates requiring them to pay Medicare premiums and cost-sharing for low income seniors. Obviously, changing this policy would increase federal costs.

Long-term Care

Investment Options

Revenue Options

HEALTH

Long Term Care and Personal Assistance Services

From Putting People First: "Expand Medicare for elderly and disabled Americans to include more long term care; place special emphasis on home- and community-based care; and make funding flexible so that those who need care can decide what serves them best." . A commitment was also made on expanding personal care services to persons with disabilities. One of the major challenges in the long term care area is how to meet needs for millions of disabled persons who require expensive services in the most cost effective manner. Without a strong commitment to at least begin the process, many politically powerful groups will object strongly to any overall health reform package.

Presented below are three options based on varying resource commitments. Each of these options recognizes the need to address the problem gradually and to limit spending in the first several years. But there is also a need to reassure Americans that long term care is not forgotten. The first option offers regulatory changes that pave the way for later reforms. Option 2 represents a more expensive approach that adds limited benefits using either the Medicare or Medicaid program. This option could serve as a first step toward the creation of either a public insurance model or a program with a limited public portion and a strong private insurance role. Option 3 would provide a comprehensive program through Medicare, but beginning only in 1996.

OPTIONS - LONG TERM CARE INVESTMENT

Option 1 - Low Cost - Regulatory changes only

Scenario:
> Reform private long term care insurance by establishing minimum standards for coverage of services (such as requirements for inflation protection and years of protection), defining terms so that consumers can compare policies, and prohibiting certain deceptive marketing practices.
> Allow home and community based services to be a Medicaid option and change the Medicaid regulations regarding these services that require nursing home bed reductions;
> Implement and enforce nursing home quality regulations delayed by OMB.
> Improve coordination of long term care, housing and related programs to ensure that we make the most effective use of existing funds.
> Ensure that care of a disabled relative is part of any family leave legislation.

	94	95	96	97	98
Costs of coverage	.1	.1	.1	.2	.2
Net deficit ($ billion)	.1	.1	.1	.2	.2

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

Political Analysis

Advantages:
These options could yield some improvements in long term care while recognizing that efforts to reform other parts of the health care system take first priority. If combined with serious promises to revisit the issue later, perhaps with a task force charged with developing a blueprint for reform, consumer interest groups such as AARP, the Alzheimers Foundation, and younger disabilities groups might be willing to wait for a year or two. (Such a task force could build on the campaign process--which we are beginnning to implement through our transition advisory groups--to create a task force on "personal assistance.") The insurance reform, in particular, could yield important benefits for consumers. While members of Congress will publicly decry this approach, privately most will not push for substantially more because of the significant costs associated with the creation of a long-term care program.

Disadvantages:
There are many who would like to see a more aggressive approach on the issue of long term care immediately. They will be skeptical of an approach that does not put any new money into the system and will argue that this is breaking a campaign pledge. If the important interest groups representing the elderly and persons with disabilities are not satisfied, they may hold health care reform hostage. Finally, insurance reform may not be politically possible without changing tax rules to provide long-term care insurance with the same preferential tax treatment that health insurance now receives--a measure that could substantially raise the costs of this option.

Option 2 - Moderate Cost Option - Expanded coverage with eligibility and service limits

Scenario: > Phase in limited coverage of long term care. Limitations could be achieved either by limiting eligibility based on income or by limiting services covered (or both). Specifically:

> Improve Medicaid by easing eligibility requirements, expanding coverage of home and community based care, increasing personal needs allowance using federal funds; OR
> Improve Medicare by expanding eligibility to some disabled persons under age 65 who are not now covered and by improving Skilled Nursing Facility Benefit, expanding hospice services , modestly expanding home health services, and adding a new respite benefit.

	94	95	96	97	98
Costs of coverage	5	10	14	17	20
Net deficit ($ billion)	5	10	14	17	20
(Revenue options below)					

A number of variations on this option are possible, allowing for fexibility that could pave the way (and buy some time) for the development of a broader social insurance system or a system that fills in some gaps but leaves a substantial role for the development of private insurance. Such flexibility would also include lowering the first 5 year costs of the option by phasing it in more slowly. Ultimately, however, the costs of this option will be significant. It is difficult to create a "moderate" option in long term care without committing substantial federal funds.

The variations can be divided into two very different possible approaches, with different philosophies and consequences.

Medicaid Option. The first type of approach would effectively expand Medicaid. The focus would thus be on the population with the lowest resources. Medicaid could be improved substantially, but it would remain a targeted welfare-based program. Specific changes would:

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

Increase personal needs allowance for nursing home residents;

Make spousal income protection requirements (which provide income protection for the non-institutionalized spouse) more generous, increasing protected income to twice the poverty level;

Ease the asset limits for nursing home eligibility for single persons, raising them substantially from their current poverty levels of about $2000 (while tightening current loopholes that permit asset transfers);

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

These benefits would largely help those with low and moderate incomes. To help ensure more protection for those with higher income and assets, there could be additional efforts to improve long-term care insurance--by developing standards (as in Option 1) and "clarifying" (that is, extending health insurance-based preferences to) the tax treatment of

long term care insurance. The full costs of this tax change are unknown.

Medicare Option. The second alternative would make changes in the Medicare program. This general approach would not limit participation based on income. To keep such an expansion to the same range of costs, the types of benefits offered would therefore need to be restricted. Under current law, disabled persons under age 65 must wait about two years to become eligible for Medicare, even while receiving Social Security Disability benefits. For this population as well as for the elderly, Medicare services can be expanded by changing the rules governing the existing Medicare skilled nursing facility (SNF) and home health benefits and by adding respite services. Medicare now finances only 2-3 percent of total nursing home expenditures and its home health benefit is also quite limited. Not only are benefits limited to persons who need skilled nursing or rehabilitative care; other restrictions mean that benefits are provided for only a limited period of time. With the exception of hospice services, Medicare does not currently provide "long-term care" services such as personal care for the disabled or respite care for family or friends who provide the bulk of such services for the disabled.

Medicare changes that would be implemented under this option include:

The two-year waiting period for disabled recipients of Social Security benefits could be eliminated for these services.

The copayment amount for Medicare SNF services can be set at 20% of the cost of care, and the maximum number of days of coverage can be extended from 100 to 150 days.

The "intermittent" rule for home health care could be eliminated, allowing home health services to be provided consecutively as long as needed (consistent with recipient's continued need for skilled services, as well); a copayment of 20% could be instituted to help control the costs of this expansion.

A respite care benefit (limited home care or nursing home services) can be established to alleviate the burden on informal (mostly family) caregivers.

Hospice services could be expanded.

Political Analysis

Advantages:

The level of spending under this option is about as low as one can go and still be considered meaningful. Whether to go with a Medicare or Medicaid approach creates separate pros and cons.

Changing Medicaid is perhaps the least costly way to address the problem of long

term care in any meaningful way. It is a targeted approach and the "new" Medicaid program that would emerge would be much improved over the system. One of the popular features would be an easing of the assets requirement, an extension of a well-received part of the Medicare Catastrophic Act of 1988. This approach retains an important role for states who have developed many creative programs. Improvements in Medicaid could also be phased in slowly, beginning with improvements in home care and some expansion of eligibility, for example. Since it is not an open-ended entitlement for all the disabled (limited, as it is, based on income and assets), its expansion can be more carefully controlled over time than social insurance options. This approach would leave an important role for private insurance for those who can afford it.

Relying on the Medicare alternative offers the political advanatage of reliance on a universal, non-welfare-oriented program. However, these benefits would be targeted to persons who need skilled nursing and rehabilitative care, rather than long-term supportive services. Nevertheless, they would fill gaps in short-term post-hospital care, which--while not the same as long-term personal care--are nevertheless burdensome. Expansions of respite and hospice care do meet some of these traditional long term care needs, albeit in a limited fashion.

Disadvantages:
Even after spending substantial sums on long term care under this option, problems will remain. Again, the specific disadvantages depend upon which general approach is chosen.

The Medicaid option remains a welfare-based approach and no amount of tinkering will satisfy many groups who are firmly committed to social insurance. This includes all the big interest groups pressing for long term care expansion. It also is counter to the campaign pledge of expanding Medicare. Even if the name changes and some major disadvantages of Medicaid are addressed over time, it will still be identified with a very unpopular program.

Despite its value in alleviating burdens on individuals and their caregivers, Medicare improvements in services to persons needing skilled care will, at best, be seen only as a move toward, rather than an expansion of, "long-term care." Finally, the political pressure that led to repeal of the Catastropic Coverage Act--which included similar benefit changes--may make Congress shy about revisiting nursing home and home health benefits.

Option 3 - High Cost Option - Limited Social Insurance

Scenario:
> Universal coverage of unskilled home care;
> 6 months up-front coverage for nursing homes for everyone;
> Income-related benefits thereafter, but more generous than those now offered by Medicaid. Spousal protections would be better and asset requirements would be substantially eased (to $30,000 for individuals; $60,000 for couples).
> When fully phased in, the annual costs could exceed $60 billion.

	94	95	96	97	98
Costs of coverage	0	0	14	20	30
Net deficit ($ billion)	0	0	14	20	30
(Revenue options below)					

Any option that provides comprehensive long term care for all ages will, by necessity, be quite expensive. The approach presented here (floated by Congressional Leadership earlier this year) includes social insurance for home care and short nursing home stays and a floor of asset protection for long nursing home stays.

Political Analysis

Advantages:
Many of the groups interested in improving long term care coverage--both in the aging and disability communities--favor this type of approach and believe that the campaign promise was for social insurance. A social insurance approach is likely to be popular with the American public as well. Further, by providing a more generous benefit for home care, this option would lead to changes in the system that most analysts and observers of long term care feel are important. By limiting the coverage for persons in nursing homes, it also meets the objections of those who argue that full nursing home coverage merely protects the assets going to the heirs. At the same time, it promises to protect the "life savings" of the middle class. Individuals who are likely to be discharged back to the community are likely to stay less than 6 months in the nursing home--and they would be fully protected by this program. At least in theory, many Americans express a willingness to pay taxes to help finance such an option.

Disadvantages:
This is a very expensive option and critics fear these numbers would rapidly rise. Nonetheless, many of the advocates of social insurance will criticize it as too little since it has some income-tested aspects. They will be satisfied only with full coverage of nursing homes and home and community based care for everyone. (A full social insurance approach would cost closer to $80 billion in 2000 when fully phased in.) On the other side will be critics of offering yet another generous benefit that helps mostly older Americans who already receive a disproportionate share of federal government spending. Members of Congress are very reluctant to support such an expensive bill, even if they publicly pay lip service to it.

HEALTH

Long Term Care

OPTIONS FOR LONG TERM CARE REVENUES

As indicated in the campaign, if a moderate or high cost approach is chosen, new financing would be necessary. The type of financing that makes the most sense is likely to be related to how the benefit is structured. A social insurance approach will particularly help those with higher incomes and assets among the disabled, so progressive financing is particularly important. If benefits are more strongly targeted to those with low and moderate incomes, other less progressive types of financing are reasonable.

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

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

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

There are strong justifications for at least partially financing long term care by cutting back Social Security or Medicare programs for the elderly and disabled. For example, higher premiums under Medicare, taxing the value of Medicare benefits or more of Social Security are likely ways to expand long term care coverage, while holding the line on overall benefits to the elderly and disabled. In fact, the eledrly can be expected to strongly resist changes lie these unless accompanied by some long-term care initiative.

Since older Americans in particular are likely to be windfall gainers from a major expansion in long term care offerings, using some financing mechanism that taps that group explicitly is likely to be important. Lifting the earnings limit on either the Social Security or

Medicare tax base is another source of financing with an obvious link to the benefits. It could be used in conjunction with taxes that require the elderly to contribute since most of the revenues from this source will come from workers under the age of 65.

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

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

Public Health

AIDS

Women's Health

Miscellaneous

HEALTH POLICY

AIDS, Women's Health, and Public Health Initiatives

Overview

The Clinton/Gore campaign laid out a number of initiatives in AIDS, women's health, and public health. AIDS initiatives included expansion in biomedical research, public education and community outreach, and improvements in funding for treatment services. Women's health initiatives included research on breast cancer, ovarian cancer, and osteoporosis, as well as services for mammography, family planning, and the prevention of domestic violence. Public health initiatives included child health (including immunizations and school-based clinics, community health centers, treatment for drug abuse, and biomedical research). In addition to these initiatives, we have proposed needed actions on tuberculosis, lead poisoning, and the infrastructure of public health systems (such as the FDA, basic disease control, and environmental health).

HEALTH
Public Health
AIDS

In Putting People First, a number of commitments were made regarding AIDS research, prevention, treatment, civil rights, and policy issues.

This memo lays out three general packages of options for responding to these commitments:

(1) one involving no new spending, a package which is made up largely of organizational issues and regulatory policy changes;

(2) one involving modest spending on research, prevention, and treatment, which would allow the funding of research at the levels identified by NIH for FY 93; incremental prevention initiatives, and funding of the Ryan White program at its originally authorized levels; and

(3) one involving full funding that would initiate a new prevention program, enlarge the Ryan White program to reach new geographic areas, and increase optional Medicaid coverage for persons who require early treatment to remain healthy.

Each of these packages includes a number of specific initiatives, many of them quite visible and subject to media attention. Programs have been organized by potential cost for the purposes of this memo, although it would be possible (and politically prudent) to "mix and match" some of these actions.

A discussion of the possible models for an AIDS Czar will be presented in a separate memo.

Option Type 1. No New Spending

Proposal:

Research: Without an increase in funds, priority setting and strategic planning at the NIH would ensure that the most needed research is done with the dollars available. Since HIV crosses so many research lines, it is important to have central coordination and planning, while still allowing the various institutes the research that each does best. A strengthened Office of AIDS Research, headed by someone other than an institute director, can create a research plan to be implemented through authority for budget preparation and disbursal of funds. This would effectively be an "AIDS Institute Without Walls."

Prevention: Lift Federal restrictions on AIDS education materials (regarding drugs, needles, sex and condoms) and allow community control of the design and implementation of such materials. Review and reorganize CDC funding to emphasize prevention and behavior change, as well as the evaluation of program effectiveness.

Treatment: (1) Amend Federal private self-insurance law (ERISA) to prevent employers from retroactively limiting services; (2) ensure that treatment programs (Ryan White, Maternal and Child Health, etc.) include women, racial and ethnic minorities, and children as appropriate, (3) direct FDA to ensure new manufacturer-user-fee revenues to speed AIDS drug actions, (4) direct CDC grantees for HIV counseling and testing to refer HIV+ persons to treatment sites, and (5) establish AIDS offices at HUD and the Substance Abuse and Mental Health Administration.

Civil Rights: (1) Lift HIV+ immigration ban, (2) parole into the country HIV+ refugees from Guantanamo, (3) eliminate unneeded HIV testing programs in Federal agencies (e.g., Peace Corps), (4) direct Justice and agency civil rights offices to enforce discrimination laws applicable to HIV, and (5) ensure that justice system and penal system workers receive AIDS education.

Cost:

94	95	96	97	98
-0-	-0-	-0-	-0-	-0-

Benefits: Specific benefits apply to each activity, but overall these actions will be very potent symbols that the Clinton-Gore Administration is confronting AIDS in a very different manner than did Reagan and Bush.

Political feasibility: All actions except the ERISA amendment could be undertaken by executive order or other administrative action; the ERISA amendment would require legislation.

A large number of bills regarding AIDS issues have been introduced in the Congress. In general, most Members of Congress defer to the health judgment of health professionals, although questions of explicit education materials and immigration are potentially volatile.

The amendment to the ERISA programmight best be dealt with in the context of health insurance reform--as long as reform moves quickly..

AIDS groups will be very pleased at these actions. If these actions are not followed up with funding increases described in Options 2 and 3, however, these groups will feel that the Clinton-Gore Administration has not lived up to its campaign commitments.

For the most part, AIDS issues are within the jurisdiction of the Health and Environment Subcommittee (Waxman) and the Labor Committee (Kennedy). The ERISA provisions are within the jurisdiction of the Education and Labor Committee (Ford) and the Labor Committee (Kennedy).

Option Type 2. Initiative at Modest Funding

Proposal:

Research: Propose appropriations to increase of funding for NIH of $400 million. This would allow the funding of the research opportunities described by the NIH in its budget for FY 93. (That budget was amended by the OMB and never submitted to the Congress.) In addition, create a discretionary fund and propose appropriations of $100 million to be used outside government procurement rules to allow the NIH Director of AIDS Research to make immediate responses to new opportunities or new crises. **These two budgets increases--plus Option 1 consolidated planning--equal a Manhattan Project.**

Prevention: Propose an increase of appropriations to CDC to restore Minority AIDS Prevention programs, to restore prevention funds cut from States, and to provide for a significantly expanded prevention effort, including locally planned and delivered programs targeting high-risk populations (women, minorities, hemophiliacs, and youth, etc.), the use of street outreach workers, and media campaigns to make condom use socially and individually acceptable.

Treatment: Propose an increase in appropriations to fully fund Ryan White treatment programs at their originally authorized levels. In addition, direct that Social Security disability regulations be issued in final form to recognize the disabling AIDS conditions of women and children, and thus to allow them entry into Medicaid.

Cost: (in millions)

94	95	96	97	98
1,400	1,680	2,020	2,420	2,900

Benefits: Research efforts on AIDS produce not only progress toward keeping people with AIDS alive and healthier longer but also additional findings in basic immunology, cancer, and related illnesses. Effective prevention programs will reduce infections and, therefore, overall illness and medical costs. Treatment programs provide alternatives to expensive hospitalization and, for many, the only source of life-prolonging prescription drugs.

Political feasibility: No new legislative authority is needed for the research changes described. Increases in funding could be made by appropriations requests alone. The NIH reauthorization bill (vetoed last year over fetal tissue transplantation and women's health provisions) will be considered very early in this session; Congress may make authorizing changes of its own in that bill.

No new authorizing legislation is needed to carry out the research initiatives described. Increases in funding could be made through appropriations legislation alone. Legislation to authorize prevention programs may be proposed in Congress this year, and such legislation could be a magnet for controversial amendments.

The Ryan White program is fully authorized through FY 95. Increases in funding could be made by appropriations requests alone. New Social Security regulations on disability and AIDS have been issued in proposed form and were immediately greeted with serious criticism as being inadequate; final regulations are now being considered by the Social Security Administration. Legislation on the Social Security issue has been proposed by Matsui and reported by a subcommittee on Ways and Means, but has proceeded no further.

AIDS groups will be very pleased if the actions described in Option 1 and these additional actions are accomplished.

Unless the research increases are complemented by increases in the general NIH program, there may be criticism from other disease groups and biomedical research groups that AIDS research is growing faster than other NIH research. (See Biomedical Research Options paper, below.)

Appropriations requests on these issues will be considered by subcommittees chaired by Natcher and Harkin.

Option Type 3. Initiative at Full Funding

Proposal:

Research: Additional work on basic science surrounding AIDS is integral to the entire NIH budget. In addition to proposing funding to increase AIDS research (as described in Option 2) propose increased funding described in the Options Paper on Biomedical Research (see below), should also be begun.

Prevention: Propose appropriations to create a comprehensive prevention effort to include local school programming; outreach to racial and ethnic minorities, women, youth, and drug users; assistance to States; and assistance to community-based groups.

Treatment: (1) Propose appropriations to fund Ryan White programs at levels beyond the original authorization to recognize the increasing caseload, (2) propose legislation to amend Medicaid to allow States the option to provide immune-compromised poor people access to outpatient care and prescription drugs, and (3) issue directive to Social Security Administration to issue regulations in final form making poor people with HIV and severely compromised immune systems presumptively eligible for disability assistance and, thus, Medicaid.

Cost:

94	95	96	97	98
1,900	2,280	2,740	3,280	3,940

Benefits: Same as Option 2. The optional Medicaid eligibility would make a very significant difference to poor people with HIV, who now must wait until they are totally disabled before receiving Medicaid assistance to buy drugs that might have prevented their disability.

Political feasibility: Same as in Option 2. In addition, the Medicaid provision, as an option, was considered favorably by some governors in 1990, although the NGA never took a formal stance.

If these initiatives were accomplished, AIDS groups would consider that the Clinton-Gore Administration had more than met its campaign commitments.

Option Type 4. Design Option

1) A number of other health proposals will also have significant impact on AIDS and are supported by AIDS groups. For analysis of these proposals see Options Papers on Drug Treatment, Community Health Centers, Biomedical Research, Tuberculosis, and Public Health Infrastructure.

2) Some of the costs of the options outlined in this Options Paper may be offset by implementation of the Clinton health reform plan. Other costs of these proposals will remain even under a full insurance plan.

HEALTH

Public Health

Women's Health: Research and Services

From Putting People First:
"Sign into law . . . legislative measures designed to address current deficiencies in the treatment of women's health problems. Use whatever means are available to find cures for diseases like ovarian cancer, breast cancer, and osteoporosis."

Women's health has been shortchanged in both research and services. Three options for remedying this neglect are possible:

(1) one involving no new spending, a package which is made up largely of organizational issues and internal policy changes;

(2) one involving modest spending on research, prevention, and services; and

(3) one involving full funding that would initiate the same actions as in Option 2, but at higher initial spending rates.

Each of these packages includes a number of specific initiatives, many of them subject to media attention. Programs have been organized by potential cost for the purposes of this memo, although it would be possible (and politically prudent) to "mix and match" some of these actions.

Option Type 1. No New Spending

Proposal:

Research: (1) Propose legislation both requiring the inclusion of women in clinical trials and requiring appropriate gender analysis of trial results in research conducted by or through NIH on diseases or conditions that affect both sexes; (2) direct that FDA institute similar requirements for pharmaceutical companies seeking FDA drug approval; and (3) direct that research on breast cancer at the Defense Department (newly initiated this year with a sizable appropriation) be coordinated with ongoing efforts at the NIH.

Services: (1) "Acquiesce" (i.e., agree not to contest, thus effectively binding other Federal circuit courts) to the ruling in the 2nd Circuit in *Grinker V. Lewis*, which requires Medicaid coverage of pregnant women regardless of their immigration documentation status; (2) direct States to comply with newly enacted provisions of the Drug Abuse Block Grant Program that require a 5% set-aside for drug-abusing pregnant women; and (3) direct the NIH Office of Women's Health Research to carry out appropriations requirements to develop a model curriculum on women's health for possible use by the Nation's medical schools.

Organizational Issues: (1) Propose legislation making the NIH Office of Research on Women's Health permanent and (2) require that women be adequately represented on all NIH and FDA advisory panels.

Cost:

94	95	96	97	98
-0-	-0-	-0-	-0-	-0-

Benefits: Specific benefits would be obtained from each activity, but overall these actions will be very strong and visible symbols that the Clinton-Gore Administration is addressing women's health.

Political feasibility: While all of these measures could be accomplished administratively, many advocates for women's issues would argue that the inclusion of women in clinical trials at NIH and the codification of the Office of Research on Women's Health should be made as a permanent change in law.

Recent legislation containing these provisions was vetoed (over these issues and issues of fetal tissue transplantation). Similar legislation will be proposed early in the next session.

Women's groups will be very supportive of these proposals, and, in light of campaign commitments to support such provisions in the NIH legislation, expect that these proposals will be adopted by the Clinton-Gore Administration.

Groups representing biomedical researchers have concerns about the specifics of such proposals, but would not actively oppose them. The current NIH Director (Dr. Healy) opposed many of these measures and lobbied the Congress against their enactment.

Legislation regarding these issues would be referred to the House Commerce Committee (Waxman/Dingell) and Senate Labor Committee (Kennedy).

Option Type 2. Initiative at Modest Funding

Proposal:
Research: (1) Propose legislation to authorize and appropriate funds for support of specific research programs on women's illnesses and needs, including research on breast cancer, reproductive cancers (ovarian, cervical, and uterine), osteoporosis, contraception and infertility, and other diseases affecting women disproportionately (e.g., multiple sclerosis, mental illness, lupus, etc.); and (2) propose legislation to authorize and appropriate funds for support of an expansion of the CDC injury control and violence epidemiology programs to include research on domestic violence.

Services: (1) Increase funding for the CDC breast and cervical cancer program (which provides screening services to low-income women) to allow more States to participate in the program; (2) expedite FDA implementation of the 1992 Mammography Standards Act, which establishes requirements for all mammography (both public and private); and (3) provide funding for the newly authorized CDC program to control chlamydia and other sexually transmitted diseases that can cause infertility in women.

Organizational Issues: Require the Office on Women's Health (within the Office of the Assistant Secretary for Health) to track Federal activities relating to women's health and to collect and analyze relevant data concerning such efforts.

Cost: (in millions)

94	95	96	97	98
460	500	530	570	610

Benefits: See Option 1.

Political feasibility: Women's groups will be very supportive of these proposals, and, in light of campaign commitments to support such provisions in the NIH legislation, expect that these proposals will be adopted by the Clinton-Gore Administration.

Because of the size of recent increases in some areas of women's health research, there may be concern that the field cannot absorb an additional infusion of funds quickly while maintaining the quality of such research. Concerns may also arise from researchers that directed research is micromanagement of the NIH. Nonetheless, none of these provisions is expected to be controversial.

Option Type 3. Initiative at Full Funding

Proposal: Same as Option 2, but with higher initial funding.

Cost: (in millions)

94	95	96	97	98
680	735	785	840	900

Benefits: Same as Option 2, but an active demonstration of commitment to these issues, beyond that proposed in the Congress last year.

Political feasibility: Same as Option 2. The advocates on behalf of breast cancer research (who are quite active) will press for this increased support.

Option Type 4. Design Option

1. The Defense Department appropriation for FY 93 includes a large sum (more than $200 million) for breast cancer research. The DOD has almost no experience in such work, and while women's health groups have been generally pleased at the initial planning of such work, there remain concerns about DOD's program. The Institute of Medicine (IOM) has recently contracted with DOD to help plan the expenditure of these funds in a useful way. Consideration should be given to allowing DOD extra time for the obligation of these funds, if the IOM recommends such a course.

2. In many ways, AIDS and HIV have recently become serious issues of women's health. Those issues are not dealt with in this Options Memo because they are discussed in the Options Memo on AIDS. Any statements about general women's health issues, however, should include AIDS and HIV.

3. Issues related to family planning, abortion, and other aspects of reproductive health are addressed in another Options Memo specifically on Reproductive Health.

4. Some of the costs of the options outlined in this Options Paper may be offset by implementation of the Clinton health reform plan. Other costs of these proposals will remain even under a full insurance plan.

HEALTH

Public Health

Women's Health: Reproductive Health

From Putting People First:
"Reduce the need for abortion by urging Congress to reauthorize the Title Ten Family Planning Program; by prioritizing research and development at NIH of safe, effective contraception; by providing improved family planing services and education programs; and by ensuring the availability of contraceptives to low-income women... Repeal President Bush's 'gag' rule.... Sign into law the Freedom of Choice Act.... Urge Congress to repeal the Hyde amendment, which prohibits federally funded abortions even for rape and incest.... Support testing of RU-486...."

Reproductive health has been held hostage by political debates over abortion. The Clinton-Gore Administration has the opportunity to make great progress, both in reducing the need for abortion and in ensuring a woman's right to choose abortion and her access to abortion services.

Option Type 1. No New Spending
Proposal:
Reducing the Need for Abortion: (1) Propose legislation to change the name of the National Institute on Child Health and Human Development to include the term "reproductive health" (e.g., the National Institute on Reproductive Health, Child Health, and Human Development); and (2) reinstate the Family Planning Program's data collection efforts which once were used to evaluate the Nation's unmet family planning needs and the Program's effectiveness in meeting those needs.

Abortion: (1) Lift all Federal restrictions concerning abortion and abortion-related services, including the Gag Rule, the FDA import ban on RU-486, and the "Mexico City" restrictions on international family planning programs; (2) propose legislation to allow coverage for abortion services under all Federal programs, including the Federal Employees Health Benefits Program, CHAMPUS, DOD insurance plans, etc., as well as to allow abortion services to be provided with local revenues in the District of Columbia (or, in the alternative, oppose re-enactment of restrictive amendments to annual appropriations bills); (3) support enactment of the Freedom of Choice Act without amendments; and (4) withdraw government support, (given in the Bush Justice Department brief filed in *Bray v. Alexandria Women's Health Clinic,* for the anti-abortion argument that Federal law permits the blockading of abortion clinics.

Cost:

94	95	96	97	98
-0-	-0-	-0-	-0-	-0-

Benefits: There are specific benefits that are obtained by each of these initiatives, but overall these actions will represent a reversal of the Federal government's position on contraception and abortion over the past twelve years.

The name change at NIH would be a significant step in recognizing the importance of reproductive health, after years of neglect and open hostility toward the field.

Political feasibility:

The renaming of the NIH institute would require legislative action. NIH legislation will be considered early in the next year. Resuming the CDC data collection could be accomplished by administrative action.

The Family Planning Gag Rule, the FDA import alert on RU 486, and the Mexico City restrictions are all administratively imposed actions that can be reversed administratively.

Prohibition of coverage of abortion services for Federal employees and in the District of Columbia has been imposed by amendments to annual appropriations bills. The reversal of these policies will require fighting such amendments each year.

The Freedom of Choice Act will require legislation. The reversal of the *Bray* position could be accomplished administratively.

There have been a multitude of bills introduced regarding reproductive health and abortion services, both pro and con. These issues remain very controversial in both the House and the Senate.

The enumerated initiatives will be widely supported by abortion rights, family planning, and women's groups; in fact, these groups expect the Clinton-Gore Administration to address these issues early in the Administration, perhaps on January 21 (the day before the 20th anniversary of the *Roe v. Wade* decision). These initiatives will be widely opposed by anti-abortion groups.

These initiatives are within the jurisdiction of a number of different committees.

Option Type 2. Initiative at Modest Funding

Proposal:

Reducing the Need for Abortion: (1) Propose enactment of legislation to reauthorize and provide appropriations for the Federal family planning program (Title Ten); (2) propose enactment of legislation to establish contraception and infertility research centers at NIH and to provide appropriations for these centers; and (3) propose enactment of legislation to establish an initiative to assist in adoption and support appropriations for this purpose.

Abortion: (1) Ensure that the NIH performs research on abortifacient drugs (e.g., RU 486); and (2) propose enactment of legislation to require State Medicaid plans to provide for abortion services.

Cost: (in millions)

94	95	96	97	98
240	260	280	295	315

Benefits: Family planning clinics reduce the number of unwanted pregnancies, lower infant mortality rates and provide basic preventive health services to many women who otherwise might not have access to them. Contraception and infertility research may provide safer and more effective reproductive health interventions. Adoption services are widely criticized as expensive, unfair, and inefficient; a well-designed, Federally supported program might provide models to address these issues..

Abortifacient drugs are a potential means of making abortions safer in the U.S.; failure to conduct research on these drugs is a statement in favor of unsafe abortions.

Political feasibility: While some of these activities can continue with administrative action, family planning, pro-choice, and women's health advocates all want them established in permanent law, not subject to future administrative action.

Legislation to address the reauthorization of the Family Planning program (and to reverse the Gag Rule) was vetoed during the previous Congress. Such legislation will be considered early in the next session.

Family planning, pro-choice, and women's health groups will support these initiatives. Anti-abortion and conservative groups will oppose.

All legislation on these topics is subject to very controversial amendments in both the House and Senate. Care should be taken to draft legislation as precisely as possible to ensure that these amendments are avoided or not in order. Of particular importance is the question of what abortions will provided with Federal funds: Limitations have frequently been imposed, limiting abortion services to cases of rape, incest, or medical necessity. Pro-choice groups will oppose all such limitations.

Inclusion of an adoption initiative may deflect some controversy over abortion, allowing the Clinton-Gore Administration to demonstrate that it has a genuine commitment to finding alternatives to abortion.

Legislation on these topics is considered by the House Commerce Committee (Waxman/Dingell) and either the Senate Finance Committee (Moynihan) (for Medicaid) or the Senate Labor Committee (Kennedy). Appropriations amendments on these topics are also common.

Option Type 3. Initiative at Full Funding

Proposal:
Reducing the Need for Abortion: Pursue the issues outline in Option 2, but provide greater initial resources to allow family planning programs not just to expand clinic activities but to establish new ones and to allow the adoption initiative to reach more States.

Abortion: Same as Option 2.

Cost: (in millions)

94	95	96	97	98
300	325	345	370	400

Benefits: Same as Option 2, but with wider geographic reach for family planning and adoption services.

Political feasibility: Same as Option 2. The incremental increase in funding probably adds no additional controversy to the proposal; once abortion amendments are debated there is little discussion about funding for family planning and adoption.

Option Type 4. Design Option

1) Under any scenario, family planning, abortion rights, and women's health groups all expect that reproductive health services will be included in the Clinton-Gore health reform plan. Any move to restrict access to these services in that plan will be vigorously opposed by these groups.

2) During the consideration of the family planning legislation during the last Congress, amendments were raised regarding the notification of parents of minors seeking abortion services with private funds at government-funded family planning clinics. These amendments were satisfactorily resolved in the Family Planning bill vetoed by Bush by the adoption of a "States-rights" provision, allowing applicable State law to determine the requirements on clinics. This amendment is expected to be considered again as part of the family planning reauthorization this year. Similar amendments may be raised to the Freedom of Choice Act, although advocacy groups are not so unified in their support of the amendment on this vehicle.

3) There remains a question of the application of the Hyde amendment (restricting the use of Federal funds to provide abortion services) to NIH funds used to research abortifacient drugs. While the Hyde language has been traditionally read to limit abortion services, the applicability of the amendment to research is unclear.

4) For an analysis of program options regarding teen pregnancy, see the Options Paper on Child Health.

HEALTH
Public Health
Child Health

In Putting People First and in various speeches, the Clinton-Gore campaign laid out a number of proposals to improve child health in the U.S., including a program of school-based clinics, improved childhood immunization efforts, and general efforts to address teen pregnancy and child health.

These issues can be addressed through a package of child health initiatives that include school-based clinics, grants to cities and States for immunizations, a demonstration program in dealing with teen pregnancy, a child health program linked with Head Start sites, and lead-poisoning control programs to screen children and eliminate lead from their surroundings. There are two possible options for beginning this package, representing a question of the size of funding and the speed of phasing in larger efforts:

1) A modest-cost initiative, including funding of current State immunization plans and slow phase-in of school-based clinics and Head-Start health programs; and

2) A full-funding initiative, including a more rapid phase-in of school-based clinics and Head-Start health programs, additional improvements in immunization, as well as an intensive effort to control lead poisoning.

Option Type 1. No New Spending

Proposal: None

Option Type 2. Initiative at Modest Funding

Proposal: Initiate a child-health package that includes:

1) Creation of a grants program for school-based clinics;
2) Expansion of the Centers for Disease Control immunization grants program to reach every State's 1994 immunization plan;
3) Creation of a demonstration program for model programs to address teen pregnancy;
4) Amend the Head Start program to provide health services for children aged zero to three; and
5) Expansion of programs to screen children for lead poisoning and to provide for removal of lead from schools and day care centers.

Cost: (in millions)

94	95	96	97	98
700	865	1,030	1195	1365

Benefits: A child health initiative could prevent serious illness and disability and avoid unnecessary hospitalization, medical care, and school absence. For programs in which family planning services are provided (see Option 4, Design Options), teen pregnancy rates and associated school drop-out rates may be reduced.

Political feasibility:

There are no Federal school-based clinic programs; legislation would probably be required. Kennedy, Waters, and Waxman have proposed such legislation in the past. School-based clinics are supported by child health groups (e.g., PTA, CDF) and opposed by anti-abortion groups.

Immunization programs are fully authorized through FY 95; this portion of the package could be accomplished with appropriations requests. Several proposals have been made for expansion of immunization. The program is widely supported by child health groups and in the Congress.

Teen pregnancy demonstrations could be accomplished either through general authority or revision of the current Adolescent Family Life (AFL or "chastity") program. The current AFL program has often been ridiculed as ideological. Teen pregnancy efforts are always complicated by questions of abortion. Progressive programs are supported by family planning groups, child health groups, and medical groups; they are opposed by anti-abortion and conservative groups.

The initiation of Head Start health programs for children aged zero to three would require amendment of the current law. Such legislation was proposed by Kennedy last year and is supported by child health groups (CDF and others). Head Start expansion legislation will be considered by the new Congress. The initiative to provide zero-to-three health coverage could be linked to this legislation and funded as a set-aside.

Some lead programs are currently authorized; those portions of the package could be accomplished with appropriations requests. Lead removal from schools would require new authorization from the House Education Committee (Ford), the House Commerce Committee (Waxman/Dingell), and by the Senate Labor Committee (Kennedy) and Senate Public Works Committee (Baucus) (all of which are expected to be supportive of new grants programs to deal with the problem). Lead has received widespread media attention recently. Action to screen children and reduce lead poisoning is supported by child health and education groups.

All funding efforts would be referred to appropriations subcommittees chaired by Harkin and Natcher.

Option Type 3. Initiative at Full Funding

Proposal: Same as Option 2, but with quicker phase-in of all programs, and provision made for significant improvements in immunization beyond current State plans.

Cost: (in millions)

94	95	96	97	98
1,085	1,390	1,760	2,175	2,655

Benefits: Same as Option 2, but with additional benefit of reaching larger number of children sooner. The lead provisions at full funding provide some lead abatement services in homes, as well as schools and day care centers.

Political feasibility: Same as Option 2.

Option Type 4. Design Option

1) Some of the costs of these proposals (e.g., vaccine purchase) may be offset by implementation of the Clinton health reform plan. Other costs of these proposals (e.g., immunization outreach) will remain even under a full insurance plan.

2) The Drug Free Schools program (which now receives about $600 million) while largely unevaluated, is judged to be diffuse and unfocussed by Congressional staff working on drug abuse issues. Transfer of some or all of these funds to a school-based clinic program (or other child health programs) would provide more comprehensive services.

3) Another possible way of reducing costs for school-based clinics would be to require a local or State match for Federal funds, e.g., one dollar of local funds for every two or five dollars of Federal funds. Such a match could result in the poorest schools not receiving services. Conversely such a match might serve to limit Federal dollars to local areas in which there is genuine support for such services.

4) The most controversial aspects of school-based clinic programs are the provision of family planning and abortion counseling and services. Legislation could either require that such services be provided in all sites or make such services optional, at the discretion of the local schools and/or parents. Mandatory provision of such services by clinics will be opposed by anti-abortion groups and conservatives. Optional provision of such services by clinics will raise concerns among family planning and abortion rights groups.

5) $47 million of HUD lead removal funding for FY 92 and $100 million for FY 93 have remained unspent, largely because of a lack of trained workers. If provision could be made for obligation in FY 94, and if funds could be used for the brief (five days) training required, offsets of new spending may be possible.

HEALTH
Public Health
Community Health Centers

From Putting People First:
"Our plan will expand... community health centers in medically underserved areas."

Community health centers are a major provider of primary health services to low-income Americans. They have long provided care to the uninsured, migrant farm workers, and underserved inner-city and rural populations. More recently, they have become a mainstay for aiding the homeless, persons with AIDS, and residents of public housing.

Even after full implementation of the Clinton-Gore health care reform plan, these providers will continue to be the chief provider of care for these Americans.

There are three options packages that can be pursued:

(1) A no-cost proposal to expedite implementation of legislation allowing community health centers to be covered under the Federal Tort Claims Act;

(2) A modest-cost initiative to expand services at existing centers, to expand migrant health centers, and to initiate health services along the U.S.-Mexico border; and

(3) A full-funding initiative providing for the expansion of services described in Option 2 as well as creation of new centers in geographic areas that have been applied for funding but have not received it..

Option Type 1. No New Spending

Proposal: Issue an executive order instructing HHS and Justice to expedite implementation of the Federal Tort Claims Act amendments of 1992, which extend coverage to federally funded health centers (including community health centers, migrant health centers, and programs for health care for the homeless).

Cost:

94	95	96	97	98
-0-	-0-	-0-	-0-	-0-

Benefits: Implementation of these statutory provisions would allow health centers to discontinue current commercially purchased liability insurance coverage. It is estimated that this would, in the aggregate, save as much as $60 million (somewhat less in the first year of implementation), an amount equal to that required to establish 60 new health centers or to serve half a million new patients.

Political feasibility: This legislation was passed in 1992. Poor cooperation from the Justice Department (who opposed enactment of the law) has slowed implementation and delayed possible savings.

The legislation was bipartisan and is in the jurisdiction of the House Commerce Committee (Waxman/Dingell) and the Senate Labor Committee (Kennedy).

Implementation will be supported by the community health centers and their supporters.

Option Type 2. Initiative at Modest Funding

Proposal: Propose appropriations increases of $200 million to supplement appropriations for existing centers would allow those centers to expand services (using second shifts, weekend clinics, etc.) and reach an additional 1 million patients at 300 sites and train needed workers to provide culturally competent primary care services in these sites. An additional $100 million would provide both for needed expansions to reach migrant farm laborers and for a new program to support primary care and disease control efforts along the U.S.-Mexico border.

Cost: (in millions)

94	95	96	97	98
300	325	350	370	400

Benefits: These community health services reach inner-city, rural populations and provides the chief care for many poor racial and ethnic minority groups. Outpatient services of this type may forestall more expensive emergency room care and will, overall, reduce infant mortality.

Political feasibility: The major community and migrant health programs are authorized through FY 94. These initiatives could proceed under that authority, pending reauthorization. The border health projects would require new legislation.

These programs are widely supported by both parties. Racial and ethnic minority groups are particularly supportive.

Funding proposals would require action by the Subcommittees chaired by Natcher and Harkin. Reauthorization of the community and migrant health (as well as authorization of the border health) programs would be acted upon by House Commerce (Waxman/Dingell) and Senate Labor (Kennedy).

Option Type 3. Initiative at Full Funding

Proposal: In addition to the services described in Option 2, propose appropriations increases to allow new centers to be opened in areas not presently served. In the last application cycle, HHS received 296 proposals that were approved but not funded because of lack of funds. These proposals (as well as new applications) could be fully funded for $200 million, for a total (with Option 2 services) of $500 million.

Cost: (in millions)

94	95	96	97	98
500	540	580	620	660

Benefits: Same as Option 2, but with additional benefits in reaching new, unserved geographic areas.

Political feasibility: Same as Option 2.

Option Type 4. Design Option

(1) While community health centers have traditionally been funded by grants, needed renovation or construction projects could also be funded through guaranteed loans or a revolving loan fund (similar to the Hill-Burton program) for expansion of centers.

(2) Some of the costs of these proposals may be offset by implementation of the Clinton health reform plan. Other costs of these proposals (e.g., immunization outreach) will remain even under a full insurance plan.

HEALTH
Public Health
Tuberculosis Control

Tuberculosis has re-emerged as a major public health problem in many American cities and is now appearing in rural areas as well. Strains of TB that are resistant to most therapies, transmission to health care workers, and outbreaks in homeless shelters are compounded by the speed of the disease among people with AIDS.

Tuberculosis research and control activities have been almost completely neglected for the past decade. Some experts say that the U.S. is already in the midst of a major epidemic; all experts agree that without immediate action, an epidemic is imminent.

Either of two options could be pursued:

1) A moderate-cost option could provide research on diagnostics, prevention, and treatment, while assisting States, cities, and clinics in outpatient care of actively infectious patients; or

2) A full-funding option could provide the services of Option 1, as well as help States, cities, and clinics to provide the infection controls (including ventilation, ultraviolet lighting, and renovation) needed to prevent spread from patient to patient or patient to worker in hospitals, nursing homes, or clinics.

Option Type 1. No New Spending

None.

Option Type 2. Initiative at Modest Funding

Proposal: Propose increased appropriations for grants funds from the Centers for Disease Control to States and cities for assistance in TB screening, purchase of therapeutics, and directly observed treatment (i.e., ensuring that patients complete their 6-month long treatment to avoid relapse and drug resistance). Biomedical research is needed on improved diagnostics, treatment, and a potential vaccine.

Cost: (in millions)

94	95	96	97	98
380	460	550	660	790

Benefits: This proposal would increase the number of individuals that could be screened and treated and would ensure that initial treatment is completed. Research measures could also improve diagnostics (which now require two visits), treatment (which now requires six months), and prevention (there is now no vaccine).

Political feasibility: Tuberculosis has gotten a great deal of media attention and will continue to do so. Failure to fund programs adequately will be criticized as short-sighted.

Tuberculosis control grants are fully authorized at an unlimited level through FY 95. This proposal could be accomplished simply by an increase in the request for appropriations.

Legislation to provide these and other TB activities was introduced by Waxman and Schumer in the House and by Fowler, Bumpers, Moynihan and D'Amato in the Senate. No action was taken on either bill.

General public health will improve by this measure. Cities will be particularly assisted. AIDS groups will be especially supportive. Health care worker and penal worker labor unions will have interest as well, but will be unsatisfied that this measure does not also include workplace infection control renovations.

Since these measures are currently authorized, the only committees that will act on this proposal will be appropriations committees chaired by Natcher and Harkin.

Option Type 3. Initiative at Full Funding

Proposal: Same as Option 2, but with additional funding to allow for installation of ventilation, ultraviolet lighting, and for building renovation to prevent TB spread in hospitals, clinics, nursing homes, and prisons.

Cost: (in millions)

94	95	96	97	98
800	880	970	1,060	1,170

Benefits: Health care and penal worker unions have been particularly concerned at the rise of the occupational risk of acquiring TB from patients. Addressing these concerns will both improve public health and workplace safety, as well as protect patients from infection.

Political feasibility: Same as Option 1, but with additional support from labor.

Option Type 4. Design Option

Traditionally TB control grants programs have gone to State and local governments. Since the last time of significant funding, however, networks of non-profit private clinics have arisen to care for the poor, the homeless, people with AIDS, and drug users. Consideration should be given to supplementing these community programs services with TB control funds. It has also been suggested that churches and non-health community groups might participate in providing directly observed therapy workers in their respective communities.

HEALTH
Public Health
Biomedical Research

From 10/29/92 speech:
"One of the things we ought to be doing more of in the wake of the end of the Cold War and the decline of the defense budget is directing our scientific energies into health care research of all kinds."
From Putting People First:
"Use whatever means are available to find cures for diseases... including lifting the fetal tissue research ban."

Biomedical research is an investment both in hope for cures and improved treatments as well as the in the retention of U.S. competitiveness in the high-tech markets of the 21st Century. The National Institutes of Health is the premier biomedical research agency of the world, and the long-term commitment of resources to it will provide for basic research, cancer, heart disease, mental illness, and other common and rare diseases.

Three options are available

(1) A no-cost option to lift the ban on fetal tissue transplantation research, as well as to direct that NIH undertake research on human sexual behavior (for use in AIDS, reproductive health, and behavioral research) and on in vitro fertilization research:

(2) A modest-cost option that would allow the NIH in FY 94 to continue to make the same number of grants in FY 93 at the same average level of support, with adjustment for biomedical research inflation rates; and

(3)) A full-funding option that would provide sufficient funds for NIH to return to the number of grants made in FY 92, with adjustment for biomedical research inflation rates.

These proposals are in addition to those proposed for AIDS and for women's health research, not in lieu of those proposals.

Option Type 1. No New Spending

Proposal: (1) Issue an executive order to lift the ban on NIH research on fetal tissue transplantation, (2) direct the NIH to ensure that it carries out research on human sexual behavior and (3) take administration actions to ensure that NIH carries out research on in vitro fertilization.

Cost:

94	95	96	97	98
-0-	-0-	-0-	-0-	-0-

Benefits: Human fetal tissue transplantation research holds great promise for the development of treatments and even cures for such diseases as Parkinson's, diabetes, Alzheimer's, epilepsy, genetic diseases, etc. Sexual behavior research (last done comprehensively in the 1940's and very dated now) could provide insights into AIDS prevention possibilities, reproductive health problems, and behavioral research questions. Research on in vitro fertilization could allow many infertile American couples can conceive a child and have a family.

Political feasibility: All of these matters can be dealt with by executive order or other administrative action. The executive order on fetal tissue transplantation should also include the ethical safeguards that were recommended to the NIH by the independent review panel that reported on this issue.

Human fetal tissue transplantation legislation was vetoed by Bush in 1992. The research proposals have broad, bipartisan support, including many well-known opponents of abortion (e.g., Dole, Thurmond, Danforth). The Senate had sufficient votes to override the President's veto; the House was close and perhaps could have found the votes if budget issues about unrelated provisions had not also confused the issue.

Legislation regarding biomedical research will be considered by the Congress very early in 1993. Provisions regarding fetal tissue could be included in this legislation, although advocates for disease groups (e.g. Parkinson's, diabetes) are very much expecting that this issue will be resolved very early by executive order. If it is not, these groups will be extremely disappointed. (Pro-choice groups are also expecting that this issue will be dealt with by executive order.)

Sexual behavior research has been the subject of amendments by Senator Helms. The most recent Senate vote was very close, and with leadership from the Clinton-Gore Administration, defending this research as important to health (as Bush never did) would probably allow the Senate to defeat future amendments.

In vitro fertilization research has been the subject of a de facto ban since the late 70's. Current regulation requires that this research be reviewed by a special ethics committee, which has not been appointed for years. This could be remedied either by amending the regulations or by appointing the needed committee for review of research.

In all instances (fetal tissue research, sexual behavior research, and IVF research) , the biomedical research community is supportive of "research freedom," a generalization that has taken on a significance greater than these three examples. Such political interference with biomedical research has generated strong reaction from universities, scientists, and disease groups and has, in some instances, resulted in the loss of distinguished researchers from the Federal government.

Option Type 2. Initiative at Modest Funding

Proposal: Propose appropriations increases sufficient to compensate for inflation in biomedical research in order to allow NIH to continue its current portfolio of research without diminution. When considered with the initiatives proposed for AIDS and for women's health, this option would make incremental progress in expanding the biomedical research investment of the U.S.

Cost: (in millions)

94	95	96	97	98
400	430	460	495	530

Benefits: Investments in biomedical research yield benefits both in disease prevention and control and in growth of high-tech markets in pharmaceutical and biotechnology.

Political feasibility: Much of the NIH can be funded under general authority. Increases would require only action by the appropriations committees. Legislation to reauthorize specific NIH activities was vetoed during the last Congress (over issues of fetal tissue transplantation research and women's health). New authorizing legislation will be considered very early in the next Congress.

Modest funding increases such as this will be supported by academic institutions (universities and medical schools) and by disease groups. They will, perhaps, express some disappointment that true expansions were not possible.

Appropriations requests will be considered by the subcommittees chaired by Harkin and Natcher. Authorizing legislation will be considered by House Commerce (Waxman/Dingell) and Senate Labor (Kennedy).

Option Type 3. Initiative at Full Funding

Proposal: Propose appropriations increases to provide for a higher investment in biomedical research in order to allow the NIH to return to the number of research grants that were made in FY 92 and to allow for an incremental increase in that number. This would be at or near a record number of research grants and would also meet the recommendations of the National Academy of Sciences regarding the needed number of research trainees .

Cost: (in millions)

94	95	96	97	98
1,400	1,510	1,620	1,730	1,850

Benefits: This option would have the advantages of Option 2, but would also demonstrate a strong commitment to investment in biomedical research. Research groups and disease groups would be very pleased.

Political feasibility: Same as Option 2.

Option Type 4. Design Option

(1) The Options Papers on AIDS and on Women's Health also contain options for significant expansions of biomedical research.

(2) When lifting the ban on fetal tissue, the Clinton-Gore Administration will also be confronted with questions of how to proceed with the Tissue Bank (which was established by President Bush in order to defeat the NIH legislation). The Bank now is intended to contain only fetal tissue from sources other than elective abortions (e.g., miscarriages, abortions for ectopic pregnancies), even though most researchers agree that such tissue is unsuitable for transplantation (because of genetic defects or disease). Funds have, however, already been invested in this proposal. One option for dealing with the Bank is to continue it but to allow it to bank tissue for research from all sources--elective abortions or other sources. This option could be pursued by administrative action and would require no legislation. It would provide a potentially valuable service to researchers, similar to that which organ banks provide to transplant surgeons. Another option, if funds have not already been fully obligated and spent, is to attempt to recapture these funds for other research issues, including fetal tissue transplantation research.

(3) Funding levels in Options 2 and 3 do not include potential costs of construction and renovation projects for either the NIH itself or university facilities that may receive research grants from the NIH. These construction funds are needed, but are substantial and are often politically controversial at a time when research projects are cut or frozen. The NIH bill vetoed by Bush included $100 million for university construction projects. Estimates for construction and renovation of the NIH itself are as high as $1 billion over a 15-year period.

HEALTH
Public Health
Drug Treatment

From Putting People First:
"In a Clinton-Gore Administration, Federal assistance will help communities dramatically increase their ability to offer drug treatment to everyone who needs help."

Alcohol and drug abuse fuels virtually all other health problems in America: HIV, TB, teen pregnancy, violence and unsafe neighborhoods, child abuse and neglect, etc. The failure to provide treatment services to all drug users continues these problems and fills the prisons. Progress toward treatment-on-demand and drug education programs will require substantial commitment of resources.

Two options are available, essentially the same program at varying levels of Federal support:

1) A moderate-cost option that would move toward treatment-on-demand for all pregnant women and all intravenous drug users, the two populations that present dual public health risks; and

2) A full-funding option that would move toward treatment-on-demand for all substance abusers.

Option Type 1. No New Spending

None.

Option Type 2. Initiative at Modest Funding

Proposal: Propose increased appropriations, both through block grants to the States and direct funding of community organizations, to allow movement toward treatment-on-demand for all pregnant women and intravenous drug users. These populations represent not just direct problems of drug abuse, but also a dual risk of infant illness and addiction, HIV infection, or both.

Cost: (in millions)

94	95	96	97	98
500	540	580	620	660

Benefits:

Reductions in drug use in these populations will result in improvements in child health and lowered HIV transmission, as well as lower medical costs for other illnesses associated with drug abuse.

Political feasibility:

Drug abuse grants are authorized through FY 94. This proposal could be accomplished through an increase in the request for appropriations in the first year. Reauthorization will, however, begin in 1993 as well.

The drug abuse program was reauthorized in 1992. The purposes of the law are widely supported, although funding formulas among the States are often contested.

Cities and States will be assisted. AIDS groups and minority health groups will support.

Because these programs are authorized, this option would require action only by the appropriations subcommittees chaired by Natcher and Harkin.

Option Type 3. Initiative at Full Funding

Proposal: Same as Option 2, but with movement toward treatment-on-demand not just for pregnant women and intravenous drug users, but for all drug users.

Cost: (in millions)

94	95	96	97	98
750	1,000	1,250	1,500	1,750

Benefits: Same as Option 2, but with greater access and a recognition of the severity of the problem of non-injected drugs (e.g., crack, amphetamines) and alcohol.

Political feasibility: Same as Option 2. Broader support, especially from less urban areas that have fewer IV users but serious problems with other drugs and alcohol.

Option Type 4. Design Option

1) During the reauthorization that will begin in 1993, formulas for distributing funds among the States will be a hotly contested issue. Formulas predicated on population change will take funds from cities and States that have long-standing problems (e.g., NY or NJ) . Formulas predicated on past history will fail to recognize the emerging problems in high population cities and States (e.g., CA, FL).

2) Some of the costs of the options outlined in this Options Paper (e.g., some drug clinic charges) may be offset by implementation of the Clinton health reform plan. Other costs of these proposals (e.g., drug education and prevention) will remain even under a full insurance plan.

HEALTH
Public Health
Public Health Infrastructure

From speech at Merck (9/24/92):
"We have to ... recognize that even if you cover everybody, not everyone will have access in the world we're living in today. Some money has to be set aside ... to establish preventive health care clinics.... We have to emphasize health education and prevention in school and the workplace."

Recent tuberculosis epidemics in major cities, measles outbreaks across the nation, and an AIDS epidemic that threatens the world are not unconnected events. Along with lead poisoning in children, increasing lung cancer in women, and low life expectancy of people of color, these are symptoms of a single problem: The neglect of public health.

As we move toward a program to reform the finance of health care, it is essential to rebuild and reinvent public health in America. Without a public health strategy, health reform will be as vulnerable to failure as a city fully insured against fire damage but lacking fire hydrants and fire fighters.

Public health provides the infrastructure on which health reform can be built.

> --It solves collectively those problems that no one consumer can solve--from control of infectious diseases to regulation for safety of food, drugs, water, and air;
>
> --It guides consumers to make better decisions about their health and health care--whether by warning people at risk of disabling conditions (with such services as hypertension screening or mammography) or through health information and behavior change (for smoking cessation or seat belts);
>
> --It provides the safety net for the inevitable gaps that will occur in any health reform plan--whether for the undocumented aliens, the homeless and the mentally ill, special populations (such as Native Americans) or the residents of underserved inner cities and rural areas; and
>
> --It provides the machinery by which the acute care portions of the health market are operated--the personnel, the clinics, the innovation, and the surveillance and evaluation.

When all these elements come together, public health can create medical miracles.

> For example, the smallpox eradication program was predicated on a public health system of shared goals, warnings, safety net services, research and personnel; without that program and its underlying system, Medicaid might still be burdened with the long-term care needs of smallpox patients.
>
> Similarly, the polio immunization initiative was dependent on a defined public health infrastructure; without this initiative and its infrastructure, America's hospitals might be crowded with (and bankrupted by) iron lungs.
>
> In the same manner, public health structures have created sanitation facilities, which prevent water-borne illnesses such as cholera that could disrupt not just the health care system but the entire economy.
>
> The same approaches are now beginning to be turned on the modern-day epidemics of domestic violence, safety in our neighborhoods, and even unintentional injury and accidents.

Unfortunately, the failure to take public health seriously over the past twelve years has left the present health system burdened by preventable disease and disability and ill-equipped to deal with emerging problems and those that have never been solved. With a renewed commitment to the infrastructure of public health, the nation would be better equipped to deal with old problems that should have been solved, as-yet-unsolved problems that are now known, and the unknown problems of the future.

Option Type 1. No new spending.

None.

Option Type 2. Initiative at Modest Funding.

Proposal: Propose appropriations increases for Federal programs that improve public health infrastructure (e.g., FDA, health professions education, Indian health, Centers for Disease Control, and programs for the evaluation of the cost and effectiveness of health finance and health services). These programs provide varied services in collective health, health promotion, safety net services, and health professions education. This proposal would provide half of the funds that these agencies have identified as needed for service improvements in FY 94.

Cost: (in millions)

94	95	96	97	98
820	885	950	1,010	1,085

Benefits: This proposal would have a wide range of results, all acting to reduce acute illness and disability before they occur. Effective programs will result in significant health care savings to the health finance system.

Political feasibility: Although some of these programs have discrete authorities, for the most part, all of them can receive funds under general authority of the Public Health Service Act. Funding can be increased by requests to the appropriations committees.

Provision of general support for these agencies is usually provided in small amounts and in an ad hoc manner. Support for a general program to improve the infrastructure of public health is without precedent.

Such a proposal will be strongly endorsed by the public health community, including State health officers, as long overdue. Opposition would arise only from fears of using funds that would otherwise be dedicated to specific health initiatives.

Legislation on this option would be referred to the House Commerce Committee (Waxman/Dingell) and the Senate Labor Committee (Kennedy). Funding requests would be directed to subcommittees chaired by Natcher and Harkin.

Option 3. Initiative at Full Funding.

Proposal: Provide for funding of Federal infrastructure agencies at the level that they have identified as optimal for FY 94.

Cost: (in millions)

94	95	96	97	98
1,640	1,770	1,895	2,025	2,170

Benefits: Same as Option 2, but with full implementation at a faster rate.

Political feasibility: Same as option 2.

Option 4. Design Options.

1) Consideration should be given to sharing public health infrastructure funding with States, which have traditionally been responsible for much of these activities. Such assistance could come in the form of matching grants or in-kind contributions to assure an increase in services rather than a re-financing of them.

2) Consideration should be given to financing this Option as a part of health reform rather than as a program of discretionary spending. Public health experts argue that preventive health efforts are the first to be slashed when economies go awry. Providing some permanent funding mechanism, perhaps as a portion of the health care financing budget, would assure ongoing public health activities.

3) This option should not be mistaken for an alternative to insurance coverage for individual preventive clinical services. Public health services are intended to supplement these activities.

4) Estimates provided in Options 2 and 3 include some support for the FDA. These are over and above the predicted revenues from the new manufacturers' user fees that were enacted this year; revenues from those user fees are intended only for the improvement of new drug applications.

5) Other Options Papers discuss specific initiatives in public health, rather than the long-term financing of its infrastructure. (See, for instance, the Options Paper on Community Health or the Immunization provisions of the Child Health Options Paper.) Funds to support those efforts are not reflected in the numbers used in this Options Paper.

State/Federal Medicaid Issues

HEALTH
STATE MEDICAID ISSUES

Background

From 1988 to 1991, national spending on Medicaid services grew from $51.6 billion to $88.1 billion. States are facing pressure from increased enrollment (from more expensive for the disabled than for mandated mothers and kids), health cost inflation, and price and service increases above inflation--the latter reflecting the threat of lawsuits from providers seeking increases in payment rates. Provider taxes and donations, disproportionate share adjustments and federal waivers are mechanisms states use to respond to these pressures.

In response to these pressing problems, you requested and we received an outline of adminstrative changes requested by the states (letter from Governors Romer and Campbello, December 11, 1992). The following outlines their requests and provides a recommended response. (In brief, however, our recommended response is crafted along the lines of subsequent conversations and recommendations made by NGA staff). This memo concludes with a brief discussion of the importance of tapping into state expertise during the development of your health care reform proposal.

Provider Taxes and Donations

In an agreement between the states and the Bush administration in 1991, access to provider taxes and donations was significantly curtailed. In narrowly defining the types of broad-based health care taxes that States can use to finance Medicaid, regulations implementing this agreement constrain the range of allowable taxes and place the tax plans enacted in several states in jeopardy. Information provided to the transition cluster team by the HCFA Medicaid Bureau indicates that the tax programs adopted by Tennessee, Illinois, Louisiana, Minnesota, Ohio, Rhode Island, South Carolina and West Virginia are inconsistent with these regulations.

The National Governors' Association has requested "immediate action to correct the regulations." Their changes would make it easier for states to enact provider taxes on which they can finance their Medicaid programs and draw Federal matching funds. These changes appear to be permissible under the statute and can be accomplished by revising the November 24 interim final regulations.

The November 24 regulations reflect the Bush Administration's philosophy that the way to control Medicaid costs is to make states pay more and limit Federal matching contributions. In interpreting the statutory provisions, these regulations opt for narrowly drawn standards that limit State flexibility in enacting provider taxes to finance their Medicaid programs.

The critical decision with regard to these regulations is whether to reverse the Bush policy and provide States with broader flexibility to draw Federal matching funds. Leaving these regulations

in force will place even greater fiscal pressure on many states. However, these regulations also serve to constrain Federal Medicaid outlays.

NGA views the requested changes in these regulations as no cost items because they conform to what states are now doing. An alternative view, previously advanced by OMB, is that once the restrictive Bush regulations are effective on December 24, any changes that provide states broader flexibility to draw Federal match funds would be a "new Federal cost" that increases Medicaid spending above the baseline.

Response: The recommendations of the National Governors'Association are that you revise the Bush regulations immediately after you take office to accurately reflect statutory intent. We believe that we can be very responsive to all or most of their specific provider tax requests and that, in doing so, there is relatively low risk that there will be any significant costs associated with this action.

* Note: The only downside to this approach is that it carries with it some relatively small risk of additional Federal costs.

Disproportionate Share Hospital Payments

The provider tax agreement also placed restrictions on states' ability to use disproportionate share hospital (DSH) payments for hospitals with high volumes of poor and uninsured patients as a way to draw Federal matching payments and finance uncompensated care. In particular it limited increases in DSH payments for states with relatively low expenditures of this kind.

On behalf of the governors, the NGA has requested that you modify the disproportionate share hospital provisions of the regulations issued November 24, 1992 be modified to allow for program growth in these states. According to NGA, a change in this provision would help 31 low-DSH states at a one time Federal cost of $390 million in FY 1993.

NGA believes this change can be accomplished by regulation because the statute leaves room for interpretation by specifying that there be a national cap, but also that low-DSH states be allowed to grow. If this interpretation does not hold, legislative change would be required.

Response: The NGA estimates that their request to modify the disproportionate share provisions would help 31 states for $380 million in FY 1993--a one-time expense. Given the priority NGA has attached to this issue and the potential inequity of freezing out states that never took advantage of this options, a positive response seems advisable.

NOTE: The only down side is the cost and the possibility that you will be unable

to do this by regulation and legislative intervention is required.

Waiver Issues

The states have requested numerous (over 40) changes to the Medicaid waiver process that would simplify State procedures for applying and receiving Federal waivers. These changes range from requesting that HCFA be directed to change its attitude toward State waiver requests to more far-reaching proposals to grant automatic approvals of some types of waivers.

Obtaining waivers, even for noncontroversial programs, has become highly political and burdensome over the last 12 years. However, some of the Federal waiver review process provides an opportunity to maintain controls on the scope and quality of Medicaid that could be essential in moving to transition Medicaid into the health care reform proposal. Some aspects of the states' request would restrict Federal oversight of Medicaid and could be criticized as "inappropriate federal management". NGA staff have indicated that they do not believe it either necessary or appropriate for you to immediately respond to their long waiver "wish list." They do recommend, however, and we strongly agree, that you should direct the next HCFA administrator to review these requests and make recommendations for action within 60 days of the time you are sworn into office.

Response: Respond to the NGA waiver requests with a thorough review of the current waiver procedures and establish a 60 day review of the entire waiver process. This review should address both the process internal to the Department of Health and Human Services and HCFA, as well as the role of OMB in the process. This review would be directed to produce a new process with firm timetables for response and expedite state review. Streamlining this process would <u>not</u> involve additional federal expenses and can be argued as administrative simplification and reducing burden. However, providing broader state access to waivers could have new federal costs if states elect to use these waivers to broaden services eligible for Federal matching.

NOTE: We believe this option has absolutely no downside.

<u>State Role in Development of Health Reform Proposal</u>

As we believe you know from conversations with Carol Rasco, since day one, we have been actively involved in receiving and soliciting state suggestions on the health care reform issue. Many states want to sit at the drafting table and, quite frankly, not all can be accommodated. Having said this, we have developed what we believe to be a mutually beneficial plan to best get the Governors linked into the policy options development process. We have worked with NGA to develop a small work group, which has representation from the leadership of the NGA and the DGA. The Members of the group are Governors Romer, Dean, Campbell, Michelson, and Waihee. We also have held, and plan to hold more, meetings with individual Governors outside of

this five Member team.

The goal of this effort is to ensure that your proposal provides for adequate state and local flexibility in the administration of any reform initiative. To date, this process and organization has been well received. We believe it will yield substantive recommendations to address both short and long term reform needs of the states.requirements of states. We will be keeping you apprised of developments with this state outreach effort.