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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	JFF.pdf (3 pages)	n.d.	P5 6189

COLLECTION:
Clinton Presidential Records
Health Care Task Force
Lynn Margherio
OA/Box Number: 4812

FOLDER TITLE:
[Computer Disk - Early POTUS Decision Memos]

2006-0885-F
jp2869

RESTRICTION CODES

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

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March 8, 1993

TO: President Bill Clinton
First Lady Hillary Rodhman Clinton

FROM: Ira C. Magaziner

SUBJECT: Health Care Reform and the Budget Process

This memo presents the argument for retaining the flexibility to combine health care reform and the economic package, pending review of the health care reform proposal when announced in May.

Decisions regarding the budget process may well effect this Administration's capacity to achieve enactment of health reform.

I. Why tie health care reform to economic reform?

In addition to the promise of comprehensive health care reform, two fundamental goals stated throughout the campaign were: 1) improving living standards for most Americans; and 2) reducing the federal deficit. Failing to pass health care reform this year may compromise our ability to meet all three goals.

1. Without health reform, most Americans may see no improvement in their living standards in the 1990's.

- CEA estimates that increased health care spending will consume 64% of total projected per capita growth in GDP between now and 1998.

- HHS estimates that increases in health care spending will absorb well over 100% of the total increase in workers compensation over the next five years.

Even if the economy grows, most families will not have more money in their paychecks, nor greater ability to afford a new car or a better home.

2. Without health care reform, long-term deficit reduction also remains unachievable.

- CBO predicts that, in the absence of health care reform, the deficit grows from $206 billion in 1997 to $399 billion by 2003. Medicare and Medicaid spending will rise from their current level of $210 billion to $567 billion by the same year; going from 14 percent of federal outlays in 1993 to 25 percent of federal outlays in 2003.

- If health care spending were limited to the rate of population growth, plus the rate of inflation, plus two percent, Medicare and Medicaid spending in 2003 would be only $422 billion, $145 billion below current projections. The deficit would be $214 billion, a reduction of $185

billion, or 46 percent.

II. Why is health care reform now possible?

Health reform will never be politically simple, given the degree of change required and the political power of interests with a stake in the status quo. Nevertheless, changes in the political environment -- **and effective use of those changes to force interest groups to the table** -- make enactment this year a real possibility.

- Health care costs have risen dramatically while middle class income has declined. The health care crisis has become a middle class economic issue. Middle class, insured Americans are afraid of losing their coverage and are frightened by skyrocketing costs. They are demanding action.

- The President's building crescendo on the importance of reform has instilled the belief among the interest groups that reform will happen this year. From appointment of the First Lady to head the task force through the President's impassioned call for action in the State of the Union, the President's commitment to action **now** has been firmly established.

- The President's commitment has instilled a fear among interest groups that is bringing them to the negotiating table -- making significant and immediate cost containment a real possibility. In meetings Ira Magaziner has held with key interest groups (the AMA, the pharmaceutical industry, small business groups, insurance companies, and so on), groups have indicated a willingness to make major concessions to avoid public recrimination as "the enemy" of needed reforms.

III. Why is it possible to present a credible policy now?

Health care reform is a complex issue. But we are not starting anew; elements of a reform package have been under legislative development for years.

Despite politically-motivated claims to the contrary, the over 400 participants in our working groups include not only nationally recognized academics, but a wide range of professionals in health care delivery. We have over 100 health professionals, including 60 physicians, 20 nurses and 6 social workers. Groups have scoured the waterfront to explore and evaluate the full range of policy options - - ranging from malpractice reform, changes in medical education, insurance reform, and so on. Our cost estimates will reflect a consolidation of government technical capacity never before developed that will provide consensus rather than conflict on the costs of reform.

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Work has already begun on translating policy options into legislative language, relying on the most experienced legislative drafting expertise in the House. The combination of policy expertise and drafting experience/skill will make it possible to generate a credible, comprehensible and comprehensive piece of legislation by May.

IV. Why consider merging health reform with the economic package?

1. If we do not include a placeholder, it may raise a signal that we are not serious about health care reform this year. Supporters may begin retreating from our efforts. Further, the elderly might be angered by the Medicare cuts in the absence of a health care package.

2. If we now need 60 votes to pass reform, the Republicans will have the opportunity to mount their own initiative which is bound to be less comprehensive and less serious than ours, but which will be more acceptable to the conservative health care providers.

3. At best, we will wind up with a pitched battle over their less comprehensive proposals and ours. Since the urgency to vote will be diminished, the debate will inevitably be put off until next year.

4. Interest groups may then decide to mobilize in opposition to our plan and in favor of a variety of watered down alternatives.

5. In an election year, with pharmaceutical companies, trial lawyers, insurance companies, physicians and other interest groups' money at stake, passage of a comprehensive bill may become less likely.

6. We will have to start over in 1995 with a Congress that may be more Republican (if history holds true to form). As the 1996 election cycle gears up, passage of comprehensive health care reform is then less likely.

We need to decide whether to phase in universal coverage more slowly and/or implement cost controls more quickly. We can recapture system savings through a tax on insurance companies. We do not have to institute a middle class tax to pay for universal coverage.

It is important to note that introducing a placeholder for health care in budget resolution does not lock us in to voting on a single package this year. It simply allows us the opportunity to continue studying what legislative strategies are best for the overall Clinton Administration agenda in May when we have more information.

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Health Care Task Force
Lynn Margherio
OA/Box Number: 4812

FOLDER TITLE:
[Computer Disk - Health Policy - POTUS Files]

2006-0885-F
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June 22, 1994

MEMORANDUM TO PRESIDENT BILL CLINTON
HILLARY RODHAM CLINTON

FROM IRA C. MAGAZINER

Before you introduced health reform to the nation last September, we talked about the inevitable fact that the bill would undergo substantial revisions as it went through Congress. This is why we proposed emphasizing principles in your speech rather than standing behind the details in the bill.

As the debate has proceeded, we have developed alternative approaches in concert with Congressional leaders to reach our goals of universal coverage and cost containment. Much of the criticism we have endured is unfair, but we must acknowledge that we have lost the communications battle on many fronts. This memo gives you a sense of where we are in our work with Congressional committees on modifying our bill.

When we relaunch a bill for the floor, we should announce that we have heard the American people and modified our bill to be smaller in scope, more gradual, less bureaucratic and less regulatory.

We should highlight the following changes:

- Deficit reduction
- Voluntary instead of mandatory alliances
- Less onerous mandates
- No premium caps
- Streamlining/simplification
- Increased support for academic health centers

Deficit reduction

According to the CBO, the Health Security Act adds $126 billion to the federal deficit over 10 years. Significant deficit reduction can be achieved with relatively minor modifications to our existing structure: better targeting of subsidies; reducing the value of the benefits package by 5%; lowering the firm size level for community rating and tightening the assessment of 1% of payroll for firms outside the community rate.

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Better targeting of subsidies: The Health Security Act proposes to give subsidies based on a firm's total average payroll. No firm within the community rate, regardless of size, would pay more than 7.9% of its total payroll for health insurance. As you recall, subsidies based on a firm's average payroll were politically attractive because we could say that a firm would never pay more than a fixed percentage for their health care expenditures. Unfortunately, many business leaders simply don't believe us because we are the government. We have developed alternatives for Representative Gephardt and Senators Mitchell and Kennedy that target subsidies based on an individual worker's wages rather than the average firm payroll. This both saves money and targets the money to those that need it most: employers of low-wage workers.

Reducing the value of the benefits package: We have always expected that our benefits package would be cut. Responding to arguments that the benefits package in the Health Security Act is too generous, we have prepared alternatives for the key committees to trim the value of the benefits package. For example, trimming the benefits package by 5% can be achieved by raising the cost sharing from 20% to 25% or raising the annual out-of-pocket limit from $1,500 to $2,500 on the fee-for-service plan and increasing the drug copay from $5 to $10 and imposing a $250 deductible for hospital stays in the HMO package. Different committees are exploring different options: The Senate Labor and Human Resources Committee proposes a 2% cut in the package; the Education and Labor subcommittee proposes increasing the package by about 5%; Ways and Means and Senate Finance are exploring benefits cuts in the 6-8% range.

Lowering the size of firms within the community rate which pay the 1% assessment of payroll: Under the Health Security Act, firms outside the community rate pay an assessment of 1% to offset savings they receive from universal coverage. Lowering the size threshold for firms outside the community rate increases the revenues raised by the corporate assessment.

Voluntary instead of mandatory alliances

The original Cooper/Breaux/Boren bill mandated all firms with 1,000 employees or fewer, all government workers, all self-employed people and all nonworkers to buy health insurance through exclusive regional purchasing cooperatives, giving states the option to set the requirement at 10,000 or less. We set ours at 5000 assuming we would have to reduce the number. The moderate Senators on the Finance committee still want to keep mandatory alliances for firms of 100-500 and below.

We lost the communications battle for mandatory alliances early. We developed a voluntary alliance model that preserves the functions of alliances (community rating, family choice, administrative functions) for the Kennedy, Dingell, Ford, Mitchell, and Gephardt

approaches. Ironically, it is more bureaucratic than mandatory alliances, involving more regulation by state insurance departments and other agencies, but it is workable and is easier to sell to the public.

Community Rating: Congressional committees, under pressure from business groups and insurance lobbies to lower the size at which firms are required to participate in a community rating pool, have proposed lowering the size threshold from firms with 5,000 workers or fewer to 1000 workers or fewer. The lower the threshold, the more opportunity there is for insurance companies to compete on risk selection and the higher the premium for firms and individuals within the community rate. This week, the Ways and Means Committee has passed an amendment to reduce the threshold to firms with 100 employees or fewer. We think going below 500 is not desirable, but could make 100 work if it becomes absolutely necessary.

Family Choice: Under the status quo where employers primarily choose health plans for their employees, a family's ability to stay with their doctor has become increasingly restricted. We proposed a system of family choice, where families, not their employers, choose among health plans. Some in the Congress, under pressure from business and insurance lobbies that want to maintain the current system of employer choice, are considering replacing family choice with employer choice. The Education and Labor and Labor and Human Resources committees preserve family choice. The Gibbons and Dingell marks have employer choice. We strongly favor family choice but could probably settle for some employer choice as long as families are guaranteed a choice of at least three plans, including a fee-for-service plan.

Administrative functions: Administrative costs are still streamlined through centralized clearinghouses which collect and administer premiums and subsidies, much as the alliance did under the Health Security Act.

Less Onerous Mandates

Under the Health Security Act, universal coverage is achieved through a combined employer/individual mandate by January 1, 1998. We chose this mechanism and this timeframe for two reasons: 1) universal coverage cannot be achieved without mandates or major taxes; 2) the longer universal coverage is postponed, the more expensive it becomes to cover everyone. Most external groups historically supported the use of employer mandates to achieve universal coverage, including the Jackson Hole group, the Chamber of Commerce, the National Association of Manufacturers, the American Medical Association, the HIAA, the American Hospital Association, the AFL-CIO, among others.

However, pressure from the National Federation of Independent Businesses, the National Restaurant Association, the National Retail Federation and Republican legislators have caused many to retreat from a mandate on businesses.

Due to the political reality that employer mandates have lost ground in the debate, we have explored the use of hard triggers and partial exemptions for small businesses of 20 or fewer employees or a combination of both.

Slower Phase-in: Some have proposed delaying universal coverage until 2000 or beyond. Achieving coverage by 2000 is something we could support, but would not recommend delaying much beyond that. If we delayed until 2000, we would recommend strategies to demonstrate progress toward universal coverage before then: for instance, covering all children by 1997 or 1998; requiring that all businesses above 1000 employees cover their employees by 1997 or 1998.

Proposals that aim to increase coverage by providing subsidies to businesses that voluntarily insure, could be acceptable if there is an automatic mechanism, "trigger", to institute an employer/individual mandate to achieve universal coverage if the subsidies do not achieve the goal. The transition period to universal coverage poses some significant challenges and would require policies that we may not like: for example, 1) allowing age rating instead of pure community rating; 2) allowing waiting periods to be imposed for the uninsured with preexisting conditions, etc. These and other policies are necessary during the transition to minimize the potential for firms to drop coverage as happened in New York when community rating was implemented in the absence of universal coverage.

I feel strongly that we cannot propose a bill without an automatic path to universal coverage. If there is pressure to dilute the "hard trigger", one strategy might be to lower the targets the private sector has to meet to avoid the pulling of the trigger. For instance, the Breaux proposal requires that 97 percent of the population has to be covered, otherwise the triggers would be pulled. We could lower the requirement to 95 percent if we combined the target with an individual mandate which would trigger, even if the targets were met. If the target was not met, then the employer/individual mandate would trigger.

Exemptions for small businesses: Because the pressure against an employer mandate is strongest among small business lobbies, an employer mandate that exempts the smallest businesses might make sense. Senate Labor and Human Resources' bill exempt firms with fewer than 10 employees from providing insurance; those that do not cover must pay an assessment. The Energy and Commerce mark proposes exempting firms with fewer than 20 employees, with an assessment on firms between 11-20 employees.

Individual Mandate: The latest proposal being floated by Senator Bradley is a trigger to an individual mandate. We have consistently stated that we have concerns about an individual mandate. It is a radical departure from today's system, and workers are not likely to believe that their employers will continue providing coverage, particularly during a time when employers are dropping coverage and reducing benefits. If employers dropped their coverage, families would

be the ones hardest hit. The cost of coverage for low-wage worker families could become unaffordable and middle-income workers who don't qualify for subsidies would be vulnerable.

No premium caps

Without adequate cost containment, universal coverage will be dangerously expensive and health care costs will continue to consume an ever-increasing share of the economy. We have proposed enhanced competition backed up by premium caps as a good way to control costs. CBO and Lewin have both found our methods to be effective.

By the standards of previous bills, the "premium cap" approach is not intrusive nor regulatory. Previous bills sponsored by Senators Kennedy and Mitchell and Representatives Stark, McDermott, Gephardt, Waxman, Dingell, Rostenkowski and Ford all have had explicit price controls on all procedures and tests.

Proposals by Senators Baucus, Bingaman, Danforth, Kassebaum and Representatives Glicksman and McCurdy have premium caps similar to those we proposed. We actually borrowed ours directly from the Danforth/Kassebaum bill.

We always anticipated that our caps on the rate of growth would be loosened, but it now appears that we must move off the model itself. However, without scoreable savings, there is no serious health reform.

We are analyzing a few possibilities to replace the premium caps:

"Reverse Trigger": This sets a baseline target which captures the initial windfall insurers would otherwise get in a system that achieves universal coverage. If we did not capture the initial windfall, insurers would get paid twice for the previously uninsured - - once through private rates that would now be artificially high because they would still include the cost shift from uncompensated care and a second time through new coverage for the uninsured. Once the baseline is set to remove the windfall, the private sector relies on market forces to control costs. If the market does not achieve savings, then premium caps are triggered. From a policy perspective, this alternative is the most likely to work, but it may resemble premium caps too much to be politically acceptable.

Bradley Approach: This replaces premium caps with targets set by the National Board. Health plans which bid higher than the target premium in their region are taxed to cover the increased cost of the federal subsidies created by their high bids. The approach encourages plans

to bid at or below the target and encourages employers and families to choose lower-cost plans by raising the price of the higher-cost plans. This approach has some significant drawbacks. It requires a large, explicit tax on high-cost plans. It's administratively complex. And, depending upon the way it was structured, it could allow private premiums to increase so much that a universal coverage trigger might never be pulled.

Opening the FEHBP Pool: Costs could be controlled if the FEHBP was opened to a broader universe of people and if it had the tools and the responsibility to hold down health plan premiums. Federal subsidies would be pegged to the constrained rate of growth in the FEHBP. A premium constrained FEHBP could increase cost shifting to those outside its pool and it might have difficulty attracting insurers to offer plans at its constrained rate. But with sufficient regulation, an option like this could work.

Cost Control enforced by States: An approach could be designed whereby subsidies were capped and the states were given the responsibility to enforce cost controls at the state level. They would have the flexibility to use a variety of tools or allow market competition to hold down costs. And, if they chose, they could also choose to opt into a federal system of premium caps. This approach has the advantage of its flexibility and "market" orientation, but has the disadvantage of likely being perceived by states as an unfunded mandate.

Streamlining/simplification:

Eliminate Breakthrough Drug Board and HHS Drug Exclusion Capability: During the taskforce process, we received significant pressure from Senators Pryor and Rockefeller and Representative Waxman to include drug price controls. Instead of doing this, we developed a compromise which included a "breakthrough drug board" and provisions to require rebates on new drugs from drug manufacturers as a condition of participation in the Medicare program. These proposals have never made sense and simply angered the drug and biotech manufacturers. The Labor and Human Resources and Energy and Commerce Committees removed these provisions. We should, too.

Eliminate boards and committees: Our bill has suffered from the label of "big government", in part because it includes dozens of boards and committees. These were established mainly at the request of HHS. The Cooper/Breaux and Chafee bills include almost as many of these kinds of boards. We should remove a series of these from our bill.

Eliminate some fraud and abuse provisions: Lloyd Cutler has correctly pointed out some areas where our fraud, abuse and compliance proposals might lead to too many lawsuits. We have worked out an agreement with the Departments of Justice and HHS to streamline some

of these proposals.

Eliminate some prescriptive language: There is too much prescriptive statutory language in our bill which could be left to regulation. If we pull a lot of this language out, the bill will be shorter, tighter and less regulatory.

Increased Support for Academic Health Centers:

The Labor and Human Resources committee bill substantially increases the dedicated pools for medical training and creates a dedicated fund for biomedical research. The Senate Finance committee mark also has a dedicated fund for biomedical research. We expect and would support additional funds going to academic health centers and biomedical research beyond what was originally proposed in the Health Security Act.

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Jack Lew & Chris Jennings; re: Legislative Status of Academic Health Center Issue (1 page)	05/05/1994	P5 COPY 6/92

COLLECTION:
Clinton Presidential Records
Health Care Task Force
Steve Edelstein
OA/Box Number: 3681

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FOLDER TITLE:
Congressional Briefing Memos - POTUS

Jimmie Purvis
2006-0885-F
jp2853

RESTRICTION CODES

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

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TO: Steve E -tHE

May 5, 1994

MEMORANDUM FOR THE PRESIDENT

FROM: Jack Lew and Chris Jennings

SUBJECT: Legislative Status of Academic Health Center Issue

Following your visit to Boston and your remarks about the importance of academic health centers, there has been heightened interest in enhancing funding for these centers and the teaching entities that are affiliated with them by supporters in and outside of the Congress. Since then, we've held numerous "technical assistance" briefings for each of the five major committees; Ira followed your trip with Senator Kennedy with a trip to New York to brief constituents of Senator Moynihan.

It is clear that the committees are committed to resolving the academic health issue. Each committee has senior members for whom this is a serious local concern. At the same time, in varying degrees the Chairmen want to make certain that the cost of the solution remains reasonable, and they are worried that a bidding war between committees could lead to a solution that is very expensive. For the moment, they are holding back and leaving the issue to be resolved at the mark-ups.

Senior staff of the House Ways and Means and Senate Finance Committees have indicated that they do not want us or the other committees to raise expectations too high. They believe it is much easier to talk about increased funding than it is to come up with a financing mechanism, as they believe they will have to do.

All of the committees are looking at ways to increase and target payments. Notably, to date, there is very little support in the Congress for a fourth pool of funds for academic centers, which is the idea being promoted by the Deans. Only Senator Kennedy and the Senate Labor Committee appear inclined in this direction.

RECOMMENDATION

Reiterate that you want to make certain that, whatever bill passes, academic health centers will be adequately funded. Given the extremely sensitive nature of this issue, not commenting on the specifics would be the most helpful approach. You might be well advised to suggest that interested persons work with the Chairmen and committees of jurisdiction (e.g., Moynihan of Finance, Rangel of Ways and Means, and Towns of Energy and Commerce.) They are all actively engaged.