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Health Care Qs and As - November 8, 1994

Y & Q 26

Q. The Washington Post this morning cited a White House official as saying that you may be doing more by executive order, including giving states waivers to experiment on health care reform. Given the Republican control of both the Senate and House and fierce Republican opposition to your original plan, will you consider abandoning federal health care reform efforts and promote reform through state waivers?

A. I have repeatedly stated that I am flexible on health care reform. I have already granted waivers to states to pursue health care reform efforts. But we as a nation must confront the fact that in spite of having the best health care system in the world, another million Americans lost their health insurance last year and costs continue to rise. I will not abandon my commitment of the American people to provide health security and make health care affordable for American families. And I hope that the new Republican majorities in the House and the Senate will work with me to achieve these goals.

Q. Congress failed to enact your health care plan last year and expectations are that with a more conservative Congress next year, it will even be more difficult to pass health care reform legislation. Will you produce a modified approach, perhaps something that will garner more Republican support - or will you introduce something that can be used as a campaign issue in 1996?

A. There have not been any decisions made on how we will approach health care next year. The only decision made is that we are not going to give up the battle. Another million Americans lost their health insurance last year and costs continue to escalate. We cannot walk away just because the road to reform is difficult.

We obviously want health care to be handled in a bipartisan fashion. We always have. We tried repeatedly during the last session to work with Republicans. They threatened to filibuster in September and it put health care reform on the shelf for now. But I think there is a good opportunity to provide people with the health security that they want - with quality, affordable health care and private insurance coverage. And it is an opportunity that can be a reality if we work together.

Q. The Republicans, with massive special interest help, successfully labeled your plan as government-run and stated it would lead to rationing and massive job losses. Will the Administration do something to help change this public perception? Will it abandon alliances, move at a slower pace, back away from universal coverage?

A. Again, no decisions have been made. We will obviously try to better explain to the American people that we are talking about preserving what is good in our system and fixing what isn't working. And when we talk about preserving what is good, we mean preserving the private insurance system. Providing Americans with private health insurance that can't be taken away if a loved one gets sick or a job is lost.

Special interests spent hundreds of millions of dollars to scare and mislead the public. Yet, in spite of their success in creating confusion, the American people still overwhelmingly believe that we must act to provide health security to American families and make health care more affordable.

Q. Reports from senior White House officials last week stated that you were removing the First Lady and Ira Magaziner as the leaders in developing health care legislation and replacing them with Carol Rasco and Bob Rubin. Is this move a recognition that last year's process was a failure?

A. First, let me state that reports that the First Lady will not be involved in health care are ridiculous. The First Lady will play an active role in policy strategy and development and she will remain the Administration's public advocate on health care. At my request, Ira will also remain involved in health care.

We are entering a different phase in the health care debate. The last two years were spent doing an enormous amount of research and policy development. We are now entering a phase that will allow us to move health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts.

Q. Given the difficulty in enacting a bill with universal coverage last year, will you pledge once again, in a more conservative Congressional environment, to veto a bill that does not achieve universal coverage?

A. We still believe that every American deserves health care coverage. Our goal is universal coverage. And we're going to do everything possible to assure that Americans have health care coverage when they need it. And we're going to do everything possible to control escalating health care costs.

The American people still overwhelmingly support universal coverage. We must continue to work toward achieving what the American people want and deserve.

Q. There is speculation that the Administration will be presenting recommendations to Congress on health care reform and that these recommendations will be part of the budget. Are you going to submit a new plan and, if yes, have you given thought to what these recommendations will include?

A. We have not had a chance to think exactly about where we will go or even in what form any such proposal would be presented. Could recommendations be submitted as part of the budget? Yes, but it is also possible they won't be part of the budget.

Q. Are you going to do this all at once or are you going to phase it in?

A. No decisions have been made.

President Clinton's
October 7 Press
Conference

- 11 -

their future and what changes they want, not necessarily about whether the parties are ideal or perfect or whatever.

We're going through a period of change. The American people are not satisfied either with the rate of change or with the certainty that it will occur. And they, like everybody else -- I mean, after all, you can't -- the people are of more than one mind on more than one issue. That is, all these interest groups that everybody reviles when they want campaign finance reform or lobby reform are the same people that have the money and the organized communications ability to change the attitudes of the people out there on issue after issue after issue.

So the important thing and the message I have to say is, what is the direction you want? Do you want continued progress in the economy? Do you want a government that takes on tough problems like crime and welfare reform and health care? Do you want a government that does things for ordinary people, like the Family Leave law or making college loans more available to middle class people? Or do you want this contract, which says clearly, give us power and we'll take you back to the '80s; we'll give you a trillion dollars worth of promises; we'll promise everybody a tax cut; we'll explode the deficit; we'll cut Medicare; we'll never fund the crime bill; but we will have told you what you wanted to hear? I think the American people will vote for the future and not the past, and that's my hope and belief.

Q Mr. President, a question about bipartisanship. Looking back on the health care reform effort, is there anything you think you could have done differently to forge a consensus? For instance, do you think it would have helped if you'd brought Republicans earlier on in the process up to the White House to negotiate the way you did at the end of the crime bill fight? And looking ahead to next year when you're going to be pushing health care reform and other issues through a more Republican Congress, is there anything that you plan to do differently to forge a coalition for governing?

THE PRESIDENT: Well, let me say, I'm sure that there are some things I could have done differently. You know, I never dealt with Congress before last year and I'm still learning all the time. I would point out that the Congressional Quarterly said that last year that the Congress and the President worked together more successfully than at any time since World War II except in President Eisenhower's first year and President Johnson's second year. So I felt that we accomplished quite a great deal.

When we were putting this health care bill together, there was a lot of consultation with Republicans. When we wanted to present a proposed bill and say, now, how would you like to change this, we were told that they had their own group working on health care and they wanted to present a bill and then we would get together. So I said, that's fine; I understand that. Then Senator Chafee, to his everlasting credit, came up with a bill that had two dozen Republican senators on it that would have covered all Americans and controlled costs. By the time we got down to serious negotiations, instead of two dozen senators for universal health care and controlled costs, there were zero. They all left. I mean, Senator Chafee was still there, but everybody had abandoned his bill. We had one Republican congressman saying they'd all been instructed not to work with us. We had one Republican senator quoted in one of your papers saying that they had killed it, now they had to keep their fingerprints off of it.

So I am more than happy to work with them in any way I can. I do not believe we have a monopoly on wisdom. Let me give you some evidence of my good faith on being flexible about changing. I have given state after state after state waiver from federal regulations to pursue universal coverage and health care costs control on their own. Tennessee has done some very exciting things,

and by the way, gotten some very impressive results I understand. We just approved Florida to do this. We're in the process of approving more states to move forward. I am very flexible on how we get this done. And if the American people are worried that the federal government has too much emphasis and they want more for the states, fine, let's talk about that. But if there's going to be a bipartisan effort, it has to be good faith on both sides.

I like working with Republicans. I proved that in the NAFTA fight, proved it in the crime bill fight. I will prove it in the health care fight. But it can't be a kind of situation where every time I move to them, they move further the other way. That's the only thing I would say.

Q Yes, sir, last question.

Q Mr. President, for Secretary of Agriculture, will you be looking for someone with farm experience, or will you be looking for somebody like Secretary Espy, who has heavy congressional experience?

THE PRESIDENT: Well, the most important thing, I think, is someone who really understands how to deal with the agriculture community, understands the interests and is committed to agriculture and to farmers and to rural development. And let me say, if I might, in closing, that I also want somebody who will faithfully implement the reforms that Secretary Espy has started.

We passed a dramatic restructuring of the Department of Agriculture. We're going to take down the number of employees by at least 7,500. We have seen an Agriculture Department that has been extremely active in helping farmers deal with disasters; that has tried to help the farmers in the Middle West with their production problems; that has given an enormous amount of emphasis to rural development. So this Agriculture Department, under this Secretary of Agriculture, has established a lot of credibility with the American people who are in agriculture, including selling rice to Japan for the first time, selling apples from Washington to Japan for the first time, doing things that haven't been done for a long time for hardworking, grass-roots farmers, whether they're Republicans or Democrats or independents.

And when I came here, out of a rural background, out of a farming background, that's what I desperately wanted to do for the agricultural community. And so when I pick another Agriculture Secretary, that is a standard that Mike Espy set that must be met for the next Agriculture Secretary.

Thank you very much.

END

2:46 P.M. EDT

MORE

To Barbara Allen

EOB Health Care

office --
412

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and sent.
RH

7-28-93

THE WHITE HOUSE

WASHINGTON

July 15, 1993

JUL 27 RECD

L. R. Sherill
429 South Rock Hill Road
St. Louis, MO 63119

Dear Mr. Sherill :

On behalf of the President and Mrs. Clinton, I would like to thank you for your interest in health care reform.

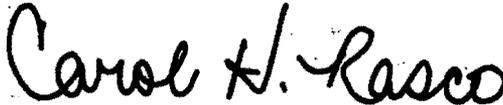
As you may know, on January 25, 1993, the President announced the creation of a Task Force on National Health Care Reform. The President asked the Task Force to provide him with proposals for comprehensive health care reform. The President also announced on January 25 the creation of an interdepartmental working group which would gather and analyze information and options for the Task Force.

In over twenty meetings held during April and May, the Task Force reviewed materials it received from the interdepartmental working group and policy suggestions such as yours, formulated proposals and options for health care reform, and presented those proposals and options to the President. Each of those Task Force meetings was announced in the Federal Register.

Having completed its mission, the Task Force was terminated on May 30, as provided in its charter. The President is now in the process of reviewing the proposals received from the Task Force and choosing from among the policy options that were presented to him.

I appreciate your participation in this vital endeavor. Your ideas have been very helpful during the deliberations on health care reform. Again, on behalf of the President and Mrs. Clinton, I thank you for your interest, time and support.

Sincerely,



Carol H. Rasco
Assistant to the President for
Domestic Policy

THANK YOU CAROL FOR THIS ENCOURAGING NOTIFICATION. HERE IS AN UPDATE ON THE ARF PLAN WHICH WE SUGGEST BE SUGGESTED AS A SUPPLEMENT COMPANION TO THE NEW OREGON HEALTH PLAN, IS THERE ANY REASON WHY THE ARF HEALTH PROGRAM CAN NOT BE ADVOCATED NATION-WIDE ASAP INASMUCH AS IT IS NOT-FOR-PROFIT & SELF SUSTAINING FINANCIALLY & NO BURDEN TO TAXPAYERS. THE ARF PROGRAM WILL HAVE SUPPORT OF BOTH SENATOR BALL & DANFORTH & NOW IS BEING CALLED TO THE ATTENTION OF CONGRESSMAN GEPHARDT. THANKS AGAIN CAROL.



7/21/93

ASTHMA RELIEF FOUNDATION
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OFFICE OF DOMESTIC POLICY

THE WHITE HOUSE

JAN 14 REC'D

FROM THE OFFICE OF: CAROL H. RASCO
ASSISTANT TO THE PRESIDENT
FOR DOMESTIC POLICY

② TO: ~~Christine~~
~~Donna~~

DRAFT RESPONSE FOR CHR BY: _____

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REMARKS:

Christine & Donna: Review & take
action as necessary. Feel
free to share w/ approp. others

small stat., edit

THE WHITE HOUSE

WASHINGTON

Dear Mr. Stearns:

Thank you for your letter and paper regarding the "Effect of Health Care Reform Upon American Indians." I appreciate the material and in addition to reviewing it myself have passed it along for review to both the health care reform staff as well as the staff which covers Native American issues for us in Domestic Policy.

Thank you again.

Sincerely,

CHR
title

HOBBS, STRAUS, DEAN & WILDER

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January 13, 1994

JAN 14 REC'D

Carol Rasco
Asst. to the President
for Domestic Policy
The White House
1600 Pennsylvania Ave., N.W.
Washington, D.C. 20500

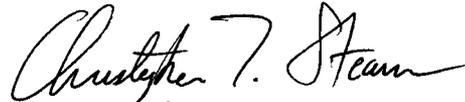
Re: Effect of Health Care Reform Upon American Indians

Dear Ms. Rasco:

Our firm represents more than 100 American Indian and Alaska Native tribes, villages, and tribal organizations throughout the country, including the National Congress of American Indians. At the request of our clients, we have been carefully monitoring the Administration's health care reform efforts. We recently prepared a general analysis of the National Health Security Act (H.R. 3600; S. 1757), which we enclose for your information. If you have any questions or comments regarding the enclosed memorandum, or if we can be of any assistance, please feel free to call me at the above-listed number.

Sincerely,

HOBBS, STRAUS, DEAN & WILDER



By: Christopher T. Stearns

Enclosure

HOBBS, STRAUS, DEAN & WILDER

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KAREN J. FUNK
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January 7, 1994

GENERAL MEMORANDUM NO. 94-4

Re: Health Care Reform Update

Introduction

On November 20 the President's proposed Health Security Act (the "Bill") was formally introduced in both houses of Congress. Senate Majority Leader Mitchell and 30 cosponsors introduced the proposal in the Senate as S. 1757, and Majority Leader Gephardt and 99 cosponsors introduced H.R. 3600 in the House. S. 1757 has not yet been referred to Committee because of disagreements between Senators Moynihan and Kennedy, who respectively chair the Senate Finance and Labor and Human Resources Committees. These senators introduced their own, nearly identical legislation on November 22 as S. 1775 (Moynihan) and S. 1779 (Kennedy). H.R. 3600 was referred jointly to the House Energy and Commerce and Ways and Means Committees, with the Education and Labor and several other committees also having jurisdiction over portions of the bill. Title VIII, Subtitle D of H.R. 3600, which contains provisions related to Indian health, was referred to the Natural Resources Committee.

The Bill represents a comprehensive and massive overhaul of the current health care system. President Clinton's legislative proposal will change the role of the states, the rights of individuals, the extent of federal regulation, and the delivery of health services to all Americans. Under the Bill, American Indians and Alaska Natives would be eligible to receive health care to the same extent as all Americans by enrolling in health plans offered through newly created regional health alliances. All Indians and Alaska Natives, however, would continue to have the option of receiving care through the Indian Health Service ("IHS") system, including tribal health programs operated pursuant to Indian Self-Determination Act contracts and Self-Governance compacts.

Regardless of whether Indians choose to enroll in a private health plan or remain in the IHS system, they would remain entitled to continue to receive all supplemental benefits and services from the IHS which are not included within a mandatory core set of benefits under the Bill -- the comprehensive benefit package. While care in the IHS system would remain free, Indians choosing to enroll in private health plans would be responsible for payments to the same extent as non-Indians. The Bill would require the IHS (and tribal contractors and compactors) to provide the comprehensive benefit package to all eligible beneficiaries by January 1, 1999. The Bill would also require the Secretary of Health and Human Services ("Secretary") to consult with Indian tribes and tribal organizations on a yearly basis regarding health care reform initiatives.

The most important provisions of the Bill which affect American Indians and Alaska Natives are described in the following paragraphs.

1. Benefits

The Secretary would be responsible for ensuring that all IHS and tribal health programs offer the comprehensive benefit package by January 1, 1999. Section 8304(a). The rest of the United States population, however, would receive the comprehensive benefit package a year earlier.^{1/} Section 8301(1) defines a health program of the IHS as:

"a program which provides health services under this Act through a facility of the Indian Health Service, a tribal organization under the authority of the Indian Self-Determination Act, or a self-governance compact, or an urban Indian program."

The definition of Indian health care is written so as to expressly include tribal contractors, compactors, and urban programs. This definition, however, creates certain ambiguities in other sections of the Bill. For example, a tribe operating a 638 contract that includes a number of facilities or clinics would, under the Bill, be operating several "programs". This may lead to administrative problems given that the Bill allows for election of services to non-Indians on a program-by-program basis, and further provides for the establishment of comprehensive benefit package funds on a program-by-program basis.

1. We are unsure why this must be so. We have raised this issue with the IHS but have not received an explanation for the January 1, 1999 start-up provision. We assume that the Administration simply believed that health care reform would place such logistical, financial and administrative burdens on the IHS as to necessitate an additional year of preparation.

Under the Bill, the comprehensive benefit package would include:

- Inpatient, outpatient and emergency room services;
- Services of health professionals;
- Clinical preventive services;
- Mental health and substance abuse services;
- Family planning and pregnancy-related services;
- Limited hospice care;
- Limited home health care;
- Limited skilled nursing care;
- Ambulance services;
- Outpatient laboratory and diagnostic services;
- Outpatient prescription drugs and biologicals;
- Outpatient rehabilitation services;
- Durable medical equipment, prosthetic and orthotic devices;
- Routine eye and ear exams, and eyeglasses for children under 18;
- Dental services for children under 18;
- Health education; and
- Investigational treatments for life-threatening conditions.

Since the IHS currently provides nearly all of the above-listed benefits -- with the major exception of long-term care, and other exceptions such as home health care and hospice care which are limited to demonstration projects -- the extent to which the Bill would actually enhance the level of services within IHS is unlikely to be substantial. The Bill would not restrict or limit any of the large number of services or benefits which the IHS currently provides but which would not be part of the comprehensive benefit package, such as community health representatives and environmental health.

Under the Bill, American Indians and Alaska Natives would have the option of enrolling in either the IHS system (which includes tribal contractors, compactors, and urban programs) or a private plan sponsored by a regional or corporate alliance. Section 8302(b). Under the Bill, the IHS would still be responsible for the provision of supplemental benefits and services (services outside of the comprehensive benefit package) to all Indians, even those who do not enroll in the IHS system. Section 8303. Thus, an Indian may choose to enroll in a private plan and still receive supplemental benefits from the IHS. This provision is important since it is intended to assure that any American Indian or Alaska Native, regardless of the plan he or she chooses, will not experience a reduction in benefits because of that choice. This provision is also important as a stabilizing mechanism for IHS funding. In the absence of this provision, funding reductions would be in direct proportion to the number of IHS beneficiaries who leave the IHS system. With this provision in place, IHS and tribal contractors and compactors -- who would

still be responsible for providing a wide range of services and benefits to beneficiaries whether or not they actually leave the system -- have a rational argument to present to Congress for maintaining at least most of the present appropriations.

Section 8310 of the Bill provides that the IHS shall construct and renovate IHS and tribal facilities in order enable such facilities to deliver the services covered under the comprehensive benefit package. The IHS estimates such renovation and expansion would cost \$3.5 billion. The Bill would permit the Secretary to utilize funds appropriated under section 8313, general purpose funds, in order to pay for the cost of these projects. Section 8310(a). These funds, however, are very limited (between \$40 and \$200 million annually), and must also remain available for carrying out any of the other provisions in the Indian subtitle of the Bill. The Bill would create a revolving loan program under which the Secretary would provide guaranteed loans to Indian health providers within the IHS system to construct and renovate facilities. Section 8310(b). This provision, however, simply shifts the burden of facilities expansion and renovation from the IHS to the tribes.

Section 8304(c) provides that all health programs of the IHS must meet certification requirements, to be developed by the Secretary of HHS, by January 1, 1999. The Secretary shall also determine which of the requirements that are applicable to regional health alliances shall also apply to the IHS. It is unclear at present what those requirements will be.

2. Eligibility

Section 8302 of the Bill provides that an individual would be eligible to enroll in the IHS system if he or she (1) is an Indian as defined in the Indian Health Care Improvement Act ("IHCIA"), or a descendent of a member of an Indian tribe and and is regarded as an Indian by the Indian community, and resides on or near an Indian reservation; (2) is an urban Indian; or (3) meets the eligibility criteria for California Indians under the IHCIA. Indians choosing to enroll in the IHS system may do so through their local service unit, tribal organization, or urban program on an annual basis. Indians selecting the IHS system will not be required to pay for any health care services. Indians choosing to enroll in private plans will be responsible for premium payments and any other applicable deductibles, co-payments, or co-insurance charges.

Although section 1323(i) of the Bill contains penalties for failure to enroll in an alliance without good cause, that particular provision is directed at "regional alliance eligible individuals". The Bill does not appear to contain any penalties for Indians failing to enroll in the IHS system. Indians who do not enroll will simply be automatically enrolled in the IHS system

whenever they first seek services at an IHS or tribally-operated program.

The Bill's definition of eligibility more faithfully tracks the current eligibility regulations of the IHS, 42 CFR Part 36, which predate the suspended September 17, 1987, Final Rule. The eligibility regulations contained in the suspended Final Rule are far more restrictive than those currently in place. Tribes have been uniformly opposed to implementation of the Final Rule. Passage of the Bill as it now reads would essentially codify the current eligibility regulations.

3. Competition with regional alliance plans

The Bill would guarantee that all Americans receive the comprehensive benefit package by January 1, 1998 but would require Indians to wait until January 1, 1999, in order to be guaranteed the same benefits. See discussion at page 2. The Bill would also provide states with a number of financial incentives to establish regional health alliances or single-payer systems before 1998. For instance, states may receive large planning grants and may provide further risk adjustments and extra health care services in order to attract population groups with limited access to care because of geographic location, income levels, or racial and cultural differences. The IHS and tribes would receive no such support. We believe that this arrangement would put the IHS and tribes at a clear disadvantage in meeting the obligation to provide the comprehensive benefit package.

We are concerned that if the IHS and tribes will not be able to offer the comprehensive benefit package prior to 1999, then they may lose many of their members to private plans that can offer the comprehensive benefit package by 1998. Many tribal members might be willing to pay the additional costs necessary to receive health care through a regional alliance plan, especially if (1) the regional alliance plan offered the comprehensive benefit package at a time when the IHS or tribe did not; (2) the additional cost of enrolling in the private plan would be substantially reduced by federal low-income subsidies; and (3) tribal members enrolling in private plans would still receive all of their current supplemental benefits from the IHS. If tribal members opt to leave the IHS system, then resulting reduction to the tribes' user population base would likely lead to a proportionate reduction in IHS funding.

The most effective way to prevent a mass exodus from the IHS system may be to ensure that IHS and tribal programs remain competitive with the regional alliance plans. Thus, the federal government should take steps to ensure that IHS and tribal programs will be in a position to offer the comprehensive benefit package at the same time that the surrounding states do. One clear improvement would be to provide the IHS and tribes with

similar incentives and financial assistance to that given the states.

4. Services to non-Indians and non-enrollees

President Clinton's Health Security Act, in some instances, would authorize the Indian Health Service to offer services to non-beneficiaries without tribal consent, thus altering the terms under which such services can now be provided under section 813 of the IHCIA. The three ways in which this could happen are discussed below. Nevertheless, tribal authorization for such services would still be required if IHS services are provided by a tribe or tribal organization pursuant to a Self-Determination Act contract or Self-Governance compact.

A. *Family members*

The Health Security Act provides that a "health program of the Indian Health Service may open enrollment to family members" of eligible Indians. Section 8306(b). Since the Bill defines an Indian health program as a program which provides services through a particular facility, the choice of whether to let non-Indian family members enroll would be made on a program-by-program basis. If a health program is directly operated by the IHS, then the IHS will have the authority to unilaterally open services to non-Indian spouses and children without the consent of the tribes served by the program. But if a health program is operated by a tribe or tribal organization pursuant to a Self-Determination Act contract or Self-Governance compact, then that tribe or tribal organization, not the IHS, will decide whether it should permit services to non-Indian family members. We note that this provision of the Bill is inconsistent with Section 813 of the Indian Health Care Improvement Act, which authorizes the delivery of services to non-eligible spouses only if authorized by tribal resolution.

The Secretary would be required to establish premiums, to be paid to the local Indian health program, for non-Indian family members who enroll in the IHS system. Section 8306(b)(4). Such individuals would qualify for the same premium discounts they would have been entitled to if had enrolled in a private health plan. Non-Indian family members who enroll in the IHS system would also be responsible for all applicable deductibles, co-payments, and co-insurance charges. Employers of non-Indian family members who enroll in the IHS system would still be responsible for their employer premium payments.

B. *Contracting with local health plans*

The Health Security Act provides that a "health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program may enter into a contract" with a private health plan in order to

provide services to individuals enrolled in that plan. Section 8306(a). The Bill also requires the IHS (or tribes) to determine first that such a contract will not result in the denial or diminution of health services to eligible Indians. Thus, the Bill would allow the IHS, where it directly operates a health program or service unit, to unilaterally enter into a contract with private health plans and serve non-beneficiaries. But where a tribe or tribal organization operates a health program or service unit pursuant to a Self-Determination Act contract or Self-Governance compact, then the tribe or tribal organization, not the IHS, will decide whether or not to enter into contracts with non-Indian health plans. This provision of the bill is also inconsistent with Section 813 of the Indian Health Care Improvement Act, which permits IHS to provide services to non-beneficiaries only upon tribal authorization.

C. *Essential Community Providers*

The Health Security Act provides that a "health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program" may elect essential community provider status. Sections 8306(c) and 1582(a). Essential community provider status is designed primarily to ensure that private health plans do not purposely avoid contracting with clinics or facilities serving remote or other underserved populations.

Thus, during a five year start-up period, health plans offered through regional health alliances will be required to: (1) enter into participation agreements with providers within the region who elect essential community provider status; or (2) enter into written agreements under which the plans must make payments to providers electing essential community provider status. Section 1431(a). The Bill would require health plans to treat essential community providers on at least as favorable terms as other participating providers. Section 1431(b).

Should an IHS or tribal health program elect essential community provider status, then that program would be required to serve (1) eligible Indians who do not enroll in the IHS system and (2) family members of eligible Indians who do not enroll in the IHS system. Section 8306(c). We assume that such election will mean that the health program will serve non-Indians, although this is not entirely clear in the present bill. Similar to the provisions above, the decision to elect essential community provider status will rest with either the IHS, if a program is directly operated by the IHS, or with a tribe or tribal organization, if a program is operated by the tribe or tribal organization pursuant to a Self-Determination Act contract or Self-Governance compact.

5. Financing

The Bill would authorize the creation of funds at the IHS or tribal program level for the purpose of delivering the comprehensive benefit package. Section 8311. Into these funds would be paid: (1) employer premiums paid by employers on behalf of Indians who enroll in the IHS system; (2) family premiums and premium discount payments; (3) annual IHS appropriations; and (4) other amounts received with respect to health services for the comprehensive benefit package. The Bill does not set specific funding levels for these funds. Section 8314 would authorize the Secretary to calculate the total amount of premium discounts (for low-income individuals) which would have been paid to eligible Indians if they had enrolled in non-IHS health plans, and then pay that sum to the IHS for the purpose of providing the comprehensive benefit package. The Bill would also restrict fund expenditures by each program to the delivery of items and services under the comprehensive benefit package. Section 8311(c)(2).

In addition to the funding provided for the delivery of the comprehensive benefit package, section 8313 of the Bill would authorize additional appropriations of \$40 million in FY 1995, \$180 million in FY 1996, and \$200 million in each FY 1997 - FY 2000, for the general funding of IHS and tribal activities under the Indian provisions of the Bill (sections 8301-8314). The Bill would also authorize \$180 million in FY 1995, \$200 million in each FY 1996 - FY 2000, and such sums as necessary thereafter, for the provision of supplemental benefits. Section 8303. Finally, section 8307 of the Bill specifically provides that the IHS may continue to seek reimbursement from other third party payors, such as Medicare and Medicaid, as currently authorized under sections 206, 401 and 402 of the Indian Health Care Improvement Act.

The Bill raises substantial questions regarding the sufficiency of funding for the provision of both the comprehensive benefit package and supplemental benefits. For instance, the plan specifically targets only up to \$200 million per year for supplemental benefits under section 8303. At the October IHS health care reform meeting, the IHS estimated that it would cost at least \$800 million annually to maintain the level of supplemental services currently provided.

We are also concerned over the level of general funding under section 8313, up to \$200 million, which must cover part of the cost of renovating and expanding IHS and tribal facilities. Recent IHS estimates place the cost of facilities renovation and expansion at approximately \$3.5 billion. Another concern is that the IHS must receive sufficient funding in order to provide the comprehensive benefit package, which it must deliver by 1999. Otherwise, the IHS will be forced to use funding designated for supplemental services. Recent IHS estimates place the cost of the comprehensive benefit package at \$2.3 billion per year.

6. Employer premium exemption

The Bill would exempt tribal governments and tribal organizations operating pursuant to Indian Self-Determination Act contracts or Self-Governance compacts from paying the employer's share of their employees' premiums. The exemption in the plan is broader than in earlier versions of the Bill which exempted only tribal governments. The IHS has stated that the exemption would only apply to employer payments on behalf of Indian employees enrolled in the IHS system, but the actual language of the Bill makes no distinction between Indian and non-Indian employees nor between Indians enrolled in the IHS system and Indians enrolled in a private plan. Although this arrangement may result in a potential loss of revenue to regional alliances (who would otherwise collect employer premiums on behalf individuals enrolled in private plans), the exemption appears to have been created in furtherance of tribal economic development and self-determination.

Tribal businesses, however, which are neither governmental nor operated pursuant to 638 contracts or compacts would still be responsible for employer premium payments. Tribal officials have expressed concern over the effect of the tribal exemption. In particular, the IHS may view the exemption as a monetary windfall, and offset the money saved in payments by a proportionate reduction in IHS funding or support. Furthermore, to the extent that the Administration seeks to enhance tribal economic development and self-determination, tribes have argued that the exemption should apply to all reservation businesses.

7. Risk sharing

Section 8301 defines IHS and tribal health programs on a facility-by-facility basis. See discussion of "Indian health program" on page 2 of this memorandum. Section 8311 calls for the creation of a comprehensive benefit package fund for each health program which would receive funding from four sources, as described above. The overall effect, however, of concentrating payments on a local level would be the creation of dangerously small risk-sharing pools.

For non-Indian plans, the Bill mandates minimal capital standards which plans must meet in order to participate in the alliance system. For instance, plans would have to maintain at least \$500,000 of capital in order to participate. Section 1551. The National Health Board could also establish additional standards, including standards based on the projected number of plan enrollees and the extent and nature of risk-sharing with participating providers. Id. The Bill, however, would not set minimum standards for IHS and tribal programs. The problem which faces tribes is that certain IHS or tribal programs may simply be so small that they may not have an adequate funding base should program beneficiaries suffer a catastrophic event such as a localized epidemic. In general, the Bill anticipates that risk

will be shared on a regional or state-wide basis. It is doubtful, however, that the drafters intended to create risk-sharing pools with less than 1,000 members, but small tribes may find themselves in exactly that situation. Tribes should consider whether the Bill should be amended to distribute risk among Indian tribes on an IHS Area or national basis.

8. Regional health alliance collections

The Bill would authorize regional alliances to act as agents for the collection of employer premium payments with respect to Indian employees who enroll in the IHS system. Section 1351(e)(3)(B). The regional alliances would then turn the collections over to the Secretary for distribution to the IHS and tribes. The Bill would permit alliances to retain a "nominal" fee in order to compensate them for collecting activities. Tribes should carefully monitor the extent to which regional alliances exercise this power since the premium beneficiaries will be served by the IHS, not the alliance, system.

9. Risk adjustments

The Bill would require the National Health Board to develop a methodology in order to adjust alliance payments to private, but not IHS or tribal, health plans which serve a greater proportion of patients who are at-risk. Section 1541. This methodology, to be based on such factors as geographic location, income levels, health status, and socio-economic status, would insure that plans serving a greater number of at-risk patients will receive additional payments in order to reflect an expected increase in utilization and cost. The restriction of risk adjustments to private health plans may be a result of the fact that the federal government will not subsidize risk adjusted payments (the zero sum methodology in section 1541(b)(3) requires an alliance to offset increased payments to certain plans with payment reductions to other plans). Nonetheless, the fact remains that certain private plans would receive greater payments based on their enrollment of higher percentages of at-risk populations. We believe the Bill should be amended to permit IHS and tribal programs, which serve large numbers of at-risk beneficiaries, to qualify for federal risk-adjusted payments.

10. Public Health Initiatives

Title III of the Bill creates a number of public health initiatives which would be available to communities and populations at large but, in general, not to tribes in the IHS system. Indian tribes and tribal organizations should be eligible to participate in many of the initiatives contained in this title, including the national health promotion and disease prevention initiative, section 3331, health care access initiatives for urban and rural medically-underserved populations, section 3411-3462, and school health education grants, sections 3651-3692. We note

that the development of new service delivery networks through "qualified community health plans" may include urban Indian programs and health programs operated by tribes pursuant to Indian Self-Determination Act contracts and Self-Governance compacts. Section 3421(d)(7).

11. Long-term care benefits

The Bill mandates the inclusion of certain hospice, home health, and long-term care benefits as part of the comprehensive benefit package. Section 1117-1119. The inclusion of long-term care, while limited in scope, in the comprehensive benefit package represents a major change in the scope of IHS services. Nevertheless, the Bill does not adequately provide for geriatric training of IHS and tribal personnel, nor does it adequately fund the necessary expansion of IHS and tribal facilities in order to provide long-term care services. While Section 2101 of the Bill would establish new home and community-based services for the severely disabled, the scope of this new program would be limited and only marginally affect Indians. Furthermore, this program would be state-operated and Indians qualifying for new home and community-based services would have to participate through the state and not the IHS system. Tribes should consider whether the Bill should be amended so that the IHS could directly deliver the new home and community-based care benefits.

12. Health Professionals

The Bill includes the services of health professionals within the comprehensive benefit package. Section 1112. The Bill defines a "health professional" as an individual who provides "health professional services". Section 1112(c)(1). The Bill leaves to the states the authority to determine which services qualify as "health professional services". Section 1112(c)(2)(B). The Bill also provides that the Secretary of HHS may certify certain health providers, including health professionals professionals as defined in section 1582(c), as additional essential community providers. Section 1583(a). Some tribes have expressed an interest in expanding the definition of health professionals to include traditional Indian healers. Tribes may wish to amend section 1112(c)(2)(B) to include services provided by a person legally authorized by a tribe in addition to a state.

13. Trust Responsibility

The Bill does not specifically refer to the federal government's trust responsibility to American Indians and Alaska Natives. Nevertheless, the Bill does state that, unless otherwise provided, none of the obligations, findings or purposes contained in the IHCIA or Indian Self-Determination Act are rescinded or modified. Both the IHCIA and Indian Self-Determination Act contain provisions affirming the trust relationship. The IHCIA, 25 U.S.C. § 1601(a), states:

"Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."

The IHCIA, 25 U.S.C. § 1602(a), also states:

"[I]t is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."

The Indian Self-Determination Act, 25 U.S.C. § 450a(b), states:

"The Congress declares its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, individual Indian tribes and to the Indian people as a whole through the establishment of a meaningful Indian self-determination policy... ."

While the Bill implicitly supports these principles, we believe that the Bill should include an affirmation of the special trust relationship that exists between the federal government and American Indian and Alaska Native tribes.

Conclusion

Although the National Health Security Act retains the mission and structure of the Indian Health Service, the Bill would materially alter both the services and relationship between Indian and non-Indian providers. Tribes should familiarize themselves with the Bill and the issues raised in the debate over health care reform in order to inform Congress how the Bill should be amended to better serve the needs of American Indians and Alaska Natives. While the primary purposes of this Bill are to (1) control the growth of health care spending, and (2) attain universal health care coverage, tribes should also consider how the Bill could be amended in order to raise the quality of health care within Indian country as well as the health status of Indians.

Sincerely,

HOBBS, STRAUS, DEAN & WILDER

HOBBS, STRAUS, DEAN & WILDER

Inquiries concerning this Memorandum may be directed to Christopher T. Stearns.

S. 1757

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

13 **Subtitle D—Indian Health Service**

14 **SEC. 8301. DEFINITIONS.**

15 For the purposes of this subtitle—

16 (1) the term “health program of the Indian
17 Health Service” means a program which provides
18 health services under this Act through a facility of
19 the Indian Health Service, a tribal organization
20 under the authority of the Indian Self-Determination
21 Act or a self-governance compact, or an urban In-
22 dian program;

23 (2) the term “reservation” means the reserva-
24 tion of any federally recognized Indian tribe, former
25 Indian reservations in Oklahoma, and lands held by

1 incorporated Native groups, regional corporations,
2 and village corporations under the provisions of the
3 Alaska Native Claims Settlement Act (43 U.S.C.
4 1601 et seq.);

5 (3) the term "urban Indian program" means
6 any program operated pursuant to title V of the In-
7 dian Health Care Improvement Act; and

8 (4) the terms "Indian", "Indian tribe", "tribal
9 organization", "urban Indian", "urban Indian orga-
10 nization", and "service unit" have the same meaning
11 as when used in the Indian Health Care Improve-
12 ment Act (25 U.S.C. 1601 et seq.).

13 **SEC. 8302. ELIGIBILITY AND HEALTH SERVICE COVERAGE**
14 **OF INDIANS.**

15 (a) **ELIGIBILITY.**—An eligible individual, as defined
16 in section 1001(c), is eligible to enroll in a health program
17 of the Indian Health Service if the individual is—

18 (1) an Indian, or a descendent of a member of
19 an Indian tribe who belongs to and is regarded as
20 an Indian by the Indian community in which the in-
21 dividual lives, who resides on or near an Indian res-
22 ervation or in a geographical area designated by
23 statute as meeting the requirements of being on or
24 near an Indian reservation notwithstanding the lack
25 of an Indian reservation;

1 (2) an urban Indian; or

2 (3) an Indian described in section 809(b) of the
3 Indian Health Care Improvement Act (25 U.S.C.
4 1679(b)).

5 (b) ELECTION.—An individual described in sub-
6 section (a) may elect a health program of the Indian
7 Health Service instead of a health plan.

8 (c) ENROLLMENT FOR BENEFITS.—An individual
9 who elects a health program of the Indian Health Service
10 under subsection (b) shall enroll in such program through
11 a service unit, tribal organization, or urban Indian pro-
12 gram. An individual who enrolls in such program is not
13 subject to any charge for health insurance premiums,
14 deductibles, copayments, coinsurance, or any other cost
15 for health services provided under such program.

16 (d) PAYMENTS BY INDIVIDUALS WHO DO NOT EN-
17 ROLL.—If an individual described in subsection (a) does
18 not enroll in a health program of the Indian Health Serv-
19 ice, no payment shall be made by the Indian Health Serv-
20 ice to the individual (or on behalf of the individual) with
21 respect to premiums charged for enrollment in an applica-
22 ble health plan or any other cost of health services under
23 the applicable health plan which the individual is required
24 to pay.

1 **SEC. 8303. SUPPLEMENTAL INDIAN HEALTH CARE BENE-**
2 **FITS.**

3 (a) **IN GENERAL.**—All individuals described in sec-
4 tions 8302(a) remain eligible for such benefits under the
5 laws administered by the Indian Health Service as supple-
6 ment the comprehensive benefit package. The individual
7 shall not be subject to any charge or any other cost for
8 such benefits.

9 (b) **AUTHORIZATION OF APPROPRIATIONS.**—In addi-
10 tion to amounts otherwise authorized to be appropriated,
11 there is authorized to be appropriated to carry out this
12 section \$180,000,000 for fiscal year 1995, \$200,000,000
13 for each of the fiscal years 1996 through 1999, and such
14 sums as may be necessary for fiscal year 2000 and each
15 fiscal year thereafter.

16 **SEC. 8304. HEALTH PLAN AND HEALTH ALLIANCE RE-**
17 **QUIREMENTS.**

18 (a) **COMPREHENSIVE BENEFIT PACKAGE.**—The Sec-
19 retary shall ensure that the comprehensive benefit package
20 is provided by all health programs of the Indian Health
21 Service effective January 1, 1999, notwithstanding section
22 1001(a).

23 (b) **APPLICABLE REQUIREMENTS OF HEALTH**
24 **PLANS.**—In addition to subsection (a), the Secretary shall
25 determine which other requirements relating to health

1 plans apply to health programs of the Indian Health Serv-
2 ice.

3 (c) CERTIFICATION.—Effective January 1, 1999, all
4 health programs of the Indian Health Service must meet
5 the certification requirements for health plans, as required
6 by the Secretary under this section, as certified from time
7 to time by the Secretary. Before January 1, 1999, all such
8 health programs shall, to the extent practicable, meet such
9 certification requirements.

10 (d) HEALTH ALLIANCE REQUIREMENTS.—The Sec-
11 retary shall determine which requirements relating to
12 health alliances apply to the Indian Health Service.

13 **SEC. 8305. EXEMPTION OF TRIBAL GOVERNMENTS AND**
14 **TRIBAL ORGANIZATIONS FROM EMPLOYER**
15 **PAYMENTS.**

16 A tribal government and a tribal organization under
17 the Indian Self-Determination and Educational Assistance
18 Act or a self-governance compact shall be exempt from
19 making employer premium payments as an employer
20 under section 6121.

21 **SEC. 8306. PROVISION OF HEALTH SERVICES TO NON-EN-**
22 **ROLLEES AND NON-INDIANS.**

23 (a) CONTRACTS WITH HEALTH PLANS.—

24 (1) IN GENERAL.—A health program of the In-
25 dian Health Service, a service unit, a tribal organi-

1 zation, or an urban Indian organization operating
2 within a health program may enter into a contract
3 with a health plan for the provision of health care
4 services to individuals enrolled in such health plan if
5 the program, unit, or organization determines that
6 the provision of such health services will not result
7 in a denial or diminution of health services to any
8 individual described in section 8302(a) who is en-
9 rolled for health services provided by such program,
10 unit, or organization.

11 (2) REIMBURSEMENT.—Any contract entered
12 into pursuant to paragraph (1) shall provide for re-
13 imbursement to such program, unit, or organization
14 in accordance with the essential community provider
15 provisions of section 1431(c), as determined by the
16 Secretary.

17 (b) FAMILY TREATMENT.—

18 (1) DETERMINATION TO OPEN ENROLLMENT.—
19 A health program of the Indian Health Service may
20 open enrollment to family members of individuals
21 described in section 8302(a).

22 (2) ELECTION.—If a health program of the In-
23 dian Health Service opens enrollment to family
24 members of individuals described in section 8302(a),
25 an individual described in that section may elect

1 family enrollment in the health program instead of
2 in a health plan.

3 (3) ENROLLMENT.—

4 (A) IN GENERAL.—An individual who
5 elects family enrollment under paragraph (2) in
6 a health program of the Indian Health Service
7 shall enroll in such program.

8 (B) APPLICABLE INDIVIDUAL CHARGES.—
9 The individual who enrolls in such program
10 under subparagraph (A) is not subject to any
11 charge for health insurance premiums,
12 deductibles, copayments, coinsurance, or any
13 other cost for health services provided under
14 such program attributable to the individual, but
15 the family members who are not eligible for a
16 health program of the Indian Health Service
17 under section 8302(a) are subject to all such
18 charges.

19 (C) APPLICABLE EMPLOYER CHARGES.—
20 Employers, other than tribal governments and
21 tribal organizations exempt under section 8305,
22 are liable for making employer premium pay-
23 ments as an employer under section 6121 in the
24 case of any family member enrolled under this
25 subsection who is not eligible for a health pro-

1 gram of the Indian Health Service under sec-
2 tion 8302(a).

3 (4) PREMIUM.—

4 (A) ESTABLISHMENT AND COLLECTION.—

5 The Secretary shall establish premiums for all
6 family members enrolled in a health program of
7 the Indian Health Service under this paragraph
8 who are not eligible for a health program of the
9 Indian Health Service under section 8302(a).

10 The Secretary shall collect each premium pay-
11 ment owed under this paragraph.

12 (B) REDUCTION.—The Secretary shall pro-
13 vide for a process for premium reduction which
14 is the same as the process, and uses the same
15 standards, used by regional alliances for the
16 areas in which individuals described in subpara-
17 graph (A) reside, except that in computing the
18 family share of the premiums the Secretary
19 shall use the lower of the premium quoted or
20 the reduced weighted average accepted bid for
21 the reference regional alliance.

22 (C) PAYMENT BY SECRETARY.—The Sec-
23 retary shall provide for payment to each health
24 program of the Indian Health Service, in the
25 same manner as payments under section 6201,

1 amounts equivalent to the amount of payments
2 that would have been made to a regional alli-
3 ance if the individuals described in subpara-
4 graph (A) were enrolled in a regional alliance
5 health plan (with a final accepted bid equal to
6 the reduced weighted average accepted bid pre-
7 mium for the regional alliance).

8 (c) ESSENTIAL COMMUNITY PROVIDER.—

9 (1) HEALTH SERVICES.—If a health program of
10 the Indian Health Service, a service unit, a tribal or-
11 ganization, or an urban Indian organization operat-
12 ing within a health program elects to be an essential
13 community provider under section 1431, an individ-
14 ual described in paragraph (2) enrolled in a health
15 plan other than a health program of the Indian
16 Health Service may receive health services from that
17 essential community provider.

18 (2) INDIVIDUAL COVERED.—An individual re-
19 ferred to in paragraph (1) is an individual who—

20 (A) is described in section 8302(a); or

21 (B) is a family member described in sub-
22 section (b) who does not enroll in a health pro-
23 gram of the Indian Health Service.

1 **SEC. 8307. PAYMENT BY OTHER PAYERS.**

2 (a) **PAYMENT FOR SERVICES PROVIDED BY INDIAN**
3 **HEALTH SERVICE PROGRAMS.**—Nothing in this subtitle
4 shall be construed as amending section 206, 401, or 402
5 of the Indian Health Care Improvement Act (relating to
6 payments on behalf of Indians for health services from
7 other Federal programs or from other third party payers).

8 (b) **PAYMENT FOR SERVICES PROVIDED BY CON-**
9 **TRACTORS.**—Nothing in this subtitle shall be construed as
10 affecting any other provision of law, regulation, or judicial
11 or administrative interpretation of law or policy concern-
12 ing the status of the Indian Health Service as the payer
13 of last resort for Indians eligible for contract health serv-
14 ices under a health program of the Indian Health Service.

15 **SEC. 8308. CONTRACTING AUTHORITY.**

16 Section 601(d)(1)(B) of the Indian Health Care Im-
17 provement Act (25 U.S.C. 1661(d)(1)(B)) is amended by
18 inserting “(including personal services for the provision of
19 direct health care services)” after “goods and services”.

20 **SEC. 8309. CONSULTATION.**

21 The Secretary shall consult with representatives of
22 Indian tribes, tribal organizations, and urban Indian orga-
23 nizations annually concerning health care reform initia-
24 tives that affect Indian communities.

1 **SEC. 8310. INFRASTRUCTURE.**

2 (a) **FACILITIES.**—The Secretary, acting through the
3 Indian Health Service, may expend amounts appropriated
4 pursuant to section 8313 for the construction and renova-
5 tion of hospitals, health centers, health stations, and other
6 facilities for the purpose of improving and expanding such
7 facilities to enable the delivery of the full array of items
8 and services guaranteed in the comprehensive benefit
9 package.

10 (b) **CAPITAL FINANCING.**—There is established in the
11 Indian Health Service a revolving loan program. Under
12 the program, the Secretary, acting through the Indian
13 Health Service, shall provide guaranteed loans under such
14 terms and conditions as the Secretary may prescribe to
15 providers within the Indian Health Service system to im-
16 prove and expand health care facilities to enable the deliv-
17 ery of the full array of items and services guaranteed in
18 the comprehensive benefit package.

19 **SEC. 8311. FINANCING.**

20 (a) **ESTABLISHMENT OF FUND.**—Each health pro-
21 gram of the Indian Health Service shall establish a com-
22 prehensive benefit package fund (hereafter in this section
23 referred to as the “fund”).

24 (b) **DEPOSITS.**—There shall be deposited into the
25 fund the following:

1 (1) All amounts received as employer premium
2 payments pursuant to section 1351(e)(3).

3 (2) All amounts received as family premium
4 payments and premium discount payments pursuant
5 to section 8306(b)(4).

6 (3) All amounts appropriated for the fund for
7 the purpose of providing the comprehensive benefit
8 package to individuals enrolled in a health program
9 of the Indian Health Service.

10 (4) Any other amount received with respect to
11 health services for the comprehensive benefit pack-
12 age.

13 (c) ADMINISTRATION AND EXPENDITURES.—

14 (1) MANAGEMENT.—The fund shall be man-
15 aged by the health program of the Indian Health
16 Service.

17 (2) EXPENDITURES.—Expenditures may be
18 made from the fund to provide for the delivery of
19 the items and services of the comprehensive benefit
20 package under the health program of the Indian
21 Health Service.

22 (3) AVAILABILITY OF FUNDS.—Amounts in the
23 fund established by a service unit of the Indian
24 Health Service under this section shall be available
25 without further appropriation and shall remain

1 available until expended for payments for the deliv-
2 ery of the items and services in the comprehensive
3 benefit package.

4 **SEC. 8312. RULE OF CONSTRUCTION.**

5 Unless otherwise provided by this Act, no part of this
6 Act shall be construed to rescind or otherwise modify any
7 obligations, findings, or purposes contained in the Indian
8 Health Care Improvement Act (25 U.S.C. 1601 et seq.)
9 and in the Indian Self-Determination and Education As-
10 sistance Act.

11 **SEC. 8313. AUTHORIZATIONS OF APPROPRIATIONS.**

12 (a) AUTHORIZATION OF APPROPRIATIONS.—For the
13 purpose of carrying out this subtitle, there are authorized
14 to be appropriated \$40,000,000 for fiscal year 1995,
15 \$180,000,000 for fiscal year 1996, and \$200,000,000 for
16 each of the fiscal years 1997 through 2000.

17 (b) RELATION TO OTHER FUNDS.—The authoriza-
18 tions of appropriations established in subsection (a) are
19 in addition to any other authorizations of appropriations
20 that are available for the purposes of carrying out this
21 subtitle.

22 **SEC. 8314. PAYMENT OF PREMIUM DISCOUNT EQUIVALENT**
23 **AMOUNTS FOR UNEMPLOYED INDIANS.**

24 (a) DETERMINATION.—The Secretary shall deter-
25 mine (and certify to the Secretary of the Treasury) for

1 each fiscal year (beginning with fiscal year 1998) an
2 amount equivalent to the aggregate amount of the pre-
3 mium discounts (established in section 6104) that would
4 have been paid to individuals described in subsection (c)
5 if such individuals had been enrolled in regional alliance
6 health plans.

7 (b) PAYMENT.—For each fiscal year for which an
8 amount is certified to the Secretary of the Treasury under
9 subsection (a), from the funds available under section
10 9102, such Secretary shall pay the amount so certified to
11 the Indian Health Service for the purpose of providing the
12 comprehensive benefit package.

13 (c) INDIVIDUAL DESCRIBED.—For purposes of this
14 section, an individual described in this subsection is an
15 individual described in section 8302(a) who is not a quali-
16 fying employee or a family member of such an employee.

SUBTITLE D - INDIAN HEALTH SERVICE
(H.R. 3600 and S. 1757 p. 1249)

Section 8301. Definitions. This section defines the following terms for the purpose of this subtitle:

(1) The term "health program of the Indian Health Service" means a program which provides health services under this Act through a facility of the Indian Health Service, a tribal organization under the authority of the Indian Self-Determination Act or a self-governance compact, or an urban Indian program.

(2) The term "reservation" means the reservation of any federally recognized Indian tribe, former Indian reservations in Oklahoma, and lands held by incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act.

(3) The term "urban Indian program" means any program operated pursuant to title V of the Indian Health Care Improvement Act.

(4) The terms "Indian", "Indian tribe", "tribal organization", and "service unit" have the same meaning as when used in the Indian Health Care Improvement Act.

Section 8302. Eligibility and Health Service Coverage of Indians. An eligible individual is eligible to enroll in a health program of the Indian Health Service, and may elect a health program of the Indian Health Service instead of a health plan, if the individual is: (1) an Indian, or a descendent of a member of an Indian tribe who belongs to and is regarded as an Indian by the Indian community in which the individual lives, who resides on or near an Indian reservation or in a geographical area designated by statute as meeting the requirements of being on or near a reservation notwithstanding the lack of an Indian reservation; (2) an urban Indian; or (3) a Indian living in certain counties in California as described in section 809(b) of the Indian Health Care Improvement Act.

An individual described above who elects a health program of the Indian Health Service must enroll in the program. The individual is not required to pay any health insurance premiums or other cost sharing. If an individual chooses not to enroll in a health program of the Indian Health Service and instead enrolls in an alliance health plan, the Indian Health Service does not pay the premiums and cost sharing required by the health plan.

Section 8303. Supplemental Indian Health Care Benefits. All individuals described in section 8302 remain eligible for supplemental benefits offered by the Indian Health Service at no charge. \$180,000,000 for fiscal year 1995 and \$200,000,000 for each of the fiscal years 1996 through 1999 are appropriated for supplemental benefits.

Section 8304. Health Plan and Health Alliance Requirements. Beginning on January 1, 1999, all health programs of the Indian Health Service must provide the comprehensive benefit package. The Secretary of Health and Human Services will determine which other health plan requirements will apply to health programs of the Indian Health Service. Beginning on January 1, 1999, all health programs of the Indian Health Service must meet the health plan requirements that the Secretary determines apply to Indian health programs. Before January 1, 1999, all health programs must, to the extent practicable, meet these requirements. The Secretary must also determine which requirements relating to health alliances apply to the Indian Health Service.

Section 8305. Exemption of Tribal Governments and Tribal Organizations from Employer Payments. Tribal governments and tribal organizations under the Indian Self-Determination and Educational Assistance Act or a self-governance compact are not required to make employer premium payments.

Section 8306. Provision of Health Services to Non-Enrollees and Non-Indians. A health program or facility of the Indian Health Service may contract with a health plan to provide services to individuals enrolled in that health plan if the program or facility determines that the contract will not result in a denial or diminution of health services to Indians enrolled in a health program of the Indian Health Service. The health program or facility is reimbursed as an essential community provider based on an alliance fee schedule or Medicare payment methodology and rates, as determined by the Secretary.

A health program of the Indian Health Service may open enrollment to family members of individuals described in section 8302. If the health program opens enrollment to family members, family members who choose to join a health program of the Indian Health Service must enroll. Family members must pay premiums and other cost sharing. The Secretary of Health and Human Services must establish and collect premiums for family members enrolled in health programs of the Indian Health Service.

The Secretary must provide for a process for premium reduction which is the same as the process used by regional alliances for the areas in which family members reside, but in computing the family share of the premiums the Secretary must use the lower of the premium quoted or the reduced weighted average accepted bid for the reference regional alliance. The Secretary must pay to each health program the amounts that would have been paid to a regional alliance if the individual had enrolled in a regional alliance health plan (with a final accepted bid equal to the reduced weighted average accepted bid premium for the regional alliance).

If a health program or facility of the Indian Health Service elects to be an essential community provider, an individual described in section 8302 or a family member of the individual may receive health services from that essential community provider.

Section 8307. Payment By Other Payers. Indian Health Service programs will continue to receive payments from other Federal programs and third party payers. The Indian Health Service continues to be the payer of last resort for Indians eligible for contract health services under a health program of the Indian Health Service.

Section 8308. Contracting Authority. The Indian Health Care Improvement Act is amended to permit contracting for personal services for the provision of direct health care services.

Section 8309. Consultation. The Secretary must consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities.

Section 8310. Infrastructure. The Secretary may expend funds appropriated under section 8313 for the construction and renovation of hospitals, health centers, health stations and other facilities for the purpose of improving and expanding these facilities to deliver the comprehensive benefit package. In order to enable health care facilities to deliver the package, the Secretary will establish a revolving loan program to provide guaranteed loans under terms and conditions determined by the Secretary to providers within the Indian Health Service.

Section 8311. Financing. Each health program of the Indian Health Service must establish a comprehensive benefit package fund. All employer premium payments, family premium payments and premium discount payments, appropriations for the purpose of delivering the comprehensive benefit package to enrollees in a health program of the Indian Health Service and any other amount received for the provision of the comprehensive benefit package must be deposited into the fund. Each fund is managed by the health program. Expenditures may be made from the fund for the delivery of the comprehensive benefit package. Amounts in the fund remain available without further appropriation and remain available until expended for payments for the delivery of the comprehensive benefit package.

Section 8312. Rule of Construction. Unless otherwise provided, no part of this act rescinds or modifies any obligations, findings or purposes contained in the Indian Health Care Improvement Act and in the Indian Self-Determination and Education Assistance Act.

Section 8313. Authorizations of Appropriations. For the purposes of carrying out this subtitle, there are authorized to be appropriated \$40,000,000 for fiscal year 1995, \$180,000,000 for fiscal year 1996, and \$200,000,000 for each of the fiscal years 1997 through 2000. These appropriations are in addition to any other authorizations of appropriations that are available for carrying out this subtitle.

Section 8314. Payment of Premium Discount Equivalent Amounts for Unemployed Indians. The Secretary determines for each fiscal year beginning in fiscal year 1998 an amount equivalent to the total amount of premium discounts that would have been

paid to an individual described in section 8302 who is unemployed. The Secretary certifies this amount to the Secretary of the Treasury who pays the amount to the Indian Health Service.

FAX TO
Sara & Kim D.

DPC Program Staff

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

05-Jan-1994 06:29pm

TO: (See Below)

FROM: Jeffrey L. Eller
 Office of Media Affairs

SUBJECT: Health Care Talking Points 1/6

The White House
Health Care Reform Today
January 6, 1994

* We must have comprehensive health care reform in order to move forward on the rest of the President's domestic agenda. Without reform, health care costs will continue to explode and eat up our investment dollars. Without reform, people will continue to be locked in current jobs or on welfare. The bottom line: we cannot end welfare unless we also have comprehensive health care reform. This initiative has four major parts: the Earned Income Tax Credit; health care reform; personal responsibility and work.

* The Earned Income Tax Credit (EITC). We ought to reward work over welfare. Enacted in last year's budget, the expanded EITC will ensure that any family that has a full-time worker will no longer live in poverty. Expanding the EITC represents a giant step forward in reducing those dependent on welfare.

* Comprehensive health care reform. Today, millions of welfare recipients stay on Medicaid -- the Federal government's health care program for the poor -- because taking a job means they will lose health benefits for themselves and their children. Comprehensive health reform will eliminate so-called "Medicaid lock" and enable people to seek jobs, secure in the knowledge that they and their children will be covered. By ensuring universal coverage, the Health Security Act provides the necessary foundation for welfare reform.

* Personal responsibility. The President's welfare reform plan will include initiatives to

prevent teen pregnancy, ensure that parents fulfill their child support obligations, dramatically increase paternity establishment, and try to keep people from going on welfare in the first place. The message is clear: Governments don't raise children, parents do.

* Work, not welfare. The final part of the President's welfare plan will build on the Family Support Act by requiring people who can work to do so within two years, either in the private sector or community service. This includes expanding child care for working families; providing education, training, and job search and placement

for those who need it; and restoring the basic social contract of providing opportunity and demanding responsibility in return. Without health care reform, a welfare reform argument carries nothing more than the weight of political rhetoric.

* Universal Coverage vs. Universal Access. What's the difference? On yesterday's TODAY Show, Senior Policy Advisor Ira Magaziner said: "(We need) universal coverage to be sure that everybody can afford health care. It's not enough to say that you can have access to an expensive restaurant if you can't go in and afford to eat. You need to be able to afford the coverage and to be able to have comprehensive benefits in order to really have universal coverage."

Health Care Reform Today * The White House *
202-456-2566 * Fax: 202-456-2362

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THE WHITE HOUSE
WASHINGTON, DC 20500
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FROM: CAROL H. BASCO
DATE: 1/6/94
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TO: Dana Rosenbaum
FAX #: 296-0025
FROM: CAROL H. BASCO
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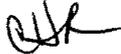
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Health Care Meetings

Carol H. Rasco

APRIL	9	Rural health care provider
	14	American Health Care Association
	16	AIDS Provider Group
	18	American Academy of Pediatrics
	27	Joanne Woodward
	28	UCPA
	29	American Academy of Physicians' Assistants Rep. Foutney H. (Pete) Stark
MAY	1	Jackson Hole Group
	3	Bill Price
	4	Pat Moran Dr. Betty Lowe
	5	Massachusetts Biotechnology Council Walt Patterson John Tisdale
	6	Medicaid Directors
	10	Paul Berry

MEMORANDUM FOR MACK MCLARTY, THE WHITE HOUSE

FROM: Carol Rasco 

SUBJECT: Weekly Report for May 10

THE WEEK AHEAD

Health Care Reform decision meetings with the President will continue.

I will speak to the CEO Institute on Monday and the following interviews are scheduled: Peter Jennings radio call-in show; Business Week; Associated Press; Washington Post on immunization; and a medical periodical.

The Welfare Reform Working Group will meet on Monday to discuss making work work.

The Interagency Working Group on Ecosystem Management Economic Issues will submit a "draft" decision memorandum to senior level advisors next week. A final decision memo is due to the President by June 1.

The Interagency Working Group on New and Growing Businesses will meet next week to examine draft OMB options on pending securitization and secondary-market legislation.

Briefings continue with criminal justice groups on National Service and public safety.

Meetings continue on the Hill with Members on the Community Development Financial Institutions Legislation.

Meetings are scheduled next week to discuss federal drug treatment programs.

CONGRESS

Senator Biden continues to support quick introduction of crime bill soon--perhaps next week.

PRESS

Julie Kosterlitz of the National Journal interview for a piece on Secretary Shalala.

Pat Rice of the Shreveport Times for a piece on children in poverty.

Joe Shapiro of US NEWS and WORLD REPORT on disability issues.

WEEK IN REVIEW

A White House interdepartmental working group on abortion and choice has been established.

I met with groups on health care reform, child support, AIDS research, employment and training programs in the states, reconciliation issues.

I spoke to White House Fellows.

The search continues for an AIDS Policy Coordinator.

DPC has worked with NEC and OEP to develop a chart of legislation and Administration issues "on the drawing board" from now through January of 1994.

The search continues for a Chairman for NEA.

Several White House staffers, including DPC, are working to prepare Sheldon Hackney for his confirmation hearings.

Mike Castle has indicated an interest in working on the welfare reform effort.

DPC is meeting with representatives from the National Indian Gaming Association to discuss the Indian Gaming Regulatory Act.

Meetings continue with DPC, OMB, and DOJ to discuss policing initiatives.

Work continues on the elimination of unnecessary commissions.

Meetings on Health Care

Carol H. Rasco

January 28

- Governor Romer/NGA Staff
- Family Voices (parents of disabled children)

February 1

- Governors at White House
- CHR spoke to COS of Governors

February 4

- CHR spoke to Women's Division of Atlanta Jewish Federation

February 5

- Sen. Kennedy

February 8

- Mike Wenger of Appalachian Regional Commission

February 11

- National Council of Jewish Women
- Federation of American Health System
- Health Care Leadership Council

February 12 & 13

- 4 meetings with different groups in Mrs. Clinton's Office

February 16

- American Jewish Committee
- American Speech & Hearing Assoc.

February 18

- 5 major insurance firms

February 22

- Southern Regional Institute on Children & Families

February 23

- Coalition for American Children

February 25

- Paul Ellwood

March 2

- NARD rep.
- National Urban League rep.

March 3

- NARAL rep.

March 5

-National Commission on Children rep.

March 8

-Alpha Center: Rural Health Care

-Mayor of San Juan

March 9

-6 biotech firms

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TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Pasco

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Jill Hargis 690-6133

RECIPIENTS FAX NUMBER: () 456-2878

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Kevin asked me to look into this situation.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

MEMORANDUM

To: Carol Rasco
From: Jill Hargis *JH*
Re: Melissa Acevedo and fetal tissue transplant surgery

Melissa Acevedo has DeGeorge's Syndrome which caused her to be born with upper respiratory and other organ malformations. She has had several reconstructive operations but still lacks a thymus gland which produces the T cells necessary for maintaining an immune system. As Melissa grows older, the immunities given to her from her mother naturally weaken and are not replaced by her own. She is increasingly having to fight off serious infections. Doctors are surprised that Melissa has lived to her age of nine months.

During the campaign, Governor Clinton spoke with the Acevedos and promised that the ban on fetal tissue research would be lifted. Since the ban on fetal tissue use was lifted there are no legal barriers to Melissa having this surgery. Because it has been a long time since anyone has done this type of transplant, however, there are few resources available. The family says that they have a qualified doctor willing to perform the surgery, but he is having a very hard time finding a fetal thymus. At this point, I am not sure of all the barriers to this surgery.

The ethics counsel at HHS says that as long as there is some policy reason as to why we are choosing to help this family, such as facilitating quick implementation of the HHS regulation, there should be no problem. Acting Assistant Secretary for Health Dr. Manley will find out for us if NIH has the capacity to help. I will keep you informed.

EXECUTIVE OFFICE OF THE PRESIDENT

26-May-1993 07:37pm

TO: (See Below)
FROM: S. Collier Andress
Office of Communications
SUBJECT: talking points

THE CLINTON HEALTH CARE PLAN

THE STATUS QUO

- ? American families do not have the security they deserve. 100,000 people a month are losing their coverage, and those who switch jobs or have a pre-existing condition are not guaranteed coverage.
- ? Americans are getting killed by skyrocketing health costs. Without immediate reform, the annual cost of health care for American families will more than double by the end of the decade -- to a whopping \$14,000 per family.
- ? The current system is broken -- and it threatens your family's future and the future of every American business.
- ? We must take action now.

THE CLINTON PLAN

President Clinton will soon present a proposal for comprehensive health reform. His plan will fundamentally overhaul the system and increase the quality of care while preserving your right to see your doctor.

The powerful lobbies of the special interests are already lining up to block the President's plan. But with your support, the President will break the gridlock.

The proposal will be based on the following principles:

- 1) Security: The Clinton plan will provide Americans with the security of knowing that they will have health coverage even if

they switch jobs, lose their job or have a preexisting condition.

- 2) Choice: The Clinton plan will allow you to choose your doctor. And most Americans will have more choice of health plans. Under the Clinton proposal, your employer or insurance company won't pick your health plan -- you will.
- 3) Quality: The Clinton plan will increase the quality of care. And it will hold doctors and hospitals accountable with a simple consumer "report card" for each health plan.
- 4) Controlling Costs: The Clinton plan will make health care affordable again. And it will control the spiralling costs that are strangling American businesses.
- 5) Comprehensiveness: The Clinton plan will guarantee all Americans a comprehensive benefits package.
- 6) Simplicity: The Clinton plan will reduce paperwork for both doctors and patients, and it will eliminate fraud and abuse. The health care bureaucracy will shrink under the Clinton plan.

THE CLINTON HEALTH REFORM PLAN
Security for Every American
Page 3

THE CLINTON HEALTH REFORM PLAN
Security for Every American

Security for you and your family. That's what the President's health reform plan is all about.

Even if you're one of those people who's satisfied with your health care today, I'll bet you know someone who's not.

Someone who lost their insurance when they switched jobs. Someone who can't afford health insurance. Someone who got terribly sick, and suddenly discovered hidden limits buried in the fine print of his policy. Someone who's paying a whole lot more this year for a whole lot less health care. And someone who can't even find a doctor for her kids.

If so, you're not alone. One of every four of you in this room risks losing the health insurance you have now in the next two years. You might lose it for a month, or two or three, or even six months or a year. And that's a terribly dangerous thing. Because if you or your child should -- God forbid -- get seriously ill when you're not protected -- all of your financial security could be wiped out. Perhaps forever.

[insert personal story about constituent or someone in your family who lost their insurance]

That's what this health care debate is about. Can your family find peace of mind? Can you -- or your child or your mother -- get the highest quality care when you need it most? And get it without going bankrupt? No matter whether you've got a great job or are

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between jobs. No matter what disease hits or when it hits or who it hits.

To help you get the security and high-quality care you need, here's what the President and I are going to change.

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Today, if you're sick or your child is sick or you can lose your job or move to a different state, you can lose your insurance. If you've got what insurance companies call a "preexisting condition," you're out of luck. You probably can't get insurance and, if you can, it costs three or four times what other people pay.

Under the President's plan, you'll get health security. Lose your job -- and you'll still be covered. Get sick -- you'll still be covered. Move to a new place -- and you'll be covered. That's what insurance is supposed to be all about.

Today, right now, there are people who are locked into jobs -- people who won't take better jobs because they're scared of losing their health care. That's because some companies offer great benefits -- while others give only bare bones coverage.

Under the President's plan, that won't happen. Everyone will be guaranteed a comprehensive package of benefits, no matter where you live or what you do or where you work.

Today, you're at the mercy of your boss. He can tell you what health plan you've got to use -- and even force you to give up your doctor if your doctor's not part of that plan.

Under the President's plan, you're in the driver's seat. You'll get to choose among health plans -- and if you want to stay with the doctor you see now, fine, no problem.

But that's not all we're going to do. We're going to make sure that what you're charged for health care is brought under control.

Every day, every hour, exploding health care costs are picking

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Security for Every American

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all our pockets and handbags. Right now, as you sit here, you're paying for someone who's been forced to go

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into an emergency room because he or she doesn't have insurance. And the next time you hear about a hospital charging \$20 for a Tylenol, you'll know that you're paying for the patients in the emergency room who will never see a bill -- and couldn't pay it if they did. The Clinton plan asks everyone to help pay their own way.

Right now you're being charged twice as much for health care as someone in Germany or Japan -- but when it comes to the survival rate for heart attacks, the United States doesn't even make the top twenty. Right now, what you're being charged for the drugs you need is rising three or four times faster than in other places -- and yet children in some parts of the Third World stand a better chance of getting immunized than they do here.

So we're going to change the way things work. We're going to crack down on those insurance companies and drug companies that are making high profits -- but not investing in better care. We're going to stop the overcharging and restrain rising costs. Only then can we get this deficit under control, and help our nation compete and win again.

Then we'll be able to give you the security you deserve. The peace of mind that your family will get affordable high quality health care -- no matter when illness strikes. No ifs. No ands. No buts.

And when the new health care plan is up and running, you're going to get a health security card. You carry that card with you. It guarantees you access to a comprehensive package of benefits, no

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matter where you live or where you work.

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And that package won't just take care of you if you wind up in the hospital or have terrible trouble or need a fancy test. It will turn around this crazy system and give you the kind of care that keeps you and your children from getting sick in the first place. In the nation that invented the polio vaccine, that's the very least we can do.

You'll be able to choose from a variety of health plans. Stick with the doctor you see now if you like. Or join a network of doctors and hospitals and pay a little less. Or pay a flat fee to a plan that covers all your services for the year. So if you become unhappy with your health care, you'll be able to vote with your feet -- and get your care somewhere else.

You'll be asked what you think of your health plan -- and the results will be displayed in a simple, easy-to-read consumer "report card." So health plans will be held accountable for the quality of their care.

And you'll be able to wave good-bye to the endless, complex forms and all the hassles. Because we're going to scrap a system that produces so much paper that even if you've got the patience to wade through it, you probably don't understand it.

That will be gone. We'll take the forms from the 1500 different insurance companies and make them into one.

Today, families that face the worst illnesses have to spend their time poring over insurance forms to figure out which insurance company is going to cover what -- rather than spending time with

THE CLINTON HEALTH REFORM PLAN
Security for Every American
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their loved ones.

That will be gone.

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Today, nurses and doctors are forced to fill out form after form, each one more complex than the last. Some nurses have to fill out 19 forms for each patient -- and then those are checked and checked again.

All of that will be gone. We're going to let medical professionals practice medicine again.

Today, companies play games with each other, trying to shift employees onto the other's plan. And if you do get injured on the job, the crazy and costly workers comp system comes into play -- and fraud is never far behind.

That will be gone. We're going to tie everything together and make our health care system whole.

Today, the government has gotten so deep into the business of micromanaging health care that it can't find its way out. The books that tell you whether Medicare or Medicaid will cover something are so big and thick that nobody can understand them. They've got checkers checking checkers. You get the feeling that there are more people writing regulations than doctors delivering care.

And that, too, will be gone. Because we're going to crack down on the waste and simplify the system and make this big mess make sense.

Now let me say to the small business owners in this room that, if you're covering your employees right now, we're going to bring your costs under control. We're going to protect you. We're going to stop the insurance schemes that discriminate against you and drive

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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your premiums through the roof. We're going to let you team up with other small businesses and negotiate for the same rates that insurance companies give the big guys.

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And if you're not able now to cover your employees, we're going to help make insurance affordable for you, your family and your workers. We're going to ask everybody -- workers and employers alike -- to chip in for health care. We're going to give you the assistance you need but we're going to stop asking the folks who are now paying for insurance to pay for those who don't. Because it's not fair when the dry cleaner who covers his workers has to pay a whole lot more because the owner of the car wash down the street can't pay the price.

The bottom line is simple: everybody benefits if everybody takes responsibility.

[story of small business from your district/state that struggles to cover its employees]

Today, if you live in rural America or in a small town, you probably can't even find a doctor. Maybe it was the ridiculous malpractice fees that forced the town obstetrician to close down shop. Or the fact that this nation is producing thousands of plastic surgeons -- but not enough pediatricians.

Under the President's plan, all that will change. We're going to bring real health care to rural America -- both in person and through technology. And we're going to produce the family doctors and pediatricians that your family needs.

Now there are a lot of people out there who are going to tell you that we don't need to change. They're going to try to scare you by making up all sorts of stories about terrible things. Then

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they'll tell you that they agree we need some reform -- but only on their terms.

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What they won't tell you is that they're the ones who have been lining their pockets while the rest of us have had our pockets emptied. The ones who have caused the gridlock that let this messy system get even more messed up. The ones who have spent their huge profits not on helping people get better -- but on lobbying and figuring out new ways to put health care out of the reach of the people who need it most.

Well, the fact is they can outspend you. But they can't outnumber you. You can win this fight for your family's security.

And when we join together and pass the President's plan, you'll have the peace of mind you deserve. A guarantee that you'll never lose your health insurance. Never. That no insurance company's fine print will steal your benefits. That you'll get comprehensive, high-quality care through a doctor or plan that you choose -- without ending up in the poorhouse.

The President and Mrs. Clinton share a deep personal commitment to this issue. Because of their own experiences. And because of the people they've met all over the country. People like you who have had enough of rising medical bills. People who just want things to make sense so they can get high-quality care. People who want peace of mind.

Bill and Hillary Clinton believe that health security is a right. Your right. And when it comes to health care, and when it comes to human needs and human suffering, there are no Republicans

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or Democrats. There are just Americans.

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And every day more American families lose their health insurance -- and even if you're one of the lucky ones who likes what you've got, the odds that you'll have it next year aren't great, and they're getting worse. Every day, what you're charged for health care keeps rising and rising -- and eating up your income and the future of your kids. And every day the special interests back in Washington keep blocking us from helping you.

You deserve the freedom from fear. Our nation deserves the freedom to grow. We all need the change. And we need it now.

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HEALTH CARE REFORM:
QUESTION AND ANSWERS

Q: Will I still be able to choose my doctor?

A: Yes. You will always be able to choose your doctor. And every American will have the choice of a variety of health plans -- you can go to an HMO, join a network of doctors and hospitals, or continue to get care on a fee-for-service basis the way most people do now. It's your choice.

Today, some businesses have limited people's choice of doctor in an effort to control costs. That won't happen under the Clinton plan. No boss will be able to tell you what doctor to go to or what health plan to join.

Q: If I have a good plan through my employer now, will the new plan be as good?

A: Your benefits package will cover at least as much as -- and probably more than -- the one you have now. It's modeled on the packages offered by Fortune 500 companies. And it's guaranteed, so your boss or insurance company can't take away your benefits or tell you to go read the fine print in your policy when you get sick.

Nobody will dictate to you what kind of plan you're on or where you have to go to get care. You choose where you get your care and how you get your care -- your boss or insurance company doesn't choose it for you.

Q: I like my health insurance. Why should I pay to insure others?

A: Like now, you'll be paying to insure yourself and you'll also be getting the peace of mind that, if you lose your job or get sick, you won't lose your insurance.

And remember: right now, you and your company are paying for the people who don't pay for their own health care. That's why you get charged \$20 for a Tylenol when you go to the hospital. Because for every person like you who pays the bill, there's another person who will never see a bill -- and couldn't pay it if they did.

The Clinton plan asks everyone who can to contribute to their own insurance. What you pay will go to your health coverage and your health security -- so that you will never be in danger of losing your insurance.

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Q: Will the new health system mean that I have to pay higher taxes? How will this reform be paid for?

A: Some people advised us to impose a new, broad-based tax -- such as a national sales tax -- to pay for health care reform. But the President rejected that advice because he believes the middle class is already paying its fair share.

Here's how the plan provides health security to American families: First, it cracks down on the health profiteers who make a killing off the current system. Next, it asks smokers to pay to make up for the high health costs they add to the system.

And finally, it asks every employer and worker to contribute to the cost of their health care. But the money will go to their health plan to provide comprehensive benefits and health security -- the guarantee that you will never lose your insurance. And the government won't collect or spend the money.

Q: How are you going to control costs?

A: Right now, what you're charged for health care is spiraling out of control. Insurance companies are raising your premiums; drug companies are charging high prices for basic prescription drugs; and unnecessary paperwork and fraud are sending the costs of the whole system through the roof.

The Clinton plan will stop all that. It will make sure that what you're charged stops rising four times faster than wages. And it will crack down on fraud and eliminate excess paperwork.

Only if we take these strong actions to control costs can we provide true peace of mind and security to all Americans.

Q: Won't quality be sacrificed for the sake of cost savings in the new system?

A: Absolutely not. That's just an old scare tactic from the special interests that profit from the status quo.

The Clinton plan will improve the quality of American health care. Under the Clinton plan, the best technologies in the world will be put to work for you. There will be more primary care doctors and nurses to give care. And there will be a simple consumer report card -- so that doctors and hospitals are held accountable based on results, not on how many forms they fill out.

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Most important, the Clinton plan will give American families the security that they will never lose their insurance.

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Q: Won't this plan kill small business?

A: No, it's today's high cost of health care that's already killing small business. Today, insurance companies either won't cover small businesses and their employees or charge them high premiums that put insurance out of reach. Anyone who has the initiative to start a small business shouldn't have to put their family's health security at risk. It's not right.

The Clinton plan will help and protect small business in three ways: First, it will aggressively control costs and prevent insurance companies from discriminating against small businesses. Second, it will eliminate the paperwork that each small business now has to deal with. And third, it will pool small businesses and individuals to give them the same bargaining power in buying insurance that big companies have.

The plan will be gradually phased-in, with government assistance, to ensure that small businesses that don't currently provide insurance can afford to cover their employees.

Q: Won't this plan cause massive job loss among small businesses?

A: No, although there is likely to be a shift in jobs in the health care industry. When the new system is up and running, more people will be directly giving health care and fewer people will be filling out forms.

The Clinton plan is designed to help and protect small business -- making it easier for small business owners to cover their families and employees. And the plan will be gradually phased-in, with government assistance, to ensure that small businesses that don't currently provide insurance can afford to cover their employees.

The "studies" on potential job loss resulting from health care reform are grossly exaggerated. They make faulty assumptions and were generated by groups ideologically opposed to the President's reform proposal.

Q: What will happen to businesses that provide insurance? Will their costs go up?

A: For many businesses, costs will actually go down. And over time, by getting health costs under control, we'll stop the chilling effect that exploding health care costs have on businesses.

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Right now, businesses that cover their employees are paying for those that don't. That's not fair. The Clinton plan is based on fairness and responsibility. Every employer has to take responsibility for covering their

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employees -- giving them the security that they will never lose their insurance.

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Q: Will insurance companies be able to deny me coverage if I have a pre-existing condition?

No. Right now, insurance companies can refuse to cover you if your daughter has asthma or if you're diagnosed with a heart condition -- and they do it all the time. Under the Clinton plan, that can't happen. Insurance companies will have to accept you -- whether you're healthy or sick. And you'll have the security of knowing that no one can ever take that insurance away from you.

Q: Will I still have my health insurance if I switch jobs?

A: Absolutely. Right now, some workers are locked into their job because they fear losing their benefits. If they do switch jobs or lose their job, they place their family's financial and health security at risk. That's not right. It's got to change -- and it will.

The Clinton plan gives you the security that you will never lose your insurance. If you switch jobs, you keep your insurance. If you lose your job, you're still covered. Complete security -- no ifs, ands or buts.

Q: Won't these "health alliances" create more bureaucracy and paperwork?

A: No. Right now, if you own the corner grocery store, you've got to spend half your time doing paperwork and negotiating with insurance companies. The health alliances will replace all that hassle.

The Clinton plan allows businesses and individuals to team up in health alliances and negotiate for high-quality care at an affordable price -- so that you and your family can have a full range of health care choices --without every person and every business going through the hassle of all that paperwork.

Q: Won't government involvement in health care just mean more paperwork for everybody?

A: No. Right now, doctors, nurses and patients are buried under a blizzard of paperwork. If you go to the doctor, you've got to fill out a bunch of different forms; and the doctor's got to fill out a bunch more. It's a waste of everybody's time and money.

The Clinton plan will take all the forms offered by the 1500 different insurance companies and turn them into one. We'll cut costs and eliminate all the hassle. There will

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be less paperwork -- and better health care.

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Q: I don't believe you. The government's going to be more involved in health care but there will be less micromanagement of doctors and hospitals?

A: That's right. In the current system, doctors and hospitals have to pass a lot of different inspections and fill out a lot of different forms. But none of it does very much to improve the quality of care.

Under the Clinton plan, the government will set standards -- high quality, choice of health plans and doctor, security that you'll never lose your insurance, controlled costs, universal coverage and reduced bureaucracy. The government is going to provide you with security and make sure you get safe care -- but then get out of the way.

Q: Why are we changing so much about health care?

A: Right now millions of American families live in fear of losing their insurance, getting some of their benefits taken away, or getting sick and stuck with an astronomical bill. The Clinton plan will provide American families with the security they deserve.

We've had too many studies, reports and commissions. We know the system's broke -- it's time to fix it. And only comprehensive reform can fix what's wrong.

The Clinton plan will keep what works -- we'll improve the quality of care and maintain your right to choose a doctor. If you like your health care now, you probably won't see much day to day change after reform.

But the system has got to change. Today the insurance companies have all the power. They pick and choose among consumers -- only covering healthy people and making a healthy profit. The Clinton plan will put consumers in the drivers' seat so that consumers get to pick and choose -- not insurance companies.

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Q: Isn't it true that managed competition is untested?

A: The Clinton plan is not managed competition. It draws on elements of many different ideas that have been put forward to reform our health care system.

It will draw on the best models -- at work today in communities all across America and states -- because what works in North Dakota won't work in New York. The plan will be a uniquely American solution to an American problem.

The plan is based on the following principles: providing security for American families; controlling skyrocketing costs; improving the quality of care; increasing choice of doctors and health plans; and simplifying the system.

Q: What are we going to do to get doctors into rural areas? How can "managed competition" work in places where there is no competition?

A: Right now, two-thirds of rural counties do not have enough doctors. It's no wonder. Rural doctors provide more charity care than any doctors in the country, and they often get paid late. In many cases, rural doctors can't even take a day off because there isn't another doctor for miles around.

The plan will include incentives for doctors to practice in rural areas, and it will help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors.

Q: How will this reform help people that live in cities get high-quality care?

A: First, by providing a comprehensive benefits package to all Americans that emphasizes primary and preventive care. In today's system, too many Americans end up in the emergency room because they didn't get the primary care they needed. That's not right, it costs the system too much money, and we're going to change it.

And second, it will increase the number of doctors in urban areas by providing incentives for doctors to practice in cities and expanding the National Health Service Corps to reach more people in cities.

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Q: Will physicians be able to practice as they do now -- or will Big Brother look over their shoulder?

A: Let's get one thing straight. Under the current system, doctors have too many people looking over their shoulders, second-guessing their professional judgement. And over the past twelve years, increased regulation by the government has meant more time filling out forms and less time caring for patients.

The Clinton plan will change that. It will create a single insurance form --so doctors don't have to figure out the thousands of different forms used by over 1,500 different insurance companies today. It will simplify peer review and coordinate inspections.

It will protect Americans' health safety and make sure you get the best care possible, but stop Washington from micromanaging doctors. So that doctors will be freed up to do what they do best -- deliver the highest quality care in the world.

Q: Will this plan do anything about all those crazy lawsuits?

A: Yes, it will. In the current system, doctors are forced to spend too much time practicing "defensive medicine" -- performing extra tests because they're looking over their shoulders for lawyers. It's not helping to improve care -- but it is helping to drive doctors out of the profession and make costs go sky-high.

The Clinton plan will include serious malpractice reform that protects doctors and patients but reduces frivolous lawsuits. And it will let doctors return to what they were trained to do -- delivering the highest quality of care in the world.

Q: Will the new system reduce doctors' independence and force them into a group practice or HMO?

A: No. Doctors will be able to continue their private practice, enter a group practice, join a network of doctors and hospitals or enter into several different arrangements. It's up to each doctor.

Q: Will I be able to stay on Medicare?

A: Yes. Older Americans will still be able to receive their Medicare benefits as they do today.

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In fact, Medicare beneficiaries are likely to have more choices after reform -- they can continue to get care the way they do today or they may be able to get their Medicare benefits through different health plans offered under the new system.

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Q: Medicare has the most bureaucracy and red tape in our current health system. If the President's plan retains Medicare, how is the new system going to reduce my paperwork and hassles?

A: The current system is choking on paper. Forms breed more forms. Checkers check checkers who check checkers. Doctors and nurses spend more time with paper than patients; and the quality of care suffers as a result.

The Clinton plan will introduce a single insurance form to replace the thousands of different forms used by over 1,500 different insurance companies today. To reduce some of the difficulties posed by the Medicare program, peer review will be simplified and inspections coordinated. And the Clinton proposal reduces micromanagement of doctors.

Q: How can you have a comprehensive health reform package that doesn't comprehensively cover long-term care?

A: This plan will take the biggest step forward ever to address the need for long-term care. Today, families all over this country live with the constant fear that they're not going to be able to take care of their parents when they get older. And those with severe disabilities face tremendous financial troubles.

The Clinton plan takes vast strides toward covering home- and community-based care with a special emphasis on creating ways for older Americans to continue to live in their own home and communities with dignity and independence. And it gives you the security that your parents or relatives with disabilities will get the care they need as they grow older.

Q: Won't your plan lead to job losses in the insurance industry?

A: Health insurance remains a small piece of the insurance industry. Efficient insurance companies are likely to do well and are likely to go into the business of running health plans. Others will put a greater emphasis on other kinds of insurance.

Looking at the health care industry as a whole, there will be a shift in jobs. More people will be directly giving care, and fewer people will be filling out forms.

Q: Will the plan cover undocumented immigrants?

A: No. Only American citizens and other legal residents will be able to get the comprehensive benefits package. But undocumented residents that currently receive coverage under community-based programs and Medicaid will continue

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to do so.

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Q: When is the President going to release his plan?

A: The American people demanded action on health care in the 1992 election, and the President is committed to passing health care reform this year. He is still consulting with members of Congress and others on exactly when to introduce his plan.

Q: I heard this plan was cooked up by a bunch of government bureaucrats. Why weren't there doctors involved?

A: More than 100 doctors, nurses and other health professionals were involved with the President's Task Force on Health Care. But the professional lobbyists did not write the legislation. That's why you heard complaints from some of the special interests in Washington.

The Task Force effort was the most thorough and inclusive policy-making process in American history. The process directly involved more than 500 people from all over the country. And Mrs. Clinton, the Task Force, and other members of the Administration reached out to over 500 groups for advice and input.