September 24, 1993

MEMORANDUM

TO: Bob Lewis
Bob McAdam

FROM: Susan Stuntz SMS

Attached is a summary prepared by Citizen Action of the basic provisions of the Clinton health care plan. This has been distributed to Members of Congress and to Citizen Action affiliates nationwide. Note in the "comments" on the last page that "consumer excise taxes and potentional (sic) increased cost-sharing for Medicaid benificiaries will have regressive impacts on low- and middle-income families."

Also attached is a press release authorized by the National Council of Senior Citizens executive board on the Clinton plan. This group, which, like Citizen Action, supports a single-payer plan, pledges to "work for additional improvements in the design and financing of the nation's health care programs." We understand that NCSC is likely to testify before the Ways & Means Committee in late October and is expected to have more specific language with regard to its concern about the excise tax component of the Clinton plan in that testimony.

As we receive additional press releases and materials on the Clinton plan, they will be forwarded to you.

Attachments

cc: Sam Chilcote
Cal George
Walter Woodson

Prepared by Citizen Action September 14, 1993

Basic Provisions of the Clinton Plan

ISSUE	PROVISION SUMMARY	COMMENTS
State single-payer option	States may opt for single-payer either state-wide or for a specific region. If so, the federal government may waive: •ERISA rules for corporate alliances •Guaranty fund rules •Rules on regional, corporate alliance participation •Medicare	States have to get waivers and the federal government may reject. We had expected only a Medicare waiver process to ensure that seniors are protected. States cannot use revenue sources in the bill for additional benefits which may be a serious obstacle for implementation. It appears also that they cannot impose a payroll tax greater than that in the bill.
Coverage	By 1/1/97, states must establish health alliances. Except for Medicare, DoD, VA and Indian Health Service, all Americans receive coverage through regional or corporate (companies with over 5,000 employees nationwide) health alliances. Medicaid beneficiaries are covered through alliances and may be provided with wraparound coverage for extra services. Health alliance enrollees can remain in the alliance once they turn 65 and states can get waivers to include all Medicare beneficiaries. Undocumented workers are eligible for emergency care but not full coverage.	The requirement of universal coverage by 1997 is a victory since there was pressure for a longer phase in. It appears that the inclusion of Medicaid beneficiaries is being done in a non-discriminatory fashion, another improvement. There is no language on current Medicare beneficiaries being able to opt into the health alliance on an individual basis, however. Current Medicaid beneficiaries may receive less coverage because of cost-sharing requirements and the limitation of eligibility for additional services.

ISSUE	PROVISION SUMMARY	COMMENTS
Corporate Health Alliances	Corporations and Taft-Hartley plans with over 5,000 employees nationwide can self-insure, contract with an insurer or join the regional alliance. They must offer the same benefits, a fee-for-service and two other options, and pay 80% of the cost of their average premium (or, if greater, 95% of the least-cost premium for low-wage workers). Business and individual subsidies are not provided for corporate plans.	Employee choice is limited to only three plans -- less than would be available through the regional health alliance. The limit of 5,000 nationally means more firms can opt out than if the limit were set for employees in the health alliance. More information is needed on employee contribution requirements, employer liability to retirees, and employee protections.
General Benefits	Medically necessary or appropriate hospital, emergency, professional services, preventive, family planning, prescription drug, medical equipment, mental health and substance abuse (with limits) vision and hearing care are covered. Preventive dental for persons below 18. Benefits expanded to include adult dental by the year 2001 if expected savings accrue. Health plans determine medically necessity. Each plan has a complaint procedure for grievances and consumers may appeal to a health alliance consumer ombudsman or go to court.	Benefits are fairly comprehensive. Since additional employer-provided benefits are not treated as taxable income to employees for 10 years, it does not appear as if workers will be harmed. A potential problem, however, is that the plans make the determination of medical necessary and appropriateness. There are no details on how consumers are protected -- i.e., are plans subject to penalty for arbitrary denial of care? do plans have to pay for out-of-network care if needed? is there a time limit on appeal of denials, terminations or reduction of care?

ISSUE	PROVISION SUMMARY	COMMENTS
Mental Health, Substance Abuse	By the year 2001, limits on benefits are eliminated. Until then, inpatient care is limited to 30 days/episode and 60 days/year until 1998, when the yearly maximum increases to 90 days. Outpatient psychotherapy limits are 30 vists/year.	The elimination of limits is not ironclad, so differential treatment may remain even beyond the year 2001.
Long-term care	A new home and community-based care program covers the severely disabled of all ages and all incomes, including personal assistance services. States can provide care through vouchers or cash payments and set "nominal" cost-sharing for persons below 150% of poverty. Low-income persons not as severely disabled get services through a continuation of Medicaid programs, with funding ultimately capped. Asset rules for Medicaid nursing home eligibility are eased. HHS sets rules for long-term care insurance.	The state flexibility to provide cash payments or vouchers may be troublesome depending on how it is structured and the level of payments. States have discretion in setting benefits which may be a problem. Also, we need additional information on cost-sharing and how the Medicaid continuation program would work.
Treatment of Seniors	Seniors are eligible for long-term care provisions (see above) plus a new prescription drug benefit with a $250 deductible and a 20% copay up to $1,000. Beneficiaries would pay 25% of the cost through increases in the Part B premium.	The increase in the Part B premium may be significant. We will also have to learn whether low-income seniors will be protected and whether seniors in HMOs pay full cost-sharing.

ISSUE	PROVISION SUMMARY	COMMENTS
Cost-sharing	Different levels are set for low-cost (in-network) and higher-cost (out-of-network or fee-for-service) plans. Low-cost: no deductibles, no copays for hospital or preventive care, $10 copay for physician visits, $5 copay for drugs, and annual out-of-pocket limits of $1500/$3000. Higher-cost plans have a $200/$400 deductible plus a $250/year drug deductible, 20% copays on all services except preventive care, and annual out-of-pocket limits of $1500/$3000. Persons below 150% of poverty receive subsidies if there is no low-cost-sharing plan available to them.	The cost-sharing requirements may present real obstacles for persons, particularly those in areas where there are no low-cost plans. Even in the low-cost plan, some low-income people may be unable to afford a $10 copay or a $5/drug copay. Particularly for drugs which require physician approval, there is no sound policy reason for cost-sharing.
Balance Billing	There are several provisions. In one place, physicians are prohibited from charging extra. In another, states are prohibited from including Medicare beneficiaries if limits are higher than allowed in Medicare (15%).	While this is a victory in that persons in the health alliance are generally protected against balance biling, Medicare beneficiaries who opt into the alliance face some (although limited) extra charges.

ISSUE	PROVISION SUMMARY	COMMENTS
Health Plan Premiums	Employers are required to pay 80% of the weighted average premium adjusted by family status, limited to. 7.9% of their aggregate payroll. Employers with under 50 employees are subsidized according to average payroll -- those paying less than $12,000/year pay 3.5% with subsidies ending at the $24,000/year level. Workers are required to pay the premium for the plan they select minus 80% of the weighted average premium. There is no percentage of income limit on worker contributions. Self-employer workers pay the employer and employee share. Non-workers and part-time workers pay the employer and family share with subsidies for families below 250% of poverty. Premiums are community-rated except for (1) an age-adjusted premium for persons over 65 and (2) an experience-rated premium phased out to a community rate over 4 years for large corporations.	The financing of the plan is more regressive than previous descriptions, since there is no limit on the individual's contribution and subsidies only for persons below 250% of poverty. Small businesses have incentives to keep workforces below 50 (in order to maintain the subsidy) and to keep salaries low (in order to get the highest subsidy).

ISSUE	PROVISION SUMMARY	COMMENTS
Cost controls	There is a budget which does not include extra benefits, cost-sharing, or auto/workers comp insurance costs. The National Health Board establishes a base national premium target and a target for each health alliance. If the target is exceeded, higher-cost plans are taxed and revenues used to reduce employer liability. States may also meet the target through negotiations, freezing enrollment in higher cost plans, rate-setting, capital budgeting. After the initial year, annual increases will be limited to growth in inflation. There are no cost controls on drugs or medical equipment.	It is difficult to see how these provisions will be effective in reducing costs especially in the base year. While the budget growth limits may be effective in limiting federal spending, it is unclear what will happen if plans refuse to provide coverage within health alliance budgets. Excluding cost-sharing and auto/workers comp insurance costs from the budget is also a problem. Since limits are set only for the aggregate, individual plans/consumers may experience higher increases.

ISSUE	PROVISION SUMMARY	COMMENTS
Medical Malpractice	•Limits attorneys fees to 33%, states can lower limits •Imposes collateral source rule •Requires periodic payments •Sets alternative dispute resolution requirements. Victims must go through ADR but can go to court if not satisfied. •Provides absolute defense for providers who follow practice guidelines •Demo project for enterprise liability •Provides more public access to National Practitioner Data Bank	While the elimination of caps on awards is a victory, these are not provisions which are balanced or which protect victims. For example, victims must accept periodic payments. Limits on contingency fees may prevent victims from obtaining quality representation. Measures to encourage better quality -- for example through experience rating of med mal premiums -- are missing.
Funding for Subsidies	Funding for subsidies and other federal programs come from the following (figures are for 1994-2000): •$124 billion in Medicare savings, including lower reimbursement for providers, higher premiums for wealthier beneficiaries, and more use of HMOS. •$114 billion in Medicaid savings •$47 billion in other federal savings •$105 billion in sin taxes •$51 billion in revenues gains	We will be undertaking more analysis of these numbers to see how realistic they are. The cuts in Medicare and Medicaid are problematic unless we can be assured that they won't reduce care. Consumer excise taxes and potentional increased cost-sharing for Medicaid beneficiaries will have regressive impacts on low- and middle-income families.

PRESS RELEASE

National Council of Senior Citizens
1331 F Street, N.W. • Washington, D.C. 20004 • (202) 347-8800

For Immediate Release
Wednesday, September 22, 1993

Contact: **Larry Smedley, Exec. Director**
Dan Schulder, Dir. of Legislation

NATIONAL SENIOR GROUP APPLAUDS CLINTON HEALTH PROPOSALS

In a policy statement to its 5,000 local club leaders, the National Council of Senior Citizens (NCSC) said today that the Clinton health reform proposal would "establish health care as an achievable right for all citizens—that alone deserves the praise of Americans, young and old."

The statement, made by NCSC Executive Director Lawrence T. Smedley, noted that the Clinton proposal would assure comprehensive health services while creating mechanisms to control health costs. The senior leader said that the proposed Clinton program "can meet many of the benchmarks contained in the single-payer, universal health system backed by the Council."

Smedley hailed the Clinton proposal's inclusion of long-term care service and a new prescription drug benefit for Medicare beneficiaries, including younger persons with disabilities. He said that the Council also welcomes coverage of "early" retirees, age 55-65, many of whom have lost health insurance protection when their former employers terminated benefits.

Smedley told the grassroots NCSC leaders that, "Our ultimate goal is quality health services provided without regard to age or employment status at affordable costs based on the ability to pay through progressive financing. In short, we are committed to a national health system, managed in the public interest, without regard to profits or differing standards based on income, age, gender, location or population group."

Smedley said that NCSC had adopted a three-point strategy on health care reform:

1. Support the Clinton measure's progressive, basic components including universal coverage, cost constraints and subsidized insurance for lower income, unemployed and retired persons;
2. Assure that any Medicare and Medicaid cost reductions will not harm older and disabled persons and the poor and assure prompt incorporation of Medicare into the new health reform system with full participation on an equal footing for Medicare beneficiaries; and
3. Continue to work for additional improvements in the design and financing of the nation's health care programs toward a single-payer system.

Smedley said that NCSC would fight against "those with a vested interest in the status quo—a health system based on waste and duplication that shortchanges seniors, punishes the poor and hard-working families and threatens to bankrupt the nation." Smedley said the Executive Board of the NCSC will be meeting in coming weeks to determine the game plan the Council will pursue in the ongoing struggle to improve and pass national health care.

The NCSC Director concluded his statement by saying: "The American people deserve an efficient single-payer health care system administered with a commitment to quality and compassion. The National Council believes that strong support of the Clinton program, while working toward further improvements, will lead the Nation to such a system. America's seniors are anxious to play a central role in the coming legislative and political debate. We are ready."

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Mary Frances:

Attached is an AP story on the Tampa town meeting. Page two quotes Clinton as saying that he supports boosting cigarette taxes "by a little under a dollar."

As I had indicated earlier, we have asked the monitoring service for all comment that references tobacco/cigarettes/cigarette excise taxes by Administration officials on news and public affairs shows through this morning. We will have that by early afternoon. Full transcripts (such as the ABC town meeting will take longer and should be available by early Monday).

sms
9/24/93

AP v5035 ra 3exec Clinton, Bjt,790 09-24 8:48a

Clinton Goes Face-to-Face With Public on Health Care
By NANCY BENAC
Associated Press Writer

TAMPA, Fla. (AP) - The self-employed painter swallowed deeply, stepped to the microphone and told President Clinton his plight: No insurance, $186,000 in medical bills and a sick daughter who needs more brain surgery.

"I don't know what to do," Joe Rossiter Jr. said, wiping tears from his eyes. "I can't get any help and there's no insurance in the world that will cover her now until she is 100 percent cured. ... There just ain't enough money to pay all of these medical bills."

Clinton responded softly: "I don't think there can be a better case for changing the current system."

The president came face-to-face with Americans' hopes and fears about health-care reform Thursday night and doled out soothing assurances that people with problems ranging from AIDS to Alzheimer's disease would be better off under his plan.

The intensely personal nature of the health-care debate was evident as Clinton fielded questions from an audience of 1,000 at a prime-time "town hall" meeting on ABC moderated by Ted Koppel.

Clinton, sitting on a stool alongside Koppel in the Tampa Performing Arts Center, took questions from the audience and from panelists assembled by the network in Chicago, Los Angeles and Boston. The local audience was selected by the network from area residents, many with direct links to the health care system.

Everyone wanted to know how it would affect them personally.

To Rossiter, Clinton explained that under his plan, self-employed people would be able to buy more affordable insurance and 100 percent of their premiums would be deductible, compared with a 25 percent deduction under current tax law.

As for Rossiter's plight, Clinton regretfully told the man: "I wish I had an answer for you right now. I don't." Later in the show, Clinton announced the hospital that treated Rossiter's daughter had promised, "We took care of her before and we'll take care of her again."

Clinton's visit to Tampa was his first trip outside Washington to promote his wide-ranging plan to overhaul the nation's health care system and guarantee coverage to all Americans by the end of 1997.

There is broad agreement that the nation's health-care system needs reform, but little consensus on how best to fix it.

The White House strategy in pushing Clinton's plan is to stress the broad-brush benefits of secure and affordable care. But Clinton plunged right into the intricacies of the plan as Tampa-area residents questioned him for two hours Thursday about how the plan would affect them personally, at times backing up to correct himself on specific details.

Over and over, he assured members of the audience they would come out ahead. Finally, a skeptical Koppel asked Clinton, "Everybody's going to be better off?"

"No, not everybody," Clinton allowed.

Single, healthy workers, people with cheap, limited coverage and people who now pay nothing all are likely to pay more, Clinton said.

But he hastened to add: "On balance, most Americans will win, and the security is worth something. And then, over the long run, we'll all win if we can bring health costs closer to inflation."

Clinton drew general applause when he said the plan would require no new broad-based taxes and that he favored boosting cigarette taxes by "a little under a dollar" and imposing a small tax on large corporations that decide to set up their own health plans.

He defended his financing plans, which have been called overly optimistic by many experts, but acknowledged that if anticipated cost-savings don't materialize, "then we are either going to have to slow down the benefits or raise more money."

The range of questions illustrated the vast reach of the Clinton plan and the wide range of concerns that Americans have about its impact.

A small businessman speculated about soaring premiums if he must buy coverage for all workers, a homemaker worried that it would be harder to continue specialized therapy for her disabled 4-year-old son, an AIDS victim wondered if it would be easier to get treatment from doctors who now discriminate.

On one tricky point, abortion, Clinton said "most people will get this service covered." He acknowledged that abortion was likely to become a "political football" when Congress debates the plan.

Carol Kaplan, a Tampa nurse, told Clinton that while she didn't want to see abortion hold up the entire reform package, "you are personally and morally involving me in the abortion issue by using my tax dollars."

Clinton responded: "We are also personally and morally improving preventive and primary health services. ... This could be a subject for a whole other program."

[cigarette]

TELECOPIER MESSAGE
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To: Jacques LaRiviere

From: Susan Stuntz

Date: September 24, 1993

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XEROX TELECOPIER 7021

September 23, 1993

MEMORANDUM

TO: Jacques LaRiviere

FROM: Susan Stuntz

Looks like we're back between 75 cents and $1, with 75-80 cents most likely. But so far the President has said nothing and there's no legislation prepared.

I am trying to locate a newspaper article or other reference to a story that was reported to me today that the mayor of Cornwall, Ontario, is under police protection after being shot at by cigarette smugglers. Do you have any clipping or other information that would help me confirm this report.

David Sweanor and others from Canada are testifying now in the U.S. that there is no smuggling problem in Canada.

Many thanks for any help you could provide.

Jim Savarese
Leslie Dawson

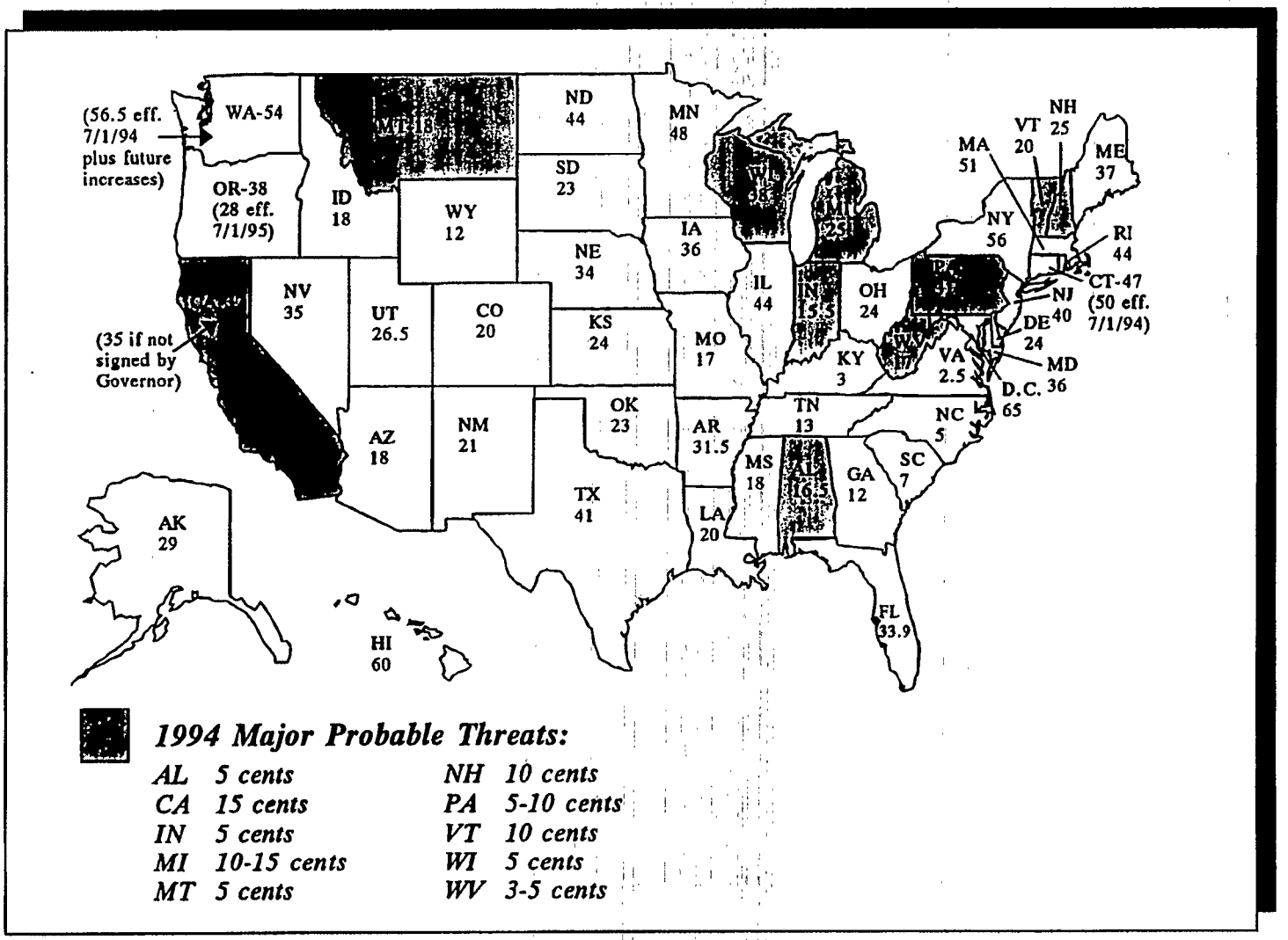
Attached for your information are the very preliminary tax and pre-emption target states for 1994. On pre-emption there really are only two we need to be aware of: Ohio and Texas. I don't have an I&R reform target map as yet, but can tell you that the two target states where we might be able to assist are Michigan (I know there were preliminary discussions with Weiland that stopped when SAD couldn't provide additional information) and Montana (which I know is dependent on the status of our relationship with MAPP).

I should have better projections in advance of the Phoenix conference.

I also attach a map on possible initiative threats in 1994.

sms
9/23/93

1994 CIGARETTE TAX PROJECTIONS
Rates shown effective 1/1/94 as of 9/15/93

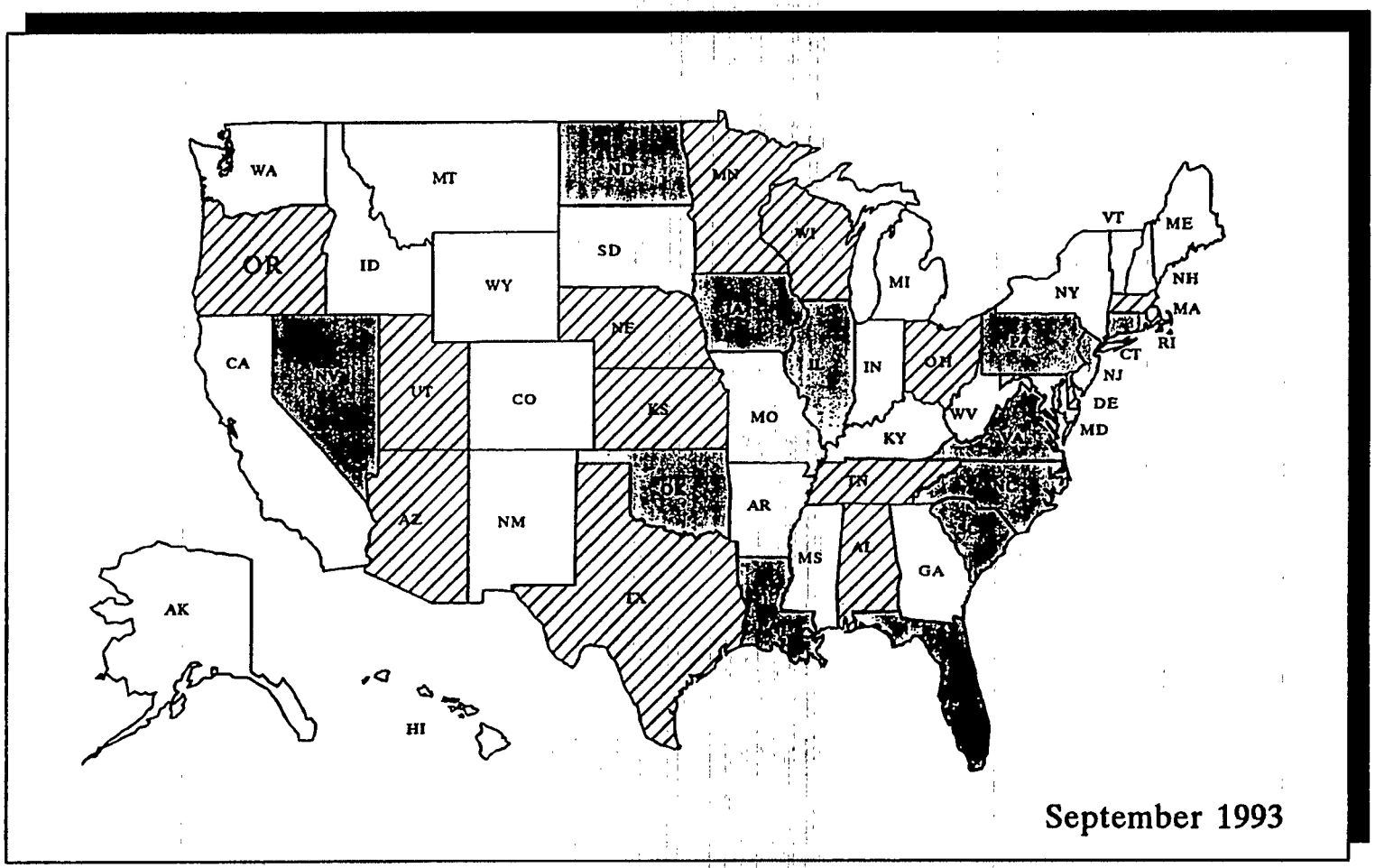


SMOKING ACCOMMODATION & PREEMPTION

1994 Priority Target States

Preemption laws in place

1994 Priority Targets



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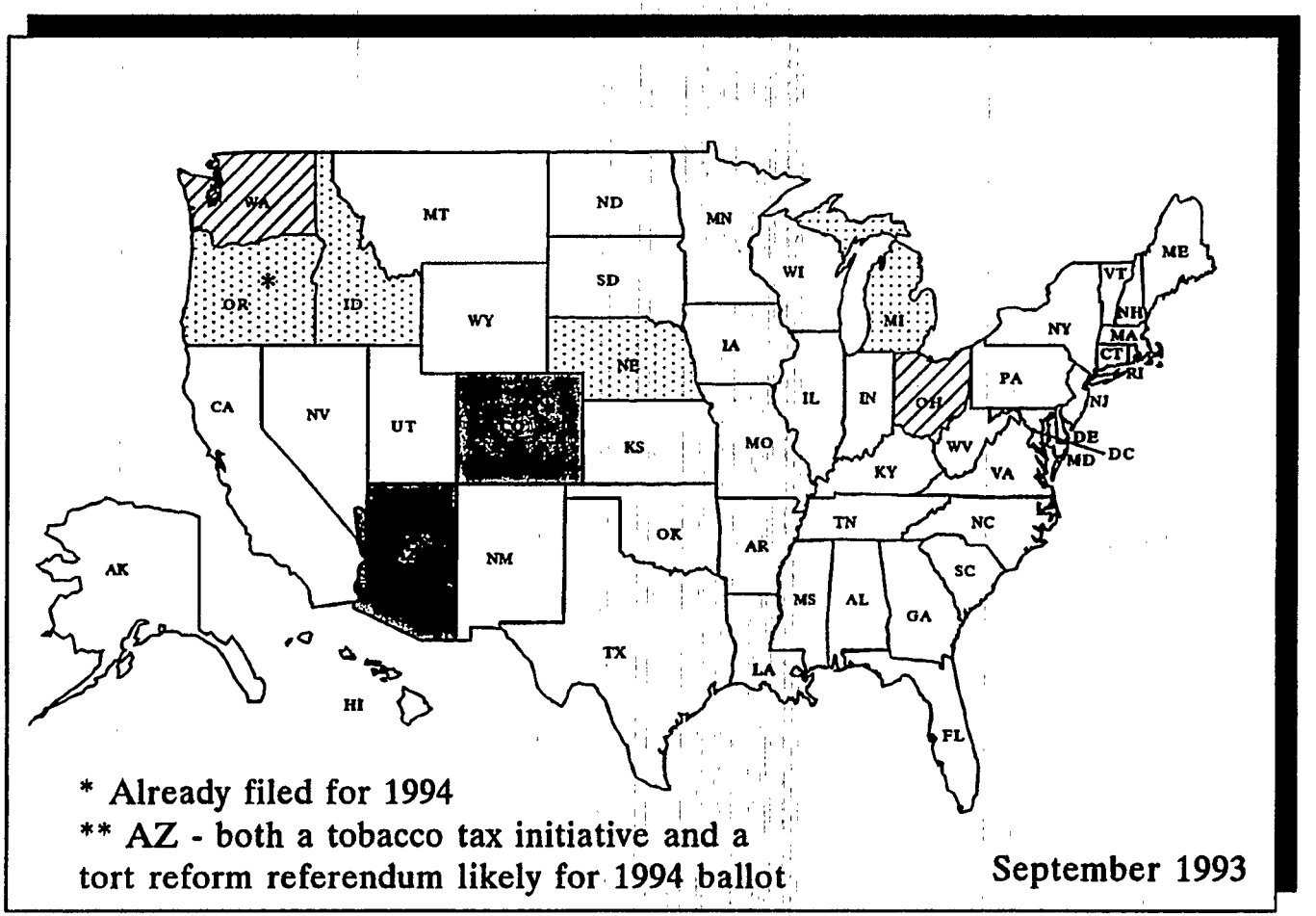
1994 STATEWIDE INITIATIVE THREATS
Chances for Initiative Tax Increases to be Filed

Likely Possible Remote



* Already filed for 1994

** AZ - both a tobacco tax initiative and a tort reform referendum likely for 1994 ballot

September 1993

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