FOIA Number: 2006-0770-F

FOIA MARKER

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Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	Resume of Julie Rovner (partial) (1 page)	nd	P6/b(6)
002. memo	From John Hart to Ira Magaziner, Judy Feder re: Priority phone call to Ray Scheppach (partial) (1 page)	09/18/93	P6/b(6)

COLLECTION:
Clinton Presidential Records
Policy Development
Magaziner, Ira (Subject Files)
OA/Box Number: 10020

FOLDER TITLE:
Intergovernmental [2]

2006-0770-F
ry520

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

June 15, 1993

MEETING WITH TENNESSEE GOVERNOR NED RAY MCWHERTER

DATE: June 16, 1993
LOCATION: Oval Office
TIME: 4:30 to 5:00 p.m.
From: John P. Hart

I. PURPOSE

Governor McWherter has requested a meeting with you and the First Lady to discuss "TennCare," Governor McWherter's health care reform proposal, and to formally present the Administration with its Medicaid waiver request. Following this meeting, Governor McWherter will meet with Secretary Shalala at HHS.

II. BACKGROUND

A. Waiver Discussions with Clinton Administration

Tennessee is one of a growing number of states that are preparing comprehensive waiver requests as part of their state health care reform efforts. The waiver will be set forth in papers you will receive at your meeting, and Governor McWherter would like a 45 to 60 day time frame for a decision on the waiver.

On March 24, 1993 the Governor's office sent a "concept paper" to HHS that outlined their idea for a waiver. HHS responded the next week, and several communications ensued, concluding with a May 27 telephone conversation between Secretary Shalala and Governor McWherter.

The White House Intergovernmental Affairs Office has worked with Tennessee state officials and officials at HHS over the past several weeks to facilitate Tennessee's waiver request.

B. Health Care Reform

As you are aware, in addition to the several briefings conducted to date between Ira Magaziner, Judy Feder, and members of the bipartisan panel of Governors, gubernatorial staff members have had extensive discussions with members of the working groups in an attempt to resolve state-federal issues.

Governor McWherter will be one of the ten Governors attending DGA's Vermont Issues Conference on Thursday (June 17). The Issues Conference will focus exclusively on health care reform, and Governor McWherter will be joined there by Governors Romer (CO), Chiles (FL), Carnahan (MO), Walters (OK), Roberts (OR),

Rosello (PR), Sundlun (RI), Dean (VT), and Wilder (VA). The Administration will be represented there by The First Lady, Ira Magaziner and John Hart.

III. PARTICIPANTS

The President
The First Lady
Governor McWherter
Governor's Aide (possible)

(Governor McWherter will drop-by to visit the Vice President after the Oval Office meeting.)

IV. PRESS PLAN

No Press.

V. SEQUENCE OF EVENTS

Open thirty-minute discussion.

VI. REMARKS

We recommend that you tell Governor McWherter that (1) you will ask HHS to give serious and timely consideration to the waiver request, (2) HHS will work closely with the Governor's office on it, and (3) you will ask HHS to review the request on an expedited basis, but **you should not commit to a specific time frame for a decision**.

In closing, it would be helpful both to remind Governor McWherter of our important federal/state partnership, as evidenced by the extensive consultations between him, his staff, and the Administration, and to stress the need for his support of our reform legislation.

VII. ADDITIONAL MATERIALS

Attached is biographical information on Governor McWherter, as well as background information on health care reform in his state and the proposed Medicaid waiver.

GOVERNOR NED RAY MCWHERTER (D - TENNESSEE)
(widower; two children)

A. Background

Governor McWherter was born in Palmersville, Tennessee in 1930 and grew up during the Depression on a small farm, where his parents were sharecroppers. He later operated several small businesses and a farm, and was elected to the Tennessee House of Representatives in 1969. He served there until he was elected Governor in November 1986, with a record seven consecutive two-year terms as House Speaker.

B. "TennCare"

Background: In an address to a joint session of Tennessee's General Assembly on April 8, 1993, Governor McWherter unveiled his proposal for health care reform in Tennessee, which he has called "TennCare." TennCare is a managed competition proposal that would replace Medicaid and provide insurance to the one million current Medicaid recipients, as well as to an estimated 500,000 uninsured working poor in Tennessee. It uses community rating and prohibits pre-existing condition exclusions.

The plan, which would require a Medicaid waiver, would allow citizens to chose from participating TennCare provider networks which would include the present Blue Cross network for state employees, the HMOs presently operating and planned for the Medicaid program, and other qualifying plans. Health care providers would be required to accept TennCare as a condition of participation in any state or state-administered federal health care program.

Enrollment: Employers would be encouraged (no mandate) to enroll and provide payroll deduction of premiums for all of their employees and dependents (full and part-time), to the extent they are not eligible for coverage in an employer sponsored health plan. State government would enroll all citizens who are eligible for Medicaid, all eligible recipients of unemployment compensation who are not covered under another health plan, and Tennesseans who were not covered by employers as of March 1, 1993. Community Health Agencies ("CHAs") would enroll eligible citizens who were not enrolled by state agencies as described above.

Cost: The individual cost for TennCare would be approximately $1600 annually (premiums and co-pay). Participants at or below the federal poverty level would not pay; participants between 100% and 400 to 500% of the poverty level would pay on a sliding scale (at 200% of the poverty level, participants would

pay 20% of the full cost ($320)). Benefits would be the same as under the state group insurance plan, but the deductible would be $1,000 - considerably more than the state plan, and no deductibles or co-pay would be required for preventive services.

Global Budget: TennCare tries to set a global budget for health care. Each community would be separately rated and all private health insurance plans would be encouraged to limit the amount their premiums (including deductibles and co-pay) could grow in future years to a rate not exceeding growth in the state's economy. Each plan within a community would be given a per capita spending target, with any plan that exceeds its target expenditure prorated back to the target. (Any plan producing a savings would be permitted to distribute the savings among its providers.)

Funding: State funding would be increased each year at a rate equal to the growth in state tax revenue, less any dedicated tax increase, not to exceed the rate of growth in the economy. Local government funds would be frozen at their current level. Federal and other funds would grow at a rate not to exceed Medicaid expenditures, which are currently increasing at 8.3% annually. In addition, TennCare "pools" all of the state's health care programs for the poor, in order to avoid "fragmenting resources."

Reducing Taxes: Currently, Tennessee hospitals pay a services tax of 6.75% of gross patient charges ($140 million annually). The TennCare proposal begins with a recommendation that this tax be eliminated on April 1, 1994. Governor McWherter calls the tax "disruptive," and has said that "from that day forward, Tennessee will pay for indigent health care with the same conservative financial policy we use for all programs of state government."

Conclusion: Governor McWherter sees TennCare as "blending very nicely" with the Clinton Administration's plan; he is convinced that TennCare will work, and that it will save the federal government money. He will also stress that Tennessee has no viable (practical?) alternative - those being huge tax increases and/or massive cuts in health care, at a time when the trend is toward more comprehensive care.

HHS, on the other hand, has several concerns about TennCare, including: (1) questions about Tennessee's figures for budget neutrality; (2) concern that the state uses savings it expects to receive as a proposed source of revenue (if the plan does not work well, who will fund it?); (3) eligibility is not limited - if TennCare attempts to cover all uninsured, regardless of income level, it could give employers an excuse to not cover their employees; (4) the $1,000 deductible might unfairly limit participation in TennCare; and (5) regarding proposed Medicaid co-payments, there is a question as to whether HCFA can legally

waive provisions of the law that prohibit imposing any form of co-payments on Medicaid beneficiaries.

C. Tennessee's Medicaid Waiver Request

In order to implement TennCare, Tennessee will need a Section 1115 Demonstration Waiver from HHS, an extensive waiver, similar to the waiver Oregon received in March 1993. The waiver will be expressly set forth in papers you will receive at your meeting with Governor McWherter.

Governor McWherter would like a 45 to 60 day time frame for a decision on the waiver.[1] (He wants to implement TennCare beginning January 1, 1994.) This is seen as a rather tight timetable for HHS, given that it is currently reviewing waiver requests for Hawaii and Kentucky, and it expects requests soon from Florida and Minnesota.

We recommend that you tell Governor McWherter that (1) you will ask HHS to give serious and timely consideration to the waiver request, (2) HHS will work closely with the Governor's office on it, and (3) you will ask HHS to review the request on an expedited basis, but **you should not commit to a specific time frame for a decision**.

---

[1] By way of comparison, Oregon made its waiver request to the Bush Administration in August 1991 and re-submitted the request in November 1992. The request was approved on March 19, 1993 - - two months after President Clinton took office.

IRA

FOLLOWING 5 PAGES

TO: John Ghost

fax #

phone #

FROM: Charlie Saxon

DATE: 6/28 TIME: 12:20

NOTE: Text of Governor's remarks to the NFB this morning

Let me know if you need anything else.

Charlie

The State of Florida's

Washington Office

444 North Capitol Street
Suite 349
Washington, D.C. 20001

Telephone (202)624-5885
Fax (202)624-5886

ICM

Governor's Copy

GOVERNOR LAWTON CHILES
National Federation of Independent Business
June 28, 1993

It's an honor to accept this plaque on behalf of all of the people in Florida who worked hard to make our health care reform plan a reality.

Even more than the award, however, I appreciate the leadership, and support from Bill Herrle and the folks at NFIB-Florida. You were a great help in passing a law that will work for all of us.

Bill, I look forward to working with you again later this year when we take on workers' compensation reform. We came close during the last session. Next time, we're going to make it.

These two issues are by far the biggest threats to our economy and to our status as a world leader.

- My state has confronted the health care crisis head on and today, I want to offer my view from the "front lines." We've examined the problem -- and we've developed a Florida solution. But, we still face a national challenge that all of us must help to solve.

- Health care costs are draining the budgets of American households, robbing state and local treasuries, contributing to the uncontrolled growth of the national deficit, and are placing a growing burden on our small businesses.

- But, those rising costs haven't translated into expanded access or greater coverage. Instead, just the opposite is true. More and more Americans are now unable to afford insurance for themselves and their families.

- One in four Americans has a member of their family who's without health insurance.

- People on pensions aren't safe either -- some are being cancelled.

- Our workers' compensation system was designed as a safety net for people injured on the job. You know firsthand how that net has grown into a tangled mass of litigation and paperwork. More resources are spent on the process than on the people who need help.

- The skyrocketing cost of workers' comp has limited the ability of our small businesses to expand, offer higher wages and take advantage of new opportunities.

- In Florida, ten percent of the cost of a new home goes to cover workers' compensation costs. Nationally, Ford now spends more money for health care than steel.

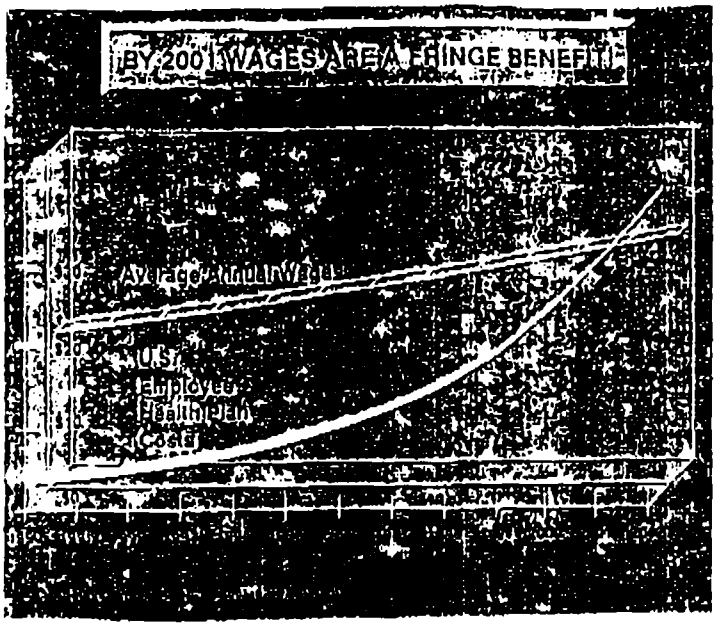
((((((KILL LIGHTS -- TURN ON SLIDE PROJECTOR))))))

- This is the cover of the January issue of "Florida Trend", a statewide business magazine. That's me on the left. On the right is Jon Shebel, the president of our state's oldest and largest business group, Associated Industries of Florida.

- The year before, we had gone head-to-head over a tax increase I needed to fund the growing needs of a growing state:
  - * Nearly 1,000 people a day move to Florida
  - * 80,000 new school children
  - * 30,000 new community college and university students
  - * Florida was number one in violent crime
  - * We had overcrowded prisons

- After absorbing increases in health care costs, we had no other revenues left over. Mr. Shebel told me about how skyrocketing health care costs were eating up members' gross profits.

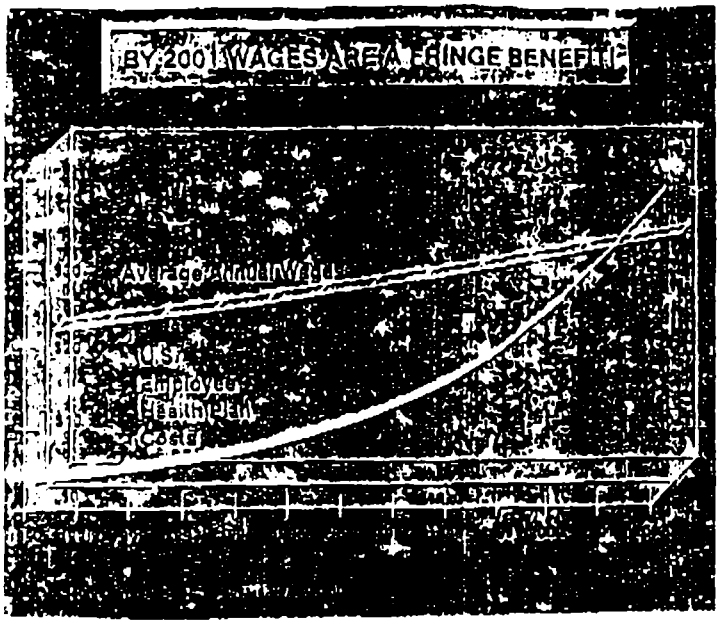
- We realized we had a common problem and decided to work together to solve it. The result was the passage of two major health care reform acts, the most recent of which takes effect in three days.



- That top red line shows the projected increase in average wages. The bottom yellow line shows the projected increase in health care costs for the average employee. Around the year 2000, health care coverage could be the primary form of compensation and salaries will be a fringe benefit of employment.

- It's the same with workers' comp premiums. They've more than tripled since 1980. Small businesses are bearing the brunt of both our workers' comp and health care problems. You represent the fastest-growing segment of our economy.

- You already pay 25 - 30 percent more in premiums than larger businesses. Will you be able to afford coverage that's growing even more expensive?



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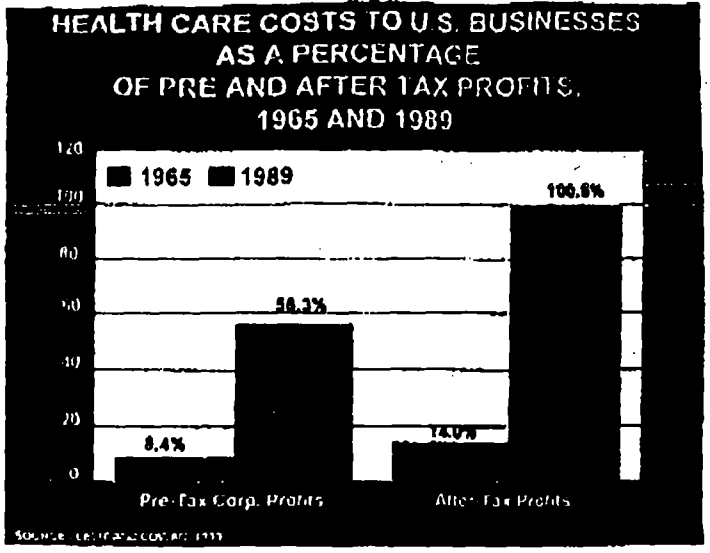


- In 1965, health costs ate up just 8.4% of pre-tax profits. By 1989, they ate up over half.

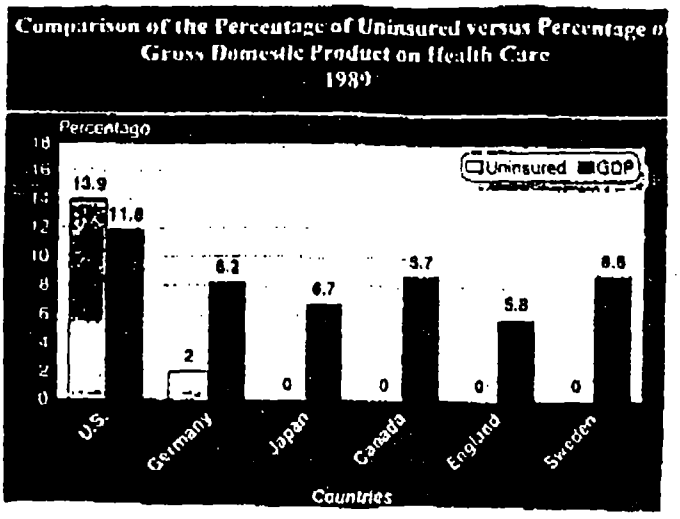
- After tax profits: In 1965, health costs took 14%. Twenty four years later, over 100% of your after-tax profits.

- You and I agree that small businesses shouldn't pay more than its fair share to finance national health care reform. Everyone should share the responsibility for paying for it.

- But you are already paying more than your share. As a result, you should also expect to see a greater share of the savings realized from health care reform.

- Some of you now provide health care coverage to your employees. Some of you have been forced to drop insurance as the prices have soared. And, some of you have never been able to provide it.

- Whatever your situation, none of you are on a level playing field with our international competition.



Let's look at how we stack up against the rest of the world in terms of what we pay versus what we get.

- Nearly 14 percent of all Americans are uninsured, yet we spend nearly 12 percent of our gross domestic product on health care. In Germany, only two percent of the population is not covered, and they spend just a little over eight percent of their G.D.P. on health care.

- Look at Japan, Canada, England and Sweden. They have everybody covered and nowhwere do they spend more than nine percent of their G.D.P. to do it.

- Those nations have made a critical investment in their human resources -- and their industries are reaping the benefits.

- I believe that our government also has a legitimate responsibility to give our businesses - especially the small businesses that are the heart of our economy -- a better chance to compete in today's world market.

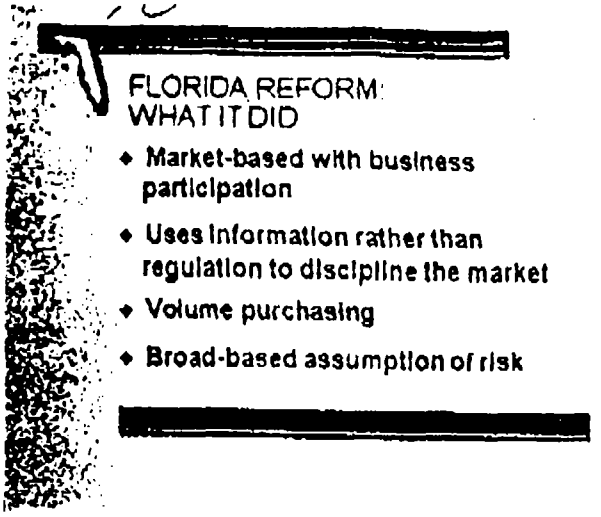
- Make no mistake, uninsured Americans do get care. But, they get it in the emergency room at four or five times the cost of a doctor's office visit.

- We all pay for it. The costs are shifted on to the people who do have insurance.

- I once believed that we couldn't have full access without cost controls. Now I realize that the reverse is true: We will never be able to control costs until we have full access.

- Ironically, I am told by many small business owners that the reason they can not afford health care is that workers' comp premiums are too high. And, we know that health care costs are driving up workers' comp prices.

- That means if we want workers' comp reform, our first step must be to fix the health care system.



- In the first hour of Saturday, April third, the Legislature passed Florida's landmark health care reforms. I remember that day well -- it was my 63rd birthday. It was the nicest birthday present I've had in a long time.

- We went with a market-based approach that involves business. There are no employer mandates.

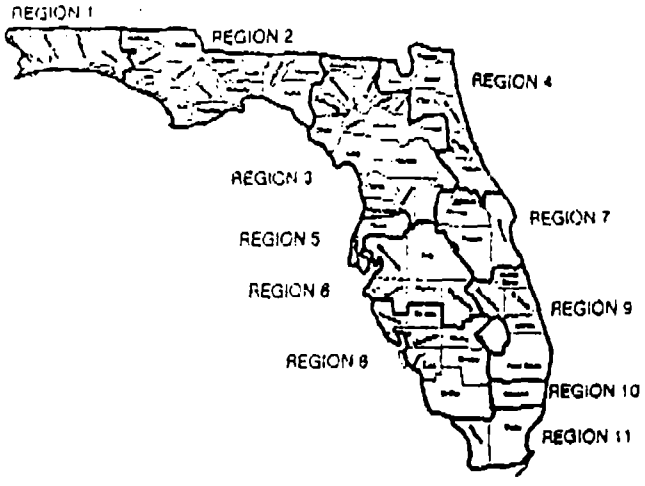
- We're going to let the market forces work the way they do in your business.

- Instead of regulations, we're counting on information to hold the providers accountable.

- We're going to pool the buying power of the self-employed, small business and government. That way, you can get the same or better deal that large businesses get.

- And we're getting back to the original concept of insurance -- spreading out the risk over a large group of people.

CHPA Regions



Best of all, the emphasis is on local control, because that's where health care is produced and consumed and that's where the decisions should be made.

- We've dividided our state up into eleven regional Community Health Purchasing Alliances. These alliances will pool their local money and bargain for the best health care at the best price.

- CHIPPAs will be private, non-profit bodies controlled by business.

- Of the 17-member boards that run them, two-thirds of the members will be from business, and the majority of those will be from small business.

I am confident now that we are on our way to a better, more efficient health care system for all our residents.

((((((KILL PROJECTOR -- TURN ON LIGHTS))))))

We accomplished this goal by engaging the very people and groups we'd have to rely on to build the new system.

- In November of 1992, we held a summit that brought together representatives from business, government, the health care and insurance industries, and many other areas.

- But all of us agreed that our biggest challenge -- and our overriding concern -- was to provide full access.

- Our next challenge is to bring together many of those same players to help us overhaul the workers' comp system.

- We need organizations like NFIB to come to the table at the beginning of our discussions -- so that we can count on their help when the issue reaches Congress and their individual state Legislatures.

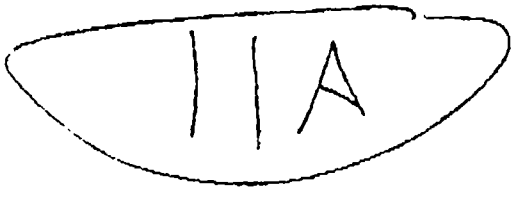
- I'm pleased that we are developing Florida solutions to national problems. But, let me emphasize that we still need the federal government as a full partner in these efforts as well.

One of your members, Daniel Richardson, from Rochester, New York, is having the kind of problems many of you are facing.

Daniel is the administrator of a nursing home owned by his family. It employs 150 people.

Providing health care coverage for those employees is getting increasingly more difficult because the costs are rising 12 to 15 percent a year.

Daniel wants to keep providing health insurance to his employees but he is going to need help to do it.



- We need a comprehensive federal plan that guarantees everyone the right to health care. Otherwise, the cost-shifting will continue, and we will be right back where we started.

- With a federal plan, we can establish some real controls on workers' comp rates too.

- I'm very encouraged that we now have a President who appreciates the magnitude of the challenge we face and is open-minded about how to get the job done.

- For the first time ever, we now have real leadership from the White House on the issue of health care reform. I am confident that the President as well as the First Lady are committed to giving states flexibility to develop and implement their own strategies.

- From talking with many of your members, I know your feelings about the proposals for a national health care plan. And, I know that tomorrow, you will travel to the Capitol and express those feelings to your elected representatives.

- Let me share some perspective from my 18 years on the Hill. There's no shortage of people who will point out problems with new ideas. There are entire industries in this town that exist for that reason.

- Realize that your political clout and influence can be put to greater use than simply opposing a bill you don't like.

- I challenge you to offer your expertise and your leadership to help build a plan you can support. Add your voices to those who are seeking a solution. Be there when the discussions begin -- and stay there until the last gavel strikes.

- That's what NFIB-Florida did on the health care issue. That's what I will ask them to do again for workers' comp. And, that's what I ask you to do now.

- If there is any lesson to be learned from our Florida solution it is that success is based on a spirit of cooperation and good-faith negotiation.

I hope that will be the focus of your efforts as we face up to our national challenge.

Thank you.

From the Office of the Chief of Staff

Phone: 202/456-6797 Fax: 202/456-1121

Date: 7/1/93 Response needed by: _____

COS Office Contact: Bill Burton

	Action	FYI		Action	FYI
Rahm Emanuel			Howard Paster		
Mark Gearan			John Podesta		
David Gergen			Jack Quinn		
Jack Gibbons			Carol Rasco		
Marcia Hale			Bob Rubin		
Alexis Herman			Eli Segal		
Nancy Hernreich			George Stephanopoulos		
Tony Lake			Christine Varney		
Bruce Lindsey			David Watkins		
Katie McGinty			Maggie Williams		
Regina Montoya			Ira Magaziner		X
Roy Neel					
Bernie Nussbaum					
Leon Panetta					

Remarks:

Response:

United States Department of the Interior

OFFICE OF THE SECRETARY
Washington, D.C. 20240

June 28, 1993

Memorandum

To: Thomas F. McLarty, Chief of Staff to the President
Bill Burton, Deputy Chief of Staff

From: Leslie M. Turner, Assistant Secretary, Territorial and International Affairs

Subject: National Health Care Reform Update -- Inclusion of U.S. Insular Areas

Islands Affected

The Office of Territorial and International Affairs has federal oversight responsibility over approximately 345,000 U.S. citizens and U.S. nationals residing in Guam, the Commonwealth of the Northern Marianas Islands (CNMI), the U.S. Virgin Islands, American Samoa and the Trust Territory of Palau. As part of our country's special obligations to these insular areas, the Administration should include residents of these islands in any national health care reform package.

Reasons For Inclusion.

1. Residents of the insular areas are U.S. citizens and U.S. nationals with a long history of social, cultural, economic and strategic ties with the United States. If status as U.S. citizens and legal residents governs baseline eligibility for access to health care benefits in the reform package, there is no legal reason to exclude insular areas. Furthermore, in light of current Congressional attempts to provide resident aliens with health benefits (most notably in California), any exclusion of U.S. citizens and nationals from the insular areas would be even harder to justify.

2. From a moral perspective, the U.S. obligations to insular areas is predicated upon the significant contributions their people have made to the United States in times of war. Since the turn of the century, islands such as Guam have played a pivotal role in projecting U.S. strategic leadership in the Asia-Pacific region. In every armed conflict since World War II, residents of the insular areas have remained steadfastly loyal to our country despite great suffering and sacrifice. Collectively, residents of the insular areas have served in the U.S. armed forces with distinction and valor in higher numbers per capita than the residents of the several states.

3. The incremental cost of including the insular areas in the reform package will be negligible in the overall scheme. The 1990 census of the insular areas within OTIA's oversight jurisdiction shows an overall population of only about 345,000 people. Puerto Rico, which is not within OTIA's administrative responsibility and which has its own forceful lobbying groups, has about 3.5 million residents.

4. The Clinton Administration has promised to have a broader, more diverse and more inclusive approach to government than previous administrations. If insular areas are excluded, President Clinton would be reinforcing previous administrations' treatment of island residents as second-class citizens.

Health Care Report

For your information, I have attached a report that contains a reassessment of health services and health systems of the U.S. Pacific island jurisdictions. The report reveals that health care systems in the territories are patterned after the U.S. model and were developed with extensive federal funding. Although the insular areas generally provide their residents with universal access to medical care, health care programs are chronically underfunded and the range and quality of health care services are much more limited than those found in the U.S. mainland.

Recommendation

We strongly recommend inclusion of insular area residents in the national health care reform package. At minimum, we encourage inclusion of the insular areas in any childhood immunization program and any employer contribution program.

DRAFT

REASSESSMENT OF HEALTH SERVICES AND SYSTEMS IN THE U.S.-RELATED PACIFIC ISLAND ENTITIES:A REPORT TO THE UNITED STATES CONGRESS

INTRODUCTION

This document, hereinafter referred to as "The Report", communicates the results of a reassessment of health services and health systems of the U.S. Pacific island jurisdictions after five years based on an earlier study completed in 1984. The 1984 study was mandated by the Congress in the Department of Health and Human Services (HHS) first Continuing Resolution (Public Law 97-276). HHS was directed to develop a "comprehensive approach to its unique Federal responsibility for the Pacific Basin region, based on our treaty obligations." The HHS "Report to the Congress on Health Services in the United States Pacific Island Jurisdictions" was transmitted to the Congress in March, 1986. The 1986 Report was based upon data collected by the University of Hawaii in 1984 under contract to the Public Health Service (PHS). The Report recommended a five-year follow-up study in 1989 to review "...progress made toward improving U.S. Pacific health systems and report findings to the Congress."

This Report provides background information regarding the Pacific region, summarizes current program initiatives which resulted from the 1984 study, summarizes the major findings and issues contained in the 1989 University of Hawaii Study (copy appended) and recommends approaches which the Department of Health and Human Services will follow to address Pacific health problems and issues. This Report focuses on a selected/limited scope of health programs which influence health services and health status in the six Pacific jurisdictions. For example, grants, contracts and/or programs from the Food and Drug Administration as well as those from the National Institutes of Health are not dealt with in this Report. In addition, programs

The 1986 Report transmitted a wealth of demographic and descriptive data relative to the Pacific region and its health systems which will not be repeated in this Report.

BACKGROUND

The area under study is the Western Pacific also referred to as the American or U.S.-Associated Pacific and is comprised of six political jurisdictions. The United States has had a long standing legal involvement with and political commitment to these Pacific island jurisdictions which constitute the "U.S. Pacific". The Western Pacific represents the vast expanse of ocean which stretches between the Hawaiian islands and the Philippine islands in which the several Pacific populations of the area are organized into autonomous governments differing in their political relationships with the United States. Also, within this same area are other independent nations which are not affiliated with the U.S., e.g., Kiribati, Nauru and

Papua New Guinea. Three of the jurisdictions within the "U.S. Pacific" (American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands) are referred to as "Flag Territories" and hold territorial or commonwealth status with the U.S. while the other three jurisdictions (the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau) are referred to as "Freely Associated States" inasmuch as they hold a semi-independent/quasi-sovereign status vis-a-vis the U.S. and other nations. In general, Flag Territories act as and are dealt with as States within the United States, whereas the Freely Associated States are sovereign nations which manage their own internal affairs in accordance with provisions in the Compact with the U. S. Government. Additionally, with respect to participation in Federal programs, the Flag Territories, being "statelike", must comply with virtually all program requirements set forth in Federal Law and regulation. The FAS were able to choose which Federal programs they wished to participate in when the Compact of Free Association was negotiated, but once having chosen, they must comply with program regulations as would any other grantee of the Federal Government.

The population of the six entities based on 1990 census data is as follows:

	1990	1986
Flag Territories		
American Samoa	37,162	34,920
Guam	137,827	113,675
Northern Marianas	39,960	16,780
Freely Associated States		
Marshall Islands	46,020	34,791
Palau	15,384	12,116
Federated States of Micronesia	101,108	73,160

Note: The substantial increase in the Northern Marianas' population is due primarily to importation of foreign labor for construction and new industries.

Although treated in this Report as a Freely Associated State (FAS), the unique status of the Republic of Palau as the last remaining vestige of the Trust Territory of the Pacific Islands is recognized. This Report assumes that the political situation regarding the Republic of Palau will be resolved in favor of FAS status and thus refers to Palau as a FAS.

The six Pacific jurisdictions differ significantly in their degrees of economic development and self-sufficiency. Guam is the most developed, sophisticated, and advanced in its health system; the Northern Marianas and American Samoa in many ways comprise a cluster with Guam in regard to being further developed and advanced than the remaining three jurisdictions. Because of professional licensing requirements in Guam, physicians and dentists who practice on the island must be trained in the United States (or receive exactly equivalent degrees from selected other nations). Those licensing laws require nurses, and technicians to meet Stateside standards as well. Guam, in particular, and the CNMI and

American Samoa to a somewhat lesser extent, have laboratory and x-ray diagnostic services available to them which are not found in the FAS. The public health system on Guam is far more sophisticated than that found in the remainder of the US-Pacific in that it is well funded (by comparison), conducts aggressive outreach in fairly well developed primary clinical care settings. Guam has a private sector of medicine (and dentistry) which augments government operated health programs. Private medical practice does not exist in the FAS or American Samoa and is only now being developing in Saipan. Also, Guam benefits from the US military hospital and clinical presence on the island. The health systems in Palau, FSM, and the Marshall Islands, are less developed and advanced. In the FAS, health care facilities, clinic/dispensary systems, and basic health systems for safe water, waste management, and general public health are in need of continued and major attention.

The Flag Territories, and in particular Guam, have relatively stable and developing economic bases with some limited capacity to contribute to the support of basic government functions, social systems, and services (See Table below, Per Capita Income). This is not the case for the Freely Associated States which remain more dependent upon federally appropriated and dispensed funding for the day-to-day operations and maintenance of basic systems including health services.

Per Capita Income, 1988

Jurisdiction	Per Capita Income
American Samoa	$4,280
CNMI	4,076
Guam	7,115
FSM	1,249
Marshalls	3,100
Palau	3,300
Puerto Rico	5,287
US	10,905

Source: U.S. Department of Commerce

The federal contribution of resources from several Federal Departments in the form of direct assistance programs and grants-in-aid are the principal means of support for health and other services in the Freely Associated States and are a critical part of the resource base for the Flag Territories.

1986 REPORT TO THE CONGRESS

The 1986 Report to the Congress contained the following general findings:

* Management structure and processes were generally not in accordance with established criteria and trained, competent managers were scarce, especially at the middle-management and supervisory levels.

* Facilities and equipment were in poor condition and the lack of routine or preventive maintenance created significant operational problems adversely affecting patient care.

* Only Guam was adequately staffed with qualified health professionals in most manpower categories; serious shortfalls were evident in all other jurisdictions, which were heavily dependent on poorly trained indigenous personnel; and local citizens found it nearly impossible to successfully compete for admission to U.S. or foreign health professional schools due to inadequate local basic education.

* Curative medical services, medical referrals, and the operation of general acute hospitals consumed most of the health services budgets in the Pacific, leaving few resources for attention to the more fundamental preventive and primary care needs of the populations.

* Due primarily to a lack of skilled health manpower and other resources, especially in remote or isolated areas, the scope of primary care services was inadequate and generally included only treatment services; except for Guam, there were little or no mental health or substance abuse services available; and dental health services lack sufficient personnel and preventive programs were deficient or non-existent.

In keeping with these findings, 1986 Report went on to propose the following general recommendations or approaches:

* Federal financial and technical support should be more focused. Locally developed and monitored health plans are essential.

* Federal waivers within existing programs should be applied whenever possible to make Federal programs more responsive to the unique local needs.

* Short-term health manpower needs should be addressed by the Federal government.

* Long-term health manpower needs should be addressed by a Federal/local/international partnership.

* Disease surveillance activities should be strengthened.

* Defense Department involvement in technical and professional assistance should be strengthened.

CURRENT PROGRAM INITIATIVES

While serious health problems still exist in the U.S.-associated Pacific, there has been steady progress during the past 25 years in large measure because of Federal support for health programs and the substantial professional and technical assistance provided in connection with these programs. Today, tuberculosis, diabetes, hepatitis (A, B and Delta), dengue fever, plague, a variety of sexually transmitted diseases, outbreaks of childhood diseases such as polio, measles and diphtheria, Vitamin A deficiency and other serious nutritional problems, dental disease, intestinal parasites, infant diarrheal disease combine in the Freely Associated States to paint a picture found in populations throughout the developing nations of the world. The Flag Territories suffer more from diseases and syndromes which plague more developed countries: heart disease including stroke, cancers, and auto accidents, for example. In the ensuing four years since the 1986 Report to the Congress, several important activities were initiated which addressed approaches contained in the Report:

* The Congress appropriated a small amount of discretionary grant funds in 1987, 1988, 1989, 1990 and 1991 under Section 301 of the PHS Act specifically to address the issues identified in the Report. These funds have been used to award 22 developmental grants for initiating the improvement of health manpower skills, data systems, and disease surveillance systems, strengthening the Pacific Islands Health Officers Association, and continuing the Medical Officer Training program which had begun in 1986.

* The Public Health Service has increased its financial and personnel investments from within its existing authorizations and yearly appropriations. Primary care, in particular was affected with the establishment of five community/primary care health center projects and subsequent application of technical assistance to sustain their growth and development. The numbers of National Health Service Corps physician and dentist providers have been increased from 17 physicians and dentists in 1986 to 35 health professionals in 1990 including physicians, dentists, nurses, a psychologist and pharmacists.

* The Public Health Service, in partnership with the private sector, began two major initiatives: a Hepatitis B eradication campaign and the transfer of radiological equipment. First, in 1988, the private pharmaceutical firm of Merck, Sharp and Dohme (MSD) donated 100,000 doses of vaccine to the PHS for use in Micronesia. In cooperation with MSD, the Department of Interior, and the Department of Health of the State of Hawaii, PHS began a Hepatitis B vaccination program in which more than 30,000 children and newborns were fully vaccinated against the disease in less than a year. This Hepatitis B vaccination campaign is ongoing and today, HepB vaccinations are routinely given to newborns in the six US related Pacific jurisdictions, the cost of which is being borne by the jurisdictions themselves with help (in 1990) from PHS Childhood Immunization grant funds. In 1989-90, PHS in cooperation with the

private, non-profit Radiology Outreach Foundation, provided radiological equipment free of charge to American Samoa. It is envisioned that other pieces of radiological equipment will be available to other jurisdictions in 1991.

* The Department of the Interior, in partnership with the Public Health Service, has embarked on a major joint venture to support the cost of short-term training and technical assistance in the Pacific. These programs have provided over 30 technical assistance visits to the Pacific jurisdictions in areas such as hospital administration and finance, pediatric, psychiatric and other nursing services, disease control systems, quality assurance systems and architectural and engineering services. Over 10 Pacific health department staff have received on the job training in Public Health Service facilities on the Mainland in areas such as blood typing and screening, public health nursing, and hospital management systems.

* There has been an increase in targeted assistance available to the Pacific from the University of Hawaii, Hawaii State Department of Health and Hawaii private sector interests, particularly for short-term training and technical assistance.

* Local Pacific jurisdictions are paying increased attention to health needs as priorities for action as evidenced by actions taken by the health officers in the individual jurisdictions as well as actions taken by the Pacific Island Health Officers Association (PIHOA) in applying for Public Health Service funds. For example, PIHOA received a PHS grant to establish a disease sentinel surveillance system throughout all six jurisdictions. Additionally, many of the Section 301 Pacific Initiative grants funded by PHS are in direct response to the local health directors increased awareness of local health system problems and the need for assistance to address problem areas.

* International health partnerships and cooperative linkages have been established or strengthened between PHS, local Pacific governments and international agencies such as the World Health Organization and the South Pacific Commission as highlighted by: 1) the development by WHO, PHS and the University of Hawaii of an outline for manpower planning for the US Pacific; 2) the participation of the SPC in a variety of programs which took place throughout the Pacific; and 3) the submission to PHS of several projects by the SPC including development of a cancer registry for the US-related Pacific, and a nutritional assessment and workshop for each jurisdiction among others. Funding was not available to support the SPC projects.

PHS Grant Support by Jurisdiction (FY 1990)

Jurisdiction	PHS Grant Support
American Samoa	$1,592,757
CNMI	$1,090,772
Guam	$3,312,480
FSM	$1,523,525
Marshalls	$1,010,750
Palau	$918,554

Note: This table only describes selected Public Health Service grants. The table does not include National Institutes of Health or FDA funds which are made available to the Pacific jurisdictions directly from those entities. Further, it does not include the 35 National Health Service Corps health professionals provided to the Pacific entities. The totals do not include funds for services provided to the Pacific entities through grants awarded to an outside entity; e.g., Section 301 Pacific Initiative grants awarded to the University of Hawaii, Marimed Foundation, Micronesia Institute and Mercy International Health Services, Inc.

1989 UNIVERSITY OF HAWAII STUDY: PROCESS AND FINDINGS

The 1989 University of Hawaii study follows the protocols of the original 1984 assessment of Pacific island health services and systems whereby a structural and process assessment was made in five focal areas: administration, manpower, facilities, health services and public health. Each of the five focal areas was evaluated utilizing several criteria and for each criterion there were several indicators which addressed the criterion. In total, all criteria and indicators represented an assessment in that they asked what was actually in place in the way of services, manpower, administrative mechanisms, and so forth and how well each was working at the time. An outcome assessment was not attempted in 1984 or 1989.

The criteria were not designed to measure optimal performance or status. Instead, they were designed to discern whether each Pacific jurisdiction met minimally acceptable levels of health services and systems, levels which might be expected of any health care system in rural America. Implicit in this approach is the assumption that Pacific island health systems should eventually achieve a level of equity with rural America. As the findings bear out, achieving this parity will likely mean a continuation of external support and participation by the U.S. Government for the foreseeable future.

The overall findings of the 1989 study show that while U.S. Pacific health systems have made slight yet measurable progress in nearly all areas since 1984, the systems and services reflect a low level of adequacy when compared to the "rural American" standard identified above.

Flag Territories have achieved more health care system stability and equity when compared to the U.S.rural health care systems than have the Freely Associated States. These slight improvements in the overall health picture for the six U.S.-Associated Pacific entities may be attributed to local government resourcefulness and in large part to external support, primarily from the U.S. federal government.

Five major issues were derived from the array of findings in the University of Hawaii study, which is appended. PHS concurs that these five issues represent major areas of concern for the U.S.-associated Pacific. (Note: The appended Study outlines the background of and how these five emergent issues were gleaned from the data presented.) These five issue areas are as follows:

* **HEALTH MANAGEMENT LEADERSHIP**

There is an emergent leadership crisis in the Pacific. Senior health leaders are retiring. Few persons with expertise are available to take their place at a time when administration of health systems is becoming increasingly complex. This leadership crisis is but a part of the larger issue of Pacific manpower needs and critical shortages.

* **HEALTH MANPOWER DEVELOPMENT & TRAINING**

Major health manpower shortages exist in the Pacific in every jurisdiction, in most categories and levels. Short term training efforts are piecemeal and fragmented. No plan exists at the jurisdictional and regional levels for the long term training, deployment, and movement into key provider and leadership positions of indigenous health personnel.

* **HEALTH SYSTEMS PLANNING AND DEVELOPMENT**

None of the Pacific jurisdictions is pursuing the deliberate development of their health systems through a process of organized planning. Little or no activity is taking place to routinely project future health related needs, goals, and directions for services and manpower development for health. The health systems are largely without direction. There are no programs of health policy evaluation, revision, and development. There is likewise little or no use of information for decision making toward policy formulation or program development. Policy decisions are often based on data gathered in response to a public health emergency or data gathered in haste in an ad hoc manner, rather than on data gathered for that decision making process.

* **RAPID POPULATION GROWTH**

All Pacific island jurisdictions studied appear to be experiencing rapid population growth due to both high birth rates and non-indigenous in-migration. This rapidly changing demography in the face of diminishing or static resources and capacities, and in the absence of routine health planning, leave Pacific jurisdictions unprepared to adjust and cope with increasing demands on jurisdictional health services.

* **PUBLIC HEALTH NEGLECT**

Public health and prevention in the U.S. Pacific continue to be neglected vis a vis acute clinical health services and tertiary care. Preventable diseases/syndromes/illnesses continue to add to the increasing health problems and economic burdens of Pacific island jurisdictions. Immunizations, nutrition, sanitation, and other preventive/promotion health programs continue to be problem areas which are somewhat neglected because of the lack of local increases in core or baseline funding in these specific areas and because many of the jurisdictions have poor outreach programs. In addition, health policy makers in the jurisdictions often are compelled to cut funding for promotion/prevention programs to deal with current acute needs if overall funding levels remain static or are decreased.

According to the University of Hawaii Study, these five emerging issues suggest a future which, without major adjustments in policy, programs, and resources, looks increasingly problematic for these jurisdictions in the U.S. Pacific.

MENTAL HEALTH AND SUBSTANCE ABUSE STUDY

An in-depth survey of mental health and substance abuse problems and issues was not a part of the original scope of the 1984 and 1989 University of Hawaii studies. To correct this shortcoming, a Section 301 Pacific Health Initiative grant was awarded to the University of Hawaii in 1988 to expand the scope of the 1989 study protocol to include a thorough review of the mental health and substance abuse area. The following summarizes findings as a result of this effort:

* Intersectoral cooperation was lacking within all jurisdictions. Strategies that will both afford the opportunity for intersectoral cooperation and assure that it occurs are critical to the success of these fragmented service systems.

* The service delivery system for mental health and substance abuse ranked low on the priorities of the health departments and appeared to be unranked for governments in general. Thus, the operating budgets were totally inadequate to meet even the most conservative estimates of potential need for staffing and facilities.

* The adoption of "western" models of mental health definition and treatment was almost universal. Little if any attention was paid to "culturally appropriate" care models. In existence is the long standing rivalry between the practitioners of "western" models and the "traditional" healing models. There is no evidence apparent that this rivalry is decreasing. Learning to work or function side-by-side in mutual cooperation and sharing and benefiting from each other's art requires constant review.

* Data to support even the most rudimentary of needs based planning in mental

health was non-existent in all jurisdictions except Palau and only marginally adequate there. Without such data, evidence of need for more resources could not be established.

* Local personnel trained in mental health were scarce to non-existent in these jurisdictions. Most professional staff were expatriate and temporary. No programs existed to attract new indigenous professionals into the field and the existing Pohnpei Medical Officers Training Program did not address this need.

RECOMMENDED APPROACHES

The following approaches are recommended by PHS. They are designed to: continue the progress initiated since the 1984 study; recognize changes and new developments reflected in the 1989 study; and provide an agenda for future PHS actions in the 1990s. These approaches acknowledge the existing commitment by the Public Health Service, including: (1) outstationing of health personnel, particularly through the National Health Service Corps program; (2) PHS grant resources; and (3) technical assistance to the jurisdictions.

The Public Health Service is faced with the dilemma of promoting self sufficiency to the degree practicable and responding to existing needs within current resources. Clearly the predominant support for health programs, particularly basic infrastructure (personnel and facilities) and acute care programs, is carried by the Department of the Interior. However, to the extent that Public Health Service categorical and block grant programs and its other personnel support and technical assistance efforts can supplement these DOI activities, PHS will actively intercede with efforts to improve the health status and quality of life of the Pacific Island populations. The recommended approaches are based on three separate but substantial and suitable input sources:

1. The data, conclusions and recommendations of the 1989 University of Hawaii Study (in addition to data, conclusions and recommendations in the 1984 Study which continue to be viable) and the University of Hawaii Mental Health and Substance Abuse study;

2. The professional views of the PHS staff; and

3. The political and professional leadership of the six Pacific entities.

Recognizing the competing demands and serious financial constraints under which PHS and HHS programs are operating, the approaches recommended will be implemented using existing resources where feasible or with minimal additions to future budget requests.

APPROACH #1

Give the highest priority to the fundamental and foundation structural needs of the Pacific health and mental health systems by developing or improving: (1) a dependable pipeline of qualified health workers to care for the needs of the population, and (2) a facility program for inpatient care, taking into account services, equipment and routine and preventive maintenance of both facilities and equipment.

Based on data in the 1984 and 1989 University of Hawaii studies and information received through discussions with political and health leaders in the Pacific, health manpower availability and development remain the most critical issues facing the Pacific jurisdictions. Nursing and dentistry remain serious problem areas. These two areas will continue to be priority health manpower concerns in the next decade. Facility and equipment problems hamper effective utilization of the scarce manpower available to the Pacific entities, contribute to provider recruitment and retention problems and add to off-island referral costs. Action to improve and maintain facilities and equipment must accompany initiatives to improve the quality and numbers of health manpower.

Physician Services

The Medical Officer training program in Pohnpei, initiated and continued with PHS financial resources, will have a substantial positive impact on the numbers of indigenous primary health care providers available in the Pacific. This program should provide a new cadre of local practitioners for future health leadership positions as the current medical officers serving in health leadership roles retire. During the course of this program it is anticipated that 75 medical officers will complete training by 1997, with the first class completing its studies in 1992. How these practitioners will be integrated into the local health care systems is not fully known at present. Notwithstanding their utilization, reliance on external sources for M.D. strength will remain significant for the foreseeable future and present methods to address this need should continue.

Nursing Manpower

GENERAL NEEDS

Nursing in the Pacific Basin has three main areas of need: 1) development and implementation of nursing practice standards; 2) development of a credentialing/licensing regulatory mechanism and/or assisting graduate nurses to attain established licensure standards (except in Guam); and 3) improvement of the nursing shortage situation. General actions recommended include:

1. PIHOA and the individual jurisdictions working with PHS, WHO and the State of Hawaii should establish priorities and determine resources needed to

improve nursing services throughout the Pacific Basin by developing an objective, multidisciplinary, multiagency and jurisdictional specific manpower plan.

2. PIHOA and the individual jurisdictions working with PHS, WHO and the State of Hawaii should identify strategies which can be taken on a regional as well as at jurisdictional level to increase admissions and retention at the College of Micronesia School of Nursing, Northern Marianas College School of Nursing, University of Guam School of Nursing and Allied Health, and University of Hawaii School of Nursing.

3. The individual jurisdictions working with PHS, WHO and the State of Hawaii should identify short and long term training needs to refocus on preventive health, family-oriented and community-based approaches, and promoting the use of nurses in the expanded roles.

4. PHS should provide continuing support to establishing the American Pacific Nurse Leaders Conference as an organized leadership group for the Pacific.

FLAG TERRITORIES

American Samoa, CNMI, and Guam share two commonalities: 1) a nursing shortage and 2) nursing education programs which lack qualified, local faculty and/or students who are academically prepared to succeed in a collegiate setting. The only National League for Nursing accredited nursing program within the Pacific Basin is at the University of Hawaii. Guam has more than ninety (90) graduate nurses, mostly foreign, who are working as Nurses Aides; CNMI uses a category of "graduate nurses" in addition to Registered. Proposed actions include:

1. A jurisdictional manpower plan, as mentioned under General Needs, should be developed by each jurisdiction.

2. PHS should utilize the NHSC program to assign a career PHS nurse to the University of Guam to strengthen the curriculum to reflect sensitivity to cultural, community and regional needs, to work with faculty towards attaining National League for Nursing accreditation, and to promote linkages with other schools of nursing in the Basin.

3. PHS, working with entities in the State of Hawaii (public and private) and the Pacific jurisdictions, should establish pilot projects on Guam and in Saipan to increase the success rate of graduate nurses writing the NCLEX-RN examinations.

FREELY ASSOCIATED STATES

Nursing needs for the islands of the Marshalls, Chuuk, Kosrae, Pohnpei and Yap include shortage in numbers of nurses as well as numbers of properly trained nurses to assume the expanding and extending roles and responsibilities of new projects and programs. There is no licensing regulatory system in place nor established standards of practice to serve as measures for quality nursing services. There are few, isolated role-models for the majority of graduate nurses to identify with and/or emulate. Proposed actions include:

1. PHS, utilizing the NHSC program, should assign career PHS nurses to each jurisdiction to assist in establishing standards and providing program activities including training to meet those standards.

2. PHS should establish working linkages with the various Pacific Basin schools of nursing and WHO to promote admission and retention of jurisdiction students and to include identification of academically sound prospective students.

3. The Pacific jurisdictions, with PHS support, should establish working linkages with nursing services units on Guam and Honolulu to provide short and long term training programs in specialized areas of need. The jurisdictions and the American Pacific Nursing Leaders Conference should work with appropriate organizations to overcome licensing and liability issues, particularly in Hawaii.

Dental Manpower

At the present time the status of dental health manpower in the US Pacific is extremely critical in all jurisdictions but Guam. There are insufficient numbers of available dental clinicians, i.e., dental officers, most of whom were trained in Fiji, and dental nurses, who were trained on-the-job or at the Micronesian Occupational College. There were 20 dental officers in 1976, 12 in 1988 and only 8 at the present time. This results in a dentist to population ratio of 1:25,000 which compares adversely to a ratio in the US of 1:1,800. (NOTE: The Public Health Service has required that a ratio of 1:5,000 be exceeded before a dental health manpower shortage area is designated.) There were 37 dental nurses in 1976 and 47 in 1988. There is no longer a dental nurse training program at the Micronesian Occupational College and the numbers of already scarce dental nurses will diminish to crisis levels in the near future. To further compound an already critical situation, many of these dental officers and dental nurses are approaching the age of retirement and there are, at present, no Micronesians in dental or dental nurse training programs anywhere in the world. In the face of these grossly inadequate health manpower resources, oral health problems in the Pacific population are rampant and increasing in severity. For example, baby bottle tooth decay (a form of rampant caries) afflicts over 36% of the four and five-year old children and high and increasing caries prevalence rates impact on school-age children. In addition, extremely high rates of untreated carious lesions exist among children and years of unmet need have resulted in high prevalence rates for oral disease in adults.

In light of these conditions, the following steps are proposed to address the dental health manpower issues in the Pacific:

1. PHS should seek appropriations for funding the establishment of a dental health manpower training center on Pohnpei as an adjunct to the medical officer training program currently in place. Three types of personnel would be trained: dental officers, dental nurses and oral health community coordinators. Dental officer training would be patterned after the present medical officer model, i.e., two to three years of classroom and clinical training in Pohnpei followed by a two year field placement/training in one of the Pacific jurisdictions. It is proposed that 30 dental officers be trained in three classes over a seven year period beginning in FY 1993 at an estimated cost, including equipment and alterations and renovation, of $7.5 million. This compares to an authorization of over $10 million for the Medical Officers Training Program. The dental program would be designed and developed in 1992 and 1993.

   Dental nurse training would focus on primary care, prevention and health promotion. Dental nurses would thus be trained to take on key roles in a community based oral health program.

   The Oral Health Community Coordinators would be dental nurses who receive additional training in the planning and implementation of community oral health programs. They would eventually become the managers of oral health teams deployed in the community.

2. During 1991, a U.S.-accredited dental school would be identified to assist in the development of the training programs outlined above. This institution will assist in designing the curricula, recruit or provide teaching faculty, train field teaching dentists in the jurisdictions and provide training on-site. Consultation and assistance would be sought from the American Association of Dental Schools.

3. In connection with 1 and 2 above, PHS would continue to augment dental personnel in the Pacific through the National Health Service Corps program. NHSC dentists are currently assigned to the Republic of the Marshall Islands, the Republic of Palau and Guam. In addition to maintaining these assignment sites, PHS would assign dentists under the NHSC authority and/or its general authority, to the CNMI, and the Federated States of Micronesia (one at the National FSM level to develop a national dental strategy, and one to Chuuk State and one to Pohnpei State. These dentists would serve as senior public health dental officers and as preceptors for the dental officer and dental nursing students during their field placement/training and may augment the teaching staff at the Pohnpei school.

4. Because dental care delivery requires special support systems, PHS should consider, directly or in cooperation with DOI, funding the development of programs to train dental laboratory technicians and dental equipment and facility maintenance personnel for each jurisdiction.

Facility Improvement and Equipment Maintenance

During the past five years, PHS has funded projects, under the Section 301 appropriation provided by the Congress for Pacific improvements, to train individuals from the Pacific jurisdictions in biomedical equipment repair and facility maintenance. These projects, which grew out of the 1984 study, have been successful in upgrading the skills of a limited number of individuals. During the past five years, the hospitals in Guam and American Samoa have received Federal funds from the Department of the Interior for renovation, new hospitals have been constructed in the Commonwealth of the Northern Mariana Islands and the Republic of the Marshall Islands and a new hospital is under construction in the Republic of Palau. Despite these positive steps, facilities within the Federated States of Micronesia continue to deteriorate and thus present significant problems which must be addressed.

Except in Guam and the Commonwealth of the Northern Mariana Islands, the issues of inadequate resources for emergency or preventive facility and equipment maintenance remain serious problems despite the age of the facilities. These issues must be addressed to protect substantial sums already invested or planned for hospital construction.

To address these issues, the following actions are proposed:

1. PHS, in conjunction with the Department of the Interior and the Government of the Federated States of Micronesia, should conduct a "floor to ceiling" facility and equipment assessment/survey of the four hospitals in the FSM States of Yap, Chuuk, Pohnpei and Kosrae. This survey, to be conducted by PHS architects and engineers or supervised by them under contract or grant, would identify deficiencies and recommend necessary corrective actions. Based on the survey's findings, follow-up actions would be recommended for the local governments and Federal agencies, as appropriate. The survey would be completed in 1992.

2. PHS should initiate contacts with the Hawaii Governor's Health Promotion and Development Center and the Department of Defense to explore potential mechanisms to provide financial support and direct training of biomedical equipment repair personnel in all Pacific jurisdictions. The objective would be the development of a long-term (at least ten year) commitment from a resource in Hawaii or Guam to serve as a central support organization. This organization would: a. provide training of new personnel; b. establish "circuit riding" biomedical equipment repair experts who would visit each jurisdiction on a quarterly basis and; c. provide routine telephone consultation and assistance to local equipment repair personnel.

APPROACH #2

Emphasize prevention and life style health promotion efforts to empower people to take individual responsibility for aspects of living which have a major bearing on their health such as smoking, alcohol and drug use, diet and exercise.

During the past several decades, although some PHS-funded public health programs in the areas of maternal and child health, childhood immunizations and communicable disease control have made significant strides, the preponderance of resources expended by Pacific governments on health in the Pacific is in the area of acute, in-hospital care and off-island referrals. In recent years it has become increasingly more evident that the emphasis must shift from acute care to disease prevention and health promotion activities. This is especially true for the Pacific jurisdictions where limited funds and manpower will not support increasing demands on acute care systems. To address this issue, PHS proposes the following actions:

1. PHS should assist the Pacific Island Health Officers Association in developing a Pacific regional policy on disease prevention and health promotion to provide a framework within which individual jurisdictions can develop new or reorient existing programs. PHS will work with PIHOA to coordinate plans and maximize resources, input will be solicited from the University of Hawaii School of Public Health, the World Health Organization Western Pacific Regional Office in Manila and the South Pacific Commission and other appropriate organizations. This activity will be initiated in 1991 and completed in 1992.

2. PHS should assist each of the six Pacific jurisdictions in initiating new local programs and re-orienting current programs to strengthen disease prevention and health promotion activities based on the regional strategy. Specific plans with goals and time-phased actions will be locally developed. Local conferences, sponsored jointly by the jurisdictional leadership and PHS, will be a part of this effort in each jurisdiction. Local plans will be completed in 1993, with program implementation projected beginning in 1994. PHS will give a funding priority to applications for support under its grant programs, including the Section 301 Pacific Initiative grant program, to projects and activities evolved through this planning process. Funding and support sources in Hawaii, such as the Governor's Center for Pacific Health Promotion and Development and the University of Hawaii, will be encouraged to support these efforts.

3. Although PHS has worked to implement several of the Year 2000 objectives outlined in the HHS publication Healthy People 2000, there is a need for the jurisdictions themselves to incorporate this document (and objectives) into their

health systems planning.

Many of the objectives articulated in Healthy People 2000 do not apply to the developing nations in the Pacific. The health leaders and decisions makers and legislative policy makers must work to alter, amend, add to or delete from the twenty-two objectives in the document. As a means of assisting each jurisdiction in this review, the Pacific Health Advisory Council authorized (but not funded) by Congress in the Minority Health Care Act of 1990 (Section 10) might play a key role when and if the Council is funded.

The Public Health Service has supported many of the objectives outlined in Healthy People 2000. For example, PHS has funded a special breastfeeding initiative in the State of Yap in the Federated States of Micronesia. Also, the traditional grants from the Centers for Disease Control, the Health Resources and Services Administration and the block grants from the various entities in the Public Health Service have all supported objectives which have assisted the jurisdictions in meeting some of goals for the Year 2000. The next step of having the jurisdictions themselves tailor those objectives to meet their individual needs must be taken soon.

APPROACH #3

Establish mechanisms to set goals and objectives and develop plans to achieve regional and local priorities over defined, extended periods of time.

The implementation of local health planning in the Pacific under P.L. 93-641 was significantly different than health planning operations funded under this program in the States. In the Pacific, where almost all facilities are government owned and operated, certificate of need was not a major part of the health planning agenda as was the case in the States. Health planning agencies in the Pacific were heavily involved in policy development and priority-setting, data system development and improvement, community empowerment in health decision-making, and development of systems for understanding health trends and facility and manpower needs. Because the health systems are government operated in the Freely Associated States, Commonwealth of the Northern Mariana Islands and American Samoa, local health planning agencies in the Pacific were the Governors' and Presidents' key advisors on health policy matters and had significant positive impacts on health system operations. This was also the case in Guam. The health planning staffs in the Pacific were the repository of the most talented health staffs and maintained the most effective health data systems. In addition, the Pacific health planners as a group provided a valuable source of information for regional decision-making by Federal agencies. The five-year plans developed by the local agencies were a valuable source of information used extensively by PHS and HHS program managers. When the Federal funding for health planning was phased out in 1986 the Pacific jurisdictions, without any other source of replacement resources or ability to divert resources

from direct patient care activities, lost this valuable resource. The pressures of scarce resources and the necessity to maintain basic public health and hospital operations did not permit continuation of health planning operations after Federal funding was terminated.

The Pacific political leaders and health directors have identified the reinstatement of some form of local and regional health planning as one of their highest priorities for Federal support. The University of Hawaii study also identified health planning as a high-priority recommendation.

In recognition of this important need, the following actions are proposed to re-establish health planning operations in the Pacific:

1. The PHS San Francisco Regional Office should be assigned the oversight responsibility for providing technical assistance to establish a voluntary health planning system in the Pacific. The Pacific health directors and the Pacific Island Health Officers Association would be consulted in the development of the health planning system. The new system would include development of five-year health plans with government-wide objectives, relationships to Year 2000 targets, and time-phased action plans for their achievement, and community-based health planning councils. Certificates of need will not be a part of the new program.

2. Appropriations would be sought from the Congress in FY 1993 for the temporary allocation of one full-time PHS position and funds to support the local hiring of health planners in the Office of the Health Director or Health Minister of Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Republic of Palau, the Federated States of Micronesia National Government and the FSM States of Yap, Chuuk, Kosrae, and Pohnpei. The one full-time PHS position would be assigned to the San Francisco PHS Regional Office; all additional funds would be given to local jurisdictions to hire planners.

The new program policies and guidelines would be developed, reviewed and approved during Fiscal Year 1992 under the leadership of the San Francisco Regional Office utilizing existing resources. The ten health planners will be assigned and full program operations will begin in Fiscal Year 1994. It is projected that the first five year plans will be developed during Fiscal Year 1995 and cover the 1995 to 2000 time period. Initial operational costs for this program will be requested in the 1994 budget.

APPROACH #4

Improve the quality and availability of mental health and substance abuse services and systems.

The following approaches address the existing inadequacies in the mental health services and systems in the Pacific entities. They essentially respond to the existing array of mental health services or lack thereof and are intended to address three serious mental health issues found in the Pacific. What can be done about the endemic nature of young male suicide? Why is there an emphasis but lack of focus on alcohol and drug abuse? What can be done about the isolation of mental health programs from the mainstream of public health?

1. PHS, working with the Pacific jurisdictions, WHO and State of Hawaii organizations, should foster a long-term focus to development of mental health and substance abuse programs in the Pacific. Incremental, year-to-year funding, manpower and other planning, and service system "adjustment" is not the solution, it is part of the problem. A minimum of a decade of improvement as a strategy of approach is required.

2. Within the long-term strategy developed under 1. above, an emphasis on preservation of culture, of social structure, and of "island pride" is a critical and necessary underlying theme. Such a theme will, in all likelihood, have to look beyond rural America for adequate models to help heal the wounds of the twentieth century.

3. PHS, working with Pacific health leaders and others as appropriate, should define that which would be agreed to as "mental health" in the Pacific region. Without such definition programs will continue to be reactive, to respond to initiatives such as the recent P.L. 99-660 mental health plans, defined in U.S. mainland terms and not necessarily appropriate for the Pacific.

4. The Pacific jurisdictions, with support from PHS, should develop integrated information systems to allow for accurate planning of their mental health systems. In particular, unlike the general health systems, these information systems must receive regular inputs from other sectors of the society including the social services, criminal justice, and the taxation system to name but three.

5. The Pacific jurisdictions should develop ways and means to be able to assure safety and security to their mentally ill and substance abusing populations. It is essential that this assurance be provided through the health care delivery system and not the criminal justice system and that there be adequate, competent medical supervision for the detention periods.

6. PHS should work with the Pacific jurisdictions to develop mechanisms for the

providers of care to the mentally ill to refer cases of complex diagnosis and/or difficult treatment to a referral center where the expertise necessary to establish realistic treatment plans is available. For the Micronesia area of the Pacific such a site might be Guam; for American Samoa it probably would be Hawaii.

The following four more specific recommendations should be viewed in the context of the previous six recommendations:

1. Increased training and educational opportunities should be developed for the existing staff. Of particular interest are those mental health workers who are often situated in positions without either formal or informal knowledge about identifying or working with mentally disabled individuals, be they mentally ill or mentally retarded. However, such training must be culturally appropriate.

2. Increased resources to fund both staff and facilities tasked to service the mentally ill should be provided by PHS through its grant programs or by Pacific governments through local resources. To the extent possible, these should be made available without the usual U.S. mainland-oriented administrative and compliance guidelines and program requirements. The Pacific cultures must remain intact. Many of the difficulties associated with inadequate treatment are based on the lack of available personnel to work with patients or facilities to service those needing assistance.

3. PHS, in cooperation with the Pacific jurisdictions and institutions in Hawaii and Guam, should provide increased educational opportunities which inform a potential natural support group of the difficulties associated with mental illness. Too often, family and friends know very little about these disabilities and through anecdotal bits of information, often Mainland U.S. in source, decide that mental illness is something to be ashamed of and warrants ostracism or neglect. The educational programs offered must be supportive of "island ways" and not simply transplants from rural America.

4. The Pacific jurisdictions should promote increased intersectoral cooperation to provide the mental health services access to hospitals by public health staff.

APPROACH #5

Improve the partnership between non-Federal colleagues in States, universities, the private sector, the international community and current entities involved in health care in the Pacific.

During the five years which have followed the completion of the original 1984 study, the number and scope of organizations actively involved in health activities in the U.S.-related

Pacific has grown substantially. In part this growth has been a direct result of the 1984 study and PHS follow-up actions to foster increased involvement of organizations such as the University of Hawaii health professional schools, elements of the Department of Defense, international agencies, non-government institutions and private sector organizations. This involvement has been helpful in that additional resources have become available to support local health systems in the Pacific. For example, the South Pacific Commission has increased its attention to the health problems of U.S.-related Pacific jurisdictions and held its annual conference in a Flag territory for the first time in 1989. WHO has indicated its desire to work with PHS on a more proactive basis to coordinate program resources to prevent duplication and focus programs on areas of high-priority needs. The Department of Defense has increased cooperative working relationships with PHS to more effectively bring to bear the resources of its Civil Action Teams and Army Reserve units on Pacific health problems. However, there is still a need to continue to expand this base of support to the Pacific and to better coordinate efforts to prevent gaps and eliminate overlap.

To address this issue, PHS will:

> Initiate, through its San Francisco Regional Office, a co-sponsored semi-annual joint planning meeting with the World Health Organization Western Pacific Regional Office. The participation in this meeting would be extended to include the South Pacific Commission, Department of Defense, U.S. Agency for International Development, the Governor's Pacific Health Promotion and Development Center in Hawaii and other appropriate organizations. The meetings will provide a forum for the exchange of information on current and planned health programs and activities in the U.S.-related Pacific. The results of these meetings will enable managers of all programs to more effectively program limited resources and influence directions for future allocations of funds by other organizations supporting programs in the Pacific. The first expanded meeting will be held in late 1991 or the Spring of 1992.

APPROACH #6

Emphasize maternal and child health programs to: (1) improve the quality of and access to clinical and preventive services (including family planning); (2) improve the quality and provision of health education; and (3) increase the supply of trained MCH-related manpower.

As the UH study indicates, women and children in selected jurisdictions of the Pacific experience extremely high rates of morbidity and mortality when compared to the U.S. as a whole. Children in the Freely Associated States are most dramatically affected by preventable diseases such as diarrhea, malnutrition, otitis media, vitamin A deficiency, intestinal parasites and immunizable diseases such as measles. In some areas children under the age of 10 comprise 33% of hospital admissions for diseases and/or conditions which were preventable with proper nutrition, immunizations, pre-natal care or proper post-natal (first year of life) care. Other areas of child health which demand attention include dental care, the

needs of handicapped children and the needs of those children who suffer from child abuse and neglect. Infant mortality in the Freely Associated States is unacceptably high.

Infant Mortality Rates for U.S.-Associated
Pacific Island Jurisdictions and the U.S.

	IMR	Year
American Samoa	8.0	1989
Guam	9.9	1988
CNMI	17.9	1988
FSM	22.0	1989
Palau	26.6	1988
Marshall Islands	63.0	1988
U.S.	10.1	1988

Women experience high rates of morbidity and mortality as a result of teenage pregnancies, high parity, poor birth-spacing, child-bearing complications, malnutrition, poor or non-existent pre-natal care and late entry of expectant mothers into the health system. These problems are exacerbated by rapid population growth, increasing population centralization and consequential crowding, social and family problems. Without substantial emphasis on MCH-targeted prevention and promotion programs, the future will hold disastrous health consequences for women and children in the U.S. Pacific.

PHS proposes the following four interrelated actions to address these problems:

1. PHS will assist each of the jurisdictions' primary care and in-hospital programs to improve the quality of perinatal care, women's reproductive health care and early childhood care and foster integration of MCH services into the local primary health care system. This includes making a maximum effort to enroll women in pre-natal programs early in the pregnancy.

2. PHS will supply technical assistance to each of the jurisdictions' health departments and hospitals in order to facilitate access to MCH services by providing services to outlying areas through the current Community Health Center/Primary Care PHS grants in each jurisdiction, as well as using outreach techniques to raise utilization in population centers.

3. The MCH Resource Center in Guam will work with each jurisdiction's primary care providers and health department to foster intensive health education around MCH issues to impart knowledge and change attitudes about the importance of early pre-natal care, family planning, breastfeeding, infant growth monitoring, nutrition, immunizations, etc.

4. Working with the World Health Organization, South Pacific Commission and

PHS, each jurisdiction should promote increased levels of trained manpower such that outlying areas can be staffed and clinics in population centers run more efficiently. Existing manpower should be trained through training on site by WHO, SPC and PHS to perform MCH related activities. Trained outreach workers are equally as important as clinical workers. Manpower improvements will affect quality and access to care as well as delivery of health education. Local health funds may have to be used to re-train personnel from other health care disciplines into clinical care workers and outreach workers able to man out-lying clinics. The graduates of the MO Training program will augment the health manpower picture in each of the Freely Associated States; thought must be given to placing these new graduates into the outlying clinics in each jurisdiction.

5. In addition to the development and improvement of standard MCH services, PHS will ensure through targeted funding that local jurisdictional efforts will be made to create services for handicapped and children with special needs. In comparison to the U.S., the Pacific has proportionately greater numbers of children who display a wider array of special health conditions and problems, such as severe nutritional disorders, including vitamin A deficiency, malnutrition, and kwashiorkor. In addition, children in the Freely Associated States suffer from worm infestations, infections, and diseases associated with developing nations such as dengue fever, cholera, encephalitis and hepatitis. Currently, virtually no treatment or rehabilitation programs exist. Similarly, levels of child abuse and neglect are on the rise in some jurisdictions, indicating an urgent need for child protection services as well as intervention and prevention programs.

6. PHS will work with its National Health Service Corps assignees, graduates of the Medical Officer Training Program, nursing schools in Guam and Majuro and primary care providers at each site to encourage health professionals to integrate health education into patient visits. Also, PHS will encourage health professionals to provide nutrition information to teenagers, mothers and teachers in grade and high schools in each jurisdiction. Each jurisdiction must survey its school based health education programs, if they conduct such programs, and improvements must be made so that this effort is strengthened. The financial feasibility of beginning school based health education programs must be explored in those locations where such programs are not available.

7. Because malnutrition and third-world deficiency diseases such as marasmus and kwashiorkor are prevalent in the Pacific according to WHO and UH studies as recently as 1990, local health personnel must improve their understanding of nutrition issues. At the same time PHS personnel will work with training institutions such as the College of Micronesia School of Nursing and the Medical Officer Training Program to improve nutrition curricula. The DOI Short-term Technical Assistance program will be requested to fund most of the

technical assistance in this regard.

8. The PHS San Francisco Regional Office will develop and conduct a one to two week nutrition course in each Pacific jurisdiction. This course will focus on food safety, sanitation and the basics of good nutrition. A portion of this course will focus on food service employees of institutions such as hospitals and restaurants and lead to a food handlers certificate. Another portion will focus on dietary employees of the hospitals and cover dietary modifications for various diseases. The course will be modified and provided on a follow-up basis on a jurisdiction-specific basis as needed. Funding for these programs will be sought from the Department of Interior and the US Department of Agriculture.

APPROACH #7

Improve accessibility, availability and acceptability of health care services for remote or outer island populations.

At the present time there is a tendency for health care resources to be expended by the local governments in the capitol cities of the six U.S.-related Pacific jurisdictions and in the State capitols of the Federated States of Micronesia. The concentration of health services in capitol cities, combined with the paucity of services in remote locations, is frequently cited as a reason for migrating to the already over-crowded capitol "cities". Continued neglect of outlying areas has serious long-term implications since it contributes to rural-to-urban migration patterns. However, an immediate concern is the present health status of the dispersed populations. Recent figures indicate that 33% of the Palau population, 50% of the Marshallese population and 75% of the Federated States of Micronesia populations live in rural, isolated areas, i.e, non-capitol cities, small villages or lightly populated remote islands. Remotely located islanders suffer largely the same preventable health problems as people living in the capitols, however, the isolated inhabitants have minimal access to basic health care and virtually no health education. Elements which constrain the delivery of health care to the dispersed populations include communication barriers, transportation delays, insufficient numbers of or inadequately trained providers, financial limitations and deficient or non-existent health care facilities.

To address this issue, PHS Region IX has developed a proposal to evaluate health care in remote areas of the Freely Associated States. The study will provide baseline information regarding current health care needs, practices, and systems in these remote locations. The results of the project will be utilized to initiate actions by PHS and other Federal agencies, the local jurisdictions and others delivering care in the Freely Associated States so that services to the isolated locations are improved.

APPROACH #8

Conduct a comprehensive status review in 1996 to evaluate progress made toward improving U.S.-related Pacific health systems and report findings to the Congress

PHS will conduct a review in 1996, using the criteria and indicators that were applied in 1984 and 1989, to determine the extent to which program initiatives have achieved their desired objectives. Following the practice established in 1984 and 1989, the Pacific health directors, key local executive and legislative leaders and outside organizations active in health in the Pacific will be involved in the process.

HON. DE LUGO
DELEGATE, VIRGIN ISLANDS

COMMITTEE ON NATURAL RESOURCES

CHAIRMAN, SUBCOMMITTEE ON INSULAR AND INTERNATIONAL AFFAIRS

COMMITTEE ON PUBLIC WORKS AND TRANSPORTATION

COMMITTEE ON EDUCATION AND LABOR

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congress of the United States
House of Representatives
Washington, DC 20515

PLEASE RESPOND TO:

☐ WASHINGTON OFFICE:
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☐ U.S. FEDERAL BUILDING, SUITE 315
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(809) 778-5900
FAX (809) 778-6111

April 20, 1993

Ms. Hillary Rodham Clinton
The First Lady
The White House
Washington, D.C. 20500

Dear Ms. Clinton:

On May 5, 1993 the Governors of the U.S. Virgin Islands, Guam, American Samoa and the Commonwealth of the Northern Mariana Islands will be in Washington D.C. to testify before the Appropriations Subcommittee on Interior on Fiscal Year 1994 territorial line items. Spring budget hearings are usually the only time during the year that the territorial governors, especially those from the Pacific, can be in Washington together.

I fully appreciate the enormous demands on your time as you and your Task Force work to finalize the national health care reform proposal. However, if it could be done, I know that the Governors of the territories would welcome the opportunity to meet with you on the proposal. The Governor of Puerto Rico could also be invited to participate should such a meeting be possible.

All of the territories, including Puerto Rico, have been working closely with Dr. Claudia Baquet who chairs Group 2 on special issues. We appreciate her commitment to inclusion of territorial concerns, and her special efforts to become knowledgable on territorial issues. She is an asset to your Task Force.

As chairman of the subcommittee of jurisidiction I thank you for your consideration of this suggestion. You have been extraordinarily generous to our nation in your dedication to the health care reform project, even with the tragic loss of your father. You have my deepest admiration.

Sincerely,

Ron de Lugo
Chairman
Subcommittee on Insular
and International Affairs

RDL:smr

EXECUTIVE OFFICE OF THE PRESIDENT

Washington, D. C.

FAX TRANSMITTAL COVER SHEET

DATE: 10-Dec-93

TO: MAGAZINER

SUBJECT: TUESDAY STAFF MEETING

FROM: ROSALYN A. MILLER (202) 456-2216
ECONOMIC AND DOMESTIC POLICY

If there are any problems receiving this transmission,
please call the sender, or (202) 395-7370.

Because of this week's budget schedule, the Tuesday Staff Meeting is cancelled. Please feel free to E-mail or call me with any items that you feel need CHR's attention.

Thanks!

EXECUTIVE OFFICE OF THE PRESIDENT

Washington, D. C.

FAX TRANSMITTAL COVER SHEET

DATE: 13-Dec-93

TO: IRA MAGAZINER

SUBJECT: CANCELLATION OF DEC. L4TH 5:30 P.M. NEC

FROM:

GAYLEN S. [illegible]R (202) 456-2802
NATIONAL [illegible]C COUNCIL

If there are problems receiving this transmission, please call sender, or (202) 395-7370.

Due to work on the budget, the NEC Weekly Meeting scheduled for December 14th at 5:30 p.m. has been cancelled. There will be a meeting next week, but the usual time and day may have to be adjusted due to budget meetings.

Hereafter, meeting notices will be sent in this form via OASIS. Please let Gaylen Barbour know at 456-[illegible], if you experience any difficulties with this system.

MEMORANDUM

To: Joan Baggett , White House Political Affairs
Maggie Williams, Office of the First Lady
Ira Magaziner, White House Health Care Task Force
Keith Mason, White House Intergovernmental Affairs
John Hart, White House Intergovernmental Affairs
Jeff Eller, White House Media Affairs
Carol Rasco, White House Domestic Policy
Bruce Reed, White House Domestic Policy
Kathryn Way, White House Domestic Policy
Ann Wally, White House Scheduling
Holly Carver, Office of the Vice President
Marla Romash, Office of the Vice President
Eli Segal, White House Office of National Service
David Wilhelm, Democratic National Committee
Kiki Moore, Democratic National Committee
Katie Whelan, Democratic Governors' Association
Kris Balderston, Labor Department
John Monohan, HHS Department
Debra Silimeo, Democratic Policy Committee
Debbie Shon, USTR
Jennifer Davis, Education Department
Joyce Carrier, Treasury Department
Oleta Garrett, Agriculture Department
Bob Sussman, EPA

From: Marcia Hale

Date: August 10, 1993

There will be a meeting at 4:00 p.m. tomorrow in the Roosevelt Room, West Wing, White House, to discuss the National Governors' Association Conference in Tulsa.

Please make every effort to attend.

Thank you.

MEMORANDUM

Date: July 30, 1993

To: Dee Dee Myers
Mark Gearan
Ira Magaziner
Jeff Eller

From: Bob Boorstin

RE: Health care spokesperson interviews

Today, Julie Rovner is coming to interview for the position as the health care spokesperson. I have attached her resume to give you an idea of her background. Maggie Williams spoke with her as a preliminary screening.

Her interview schedule for today is as follows:

Ira Magaziner	12:00-12:45
Dee Dee Myers	2:00-2:15
Mark Gearan	2:15-2:30
Jeff Eller	2:30
Bob Boorstin	

If you have any questions, please call me for more information.

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	Resume of Julie Rovner (partial) (1 page)	nd	P6/b(6)

COLLECTION:
Clinton Presidential Records
Policy Development
Magaziner, Ira (Subject Files)
OA/Box Number: 10020

FOLDER TITLE:
Intergovernmental [2]

2006-0770-F
ry520

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

JULIE ROVNER

(b)(6)

[001]

WORK EXPERIENCE

ON-AIR CORRESPONDENT, MEDICAL NEWS NETWORK, 1993-present.
Cover health-reform efforts and other health policy stories for national, satellite-delivered daily television news program for physicians.

REPORTER, CONGRESSIONAL QUARTERLY WEEKLY REPORT, 1986-1992
Covered health/human services beat, including coverage of passage and repeal of 1988 Medicare Catastrophic Coverage Act and passage of landmark welfare reform, child care, and civil rights for the disabled bills.

FREELANCE WRITER, 1980-present.
Have written regularly for Better Homes and Gardens and The Washington Post. Have written multiple articles for Washington Woman Magazine, the Washingtonian, and Governing magazines. Articles have also appeared in The Saturday Evening Post, People Magazine, Woman's World, Ladies' Home Journal and the International Herald Tribune.

REPORTER, LEGAL TIMES, 1985-1986.
Covered banking and other issues for national weekly legal newspaper.

PRESS ASSISTANT, U.S. REP. CHARLES SCHUMER, 1983-85.
Wrote and edited newsletters, press releases, op-eds, and statements for U.S. Congressman from Brooklyn.

MANAGING EDITOR, THE MICHIGAN DAILY, 1979-1980.
Also served as Editorial Director and Night Editor. Reported, wrote, and edited news, feature and investigative stories for 6 day-a-week broadsheet college newspaper. Second-in-command of a staff of 40+.

REPORTER INTERN, NEWSDAY, Summer, 1979
Reported and wrote local news and feature stories, often several per day, for Long Island, NY daily newspaper.

AWARDS AND HONORS

1983 Writer of the Year, Dog Writers' Association of America
1980 Michigan Children's Book Council award (for children's novel)
1977 Winner, newswriting, Detroit Press Club Collegiate Competition

EDUCATION

University of Michigan/Ann Arbor; A.B. with Distinction (Political Science), 1980

Walt Whitman High School, Bethesda, MD, 1976

REFERENCES AVAILABLE ON REQUEST

THE WHITE HOUSE

WASHINGTON

August 18, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

CC: IRA MAGAZINER

FROM: JANET HANDAL

SUBJECT: Debrief of Reconciliation Room and Technology Support for Health Care

I want to follow up on the conversation we had at the signing of the budget bill. I spoke with Roger Altman regarding your suggestion of having the health care war room team debrief the Reconciliation Boiler Room team to learn what worked and what didn't. All that needs to be done is to set a date and develop an agenda. It would probably be best if it's done while people's memories are fresh. I would be happy to coordinate the meeting if you would like.

I began working in the Rec Room one week into the three week effort and designed and implemented a system to count votes and capture information regarding members gleaned from our Cabinet lobbying effort. There were certainly many other activities which could have operated more efficiently by using software tools, but without prior planning there was simply no time. I believe that the health care effort can be greatly enhanced by planning for the use of technology to support the effort. I would like to work with you and your team to achieve this and believe I am uniquely qualified to do so.

I was Director of Technology for the Campaign and the Transition. I put in place in 24 hours the graphics effort for the Economic Conference after persuading the planners of their value. During the campaign I developed the interdisciplinary process to produce the maps which were used to plan schedules, and track and allocate resources. At the White House, I chair the Task Force on Information Technology. I think what makes me uniquely qualified to help is that I have a solid business background, with an MBA from Columbia University and Corporate Planning at Chemical Bank, and sophisticated computer skills. This enables me to understand what information is needed to make decisions and what tools or combination of tools are available to develop this information.

I would be happy to meet with you to learn what your needs are and discuss how technology could help.

ICM/MT

M E M O R A N D U M

TO: **CAROL RASCO AND IRA MAGAZINER**
FR: **JOHN HART/CHRIS LEHANE (X2896)**
RE: **ROLL OUT PLAN**
DATE: **8/12/93**

==========

The following is a summary of IGA's proposed Roll Out plan for the Clinton Health Care Proposal.

STAGE I: NGA STAFF

When: 1st Week in September
What: National governors' staffs will receive a briefing at the White House on the plan. At this time, the pre-plan briefing material being prepared by Communications will be disbursed. This event will be coordinated in conjunction with Ray Scheppach of the NGA. The event will be open to a specified number of representatives from each governors' office.

STAGE II: BI-PARTISAN NGA HEALTH CARE COMMITTEE

When: 2nd Week in September

What: The Bi-Partisan NGA Health Care Committee will come to the White House for a briefing. The Health Care Committee is chaired by Governor Howard Dean (D-VT) and includes Governors Carroll Campbell (R-SC), Arne Carlson (R-MI), Lawton Chiles (D-FL), Brereton Jones (D-KY), Mike Leavitt (R-UT), Roy Romer (D-CO), and Thommy Tompson (R-WI).

STAGE III: DEMOCRATIC GOVERNORS BRIEFING

When: 3rd Week in September (either the day prior to the plan's release or on the day of the plan's release).
What: HRC and Ira Magaziner will brief the 31 Democratic Governors at the White House. This briefing will provide an overview of the plan with a particular focus on those issues of importance to the states (e.g. flexibility). Press material and appropriate material will be distributed to these governors, as they will serve as our surrogates.

STAGE IV: WRAP-UP

When: Immediately following the announcement

What: National governors' staffs will receive a thorough debriefing on the plan. This will be a session in which to answer some of the nuts and bolts questions of the plan which the governors' health care experts will have. Copies of the plan with the in-depth explanations will be distributed.

Memo

To: Ira Magaziner
Judy Feder
Rick Kronick
Walter Zellman
Lynn Margherio
Christeen Heenan
Dr. Helen Smitts

From: John Hart
Re: Health Care Analysis Sheet
Date: September 14, 1993

Thank you for your assistance in composing the list of Advantages and Disadvantages to States to be used for this afternoon's Governor's meeting. Attached please find the results of your efforts.

On Thursday the President is meeting with state legislators and local officials (mayors and county officials). In preparation for that meeting would you kindly review the attached list and make appropriate edits to adapt it to take into consideration the impact of health care reform on cities and counties.

Please fax your comments to me by the close of business today. We will circulate a preliminary cut of the revised sheet tomorrow for inclusion in the President's briefing.

My fax number is: 456-2889.

Thank you again.

POTENTIAL ADVANTAGES AND DISADVANTAGES FOR STATES

POTENTIAL ADVANTAGES

* State Medicaid spending for guaranteed benefits is capped at the budgeted rate of growth, which is substantially lower than the projected increase in Medicaid spending. This provides significant fiscal relief for states.

* Subsidies for early retirees will produce large savings for state employee health programs.

* Increases in state health spending for public employees will be capped under the budget.

* Federal government is taking the political heat for imposing the mandate and implementing the budget.

* Reform at national level offers chance for states to achieve universal access. Many states are afraid that expanding access on their own would make them a magnet for those with high cost illnesses. Additionally, they fear that it would put them at a competitive disadvantage relative to employment requirements in other states -- especially if they make businesses pay for it. Under our plan the effects of an employer mandate will be reasonably consistent across the country. No one state is asking its people and businesses to do something unique.

* States are responsible for establishing alliances and administering employer/consumer payments and subsidies. Administrative funds, however, are provided through premium surcharges.

* States have considerable flexibility under federal parameters in administering alliances especially on the key issues of how, where, under what structures to establish alliances. States also have the option to establish a single-payor system.

* Federal government is assisting states financially
  --subsidies to small and low-wage firms and individuals up to 150% of poverty.
  --reductions in Medicaid costs
  --reductions in cost to state of retiree health care.

--current and projected levels of spending for public employees will decrease substantially under the budgeted system.
--federal government will provide technical assistance, start up funds.

* Medicaid long term care services that get transferred to the new long term care program are capped at the budgeted rate of growth, when fully implemented.

* States will be able to reduce spending on General Assistance/General Relief medical assistance under a system of universal coverage.

* States and localities will be able to reduce direct support to hospitals and clinics to care for the uninsured. State owned facilities providing free care will particularly benefit.

* States will be able to reduce spending for inpatient psychiatric care under universal coverage, and will be able to stretch outpatient mental health dollars further.

* For AFDC and SSI recipients, state per capita Medicaid payments to alliances are at 95% of current levels.

* The federal government will provide the employer and consumer subsidy payments necessary to achieve universal coverage, with no financial risk to states.

* The federal government takes responsibility for enforcing caps on premium increases.

POTENTIAL DISADVANTAGES

* States lose current federal disproportionate share payments.

* States will need to pay at least 80% of the community-rated average premium in each alliance for public employees, including pro-rated contributions for part-time workers. This may be more (or less) than what some states are paying today.

* In the near term, differentials in practice patterns and payment variations across states are maintained. Low cost states may view this as unfair.

* Undocumented citizens not covered under the plan results in continued state exposure.

* States must continue to maintain eligibility to administer subsidies, although the proposed system is far simpler than the current eligibility process under Medicaid.

ICM

To: First Lady Hillary Rodham Clinton
Ira Magaziner
Governor Celeste
From: John Hart
Re: Gov. Cuomo

I wanted to alert you to a potential problem : Gov. Cuomo. To date we have set up private meetings with members of the Governors staff for consultation on the plan. We are meeting again with Cuomo's staff prior to release.

The problem boils down to Medicaid funding. The Governor feels very strongly that New York does not receive its' fair share (most notably compared to other states). The Governor knows that our plan will not satisfy New York's concerns and has chosen to closely align himself with Senator Moynihan and bet on resolution of the funding issue through the Finance Committee. More troubling, however, is the Governor's increased propensity to air his differences through the media (see attached article.)

We have urged the Governor to meet with Ira, Mrs. Clinton or the President to directly express his concerns. We are awaiting the Governors' response.

I have discussed this with Governor Celeste and he agreed to give it some thought.

Health Care Consultations

Cuomo: Plan Must Curb Medicaid Cost

By Dena Bunis
STAFF CORRESPONDENT

Washington — While he is not yet drawing a line in the sand, New York Gov. Mario Cuomo says any national health plan President Bill Clinton proposes can succeed in the Empire State only if it deals with the stranglehold Medicaid has on the state's finances.

"We're not going to ask for a break, but we are going to insist on fairness," Cuomo said in a telephone interview yesterday.

Medicaid is the state and federal program that pays for health care for the poor and for low-income elderly. Cuomo has repeatedly complained that the federal contribution to Medicaid is 50 percent for New York but as much as 80 percent for other states deemed by Washington to be poorer.

Before the administration contemplates cuts in Medicaid to help pay for health-care reform, Cuomo said, it should adjust the formula to raise federal contributions to so-called rich states like New York and California.

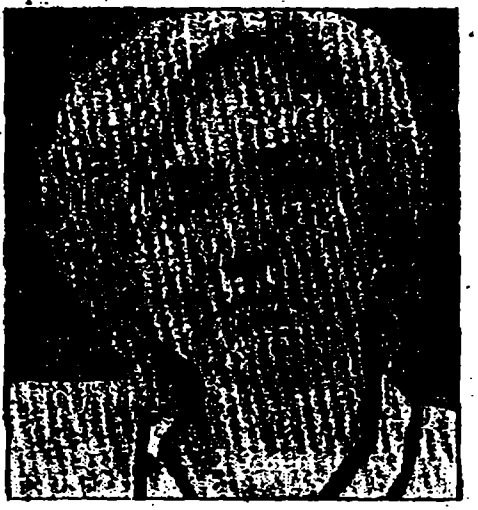
White House health advisers have said they hope to save $19 billion from Medicaid once all employers have to contribute to their workers' health insurance, including insurance for Medicaid recipients who work. But state officials are concerned because they have not heard much about how the reimbursement formula would work and whether there could be other as yet unspecified Medicaid cuts.

"I hope when he says there's a plan that he does not start by punishing us further," Cuomo said.

At health briefings last weekend, White House officials said they hoped to be able to work out the disparities in Medicaid reimbursments among the states, but they gave no specifics.

There are some health initiatives that New York could have difficulty implementing. Clinton's plan will rely heavily on managed-care plans to deliver services. New York has been slow to move to managed care, with only an estimated 10 to 20 percent of residents enrolled in such plans. And Clinton's plan will not cover undocumented aliens, who are present in New York City in significant numbers.

Cuomo said that while he has not spoken about Medicaid to Clinton or first lady Hillary Rodham Clinton, who chaired the health-care reform task force, members of his staff have.



AP File Photo
Hillary Rodham Clinton

First lady wooing Congress

By Marilyn Milloy
WASHINGTON BUREAU

Washington — The White House's push to stir up congressional goodwill around President Bill Clinton's health care proposal begins in earnest today when Hillary Rodham Clinton goes to Capitol Hill to kick off a round of consultations with key lawmakers.

The concerns she will hear are sure to run the gamut, but a few will touch upon some grave, hard-to-reconcile views about health care that are as much philosophical as they are partisan. The delicate political mission now is to finesse a needed coalition with Republicans and unite several fervently divided bands of Democrats who currently see neither eye-to-eye with the president nor each other.

The task does not promise to be easy, despite numerous overtures from lawmakers, Republican and Democrat alike, about a spirit of cooperation being in the air, about a health care bill having a real chance to pass next year.

Already key members of Congress, including avid administration supporters, are beginning to express nervousness about whether the president's proposals to finance his plan are workable and politically acceptable.

Administration officials have said that along with requiring employers to pick up the lions' share of the tab, they will be leaning heavily for resources on savings from within the system, namely $238 billion over five years from the Medicare and Medicaid programs. There also would be dramatic savings in the private sector, achieved largely by limiting the rate at which insurance premiums rise each year.

But actually proving to lawmakers they can get those savings will take some doing. And beyond such questions, there are the divisions.

For starters, there are the 30 or so Democrats in Congress who favor a government-run or single payer system.

They want, for instance, consumers to have more choice of doctors than they perceive the administration's plan allowing. In addition, they oppose the idea of allowing corporations with more than 5,000 employees to form their own health alliances; and they say the federally guaranteed benefits package should be even beefier than the comprehensive one the president proposed, to avoid development of a two-tiered system.

Republicans generally loathe employer mandates, and some conservative Democrats, led by Rep. Jim Cooper of Tennessee are opposed to them, too. However, Republicans are divided over the issue of universal coverage. The administration thinks universal coverage should happen as quickly as possible — December, 1997 is the target date.

There is also the issue of government regulation and price controls. Moderate Republicans and conservative Democrats generally think government should not be involved in bringing down costs and running the new system as much as Clinton has proposed and that market reforms should be leaned on more heavily; some very conservative Republicans such as Sen. Phil Gramm of Texas believe the government should have no role beyond giving minimal vouchers to low income people who can't afford to buy insurance.

The good news for the administration is that key Senate Republicans and conservative Democrats, agree on the framework of the plan.

NEW YORK NEWSDAY, THURSDAY, SEPTEMBER, 9, 1993

MEMORANDUM

TO: Ira

FROM: Meeghan

DATE: September 15, 1993

CC: Marge
Charlotte

RE: **Hamilton College Follow-Up**

The Hamilton College students have been sent a copy of the proposal this morning. As you know, we promised them a follow-up phone call to discuss our proposal once they had a chance to look at it.

There would be no rush except that they have been scheduled to appear again on the Today show next Friday (September 24th). You'll remember that they were on when they first released their plan and the show is anxious to see what they thought of the final proposal.

I thought that a conversation with you -- preceding the taping -- would be a good idea. It is a pretty huge document for them to go through and they might get confused and say negative things. Could we do it on Tuesday -- before the plan release -- or Thursday -- day after speech but before taping?

THE WHITE HOUSE

WASHINGTON

DATE: SEPTEMBER 16, 1993

HEALTH CARE CONSULTATION WITH STATE AND LOCAL OFFICIALS

DATE OF EVENT: Thursday, September 16, 1993
LOCATION: The State Dining Room, The White House
TIME: 3:30pm to 4:15pm (President in Attendance approx. 3:35pm-4:15pm)
FROM: John Hart, Deputy Assistant to the President for Intergovernmental Affairs

I. PURPOSE

The purpose of this meeting is to explain to elected officials how they can be constructively involved in the administration's health care reform effort; it will allow the President an opportunity to respond to participants' questions and concerns and to rally their support for passage of the President's plan in Congress. In addition, this consultation will offer all state and local officials an opportunity to discuss the Health Security Plan with the President before its unveiling on September 22. State and local officials bring to the health care discussion their concerns as providers of last resort, as public employees, and as political leaders concerned with the overall health of their communities.

II. BACKGROUND

A) Consultation Process

This meeting is the culmination of the ongoing dialogue on health care reform between the President and the Nation's state and local officials. We will need bipartisan coalitions of these local officials to help sell the Clinton Administration's plan. This meeting is the next stage of the Administration's health care outreach to them.

Throughout the policy development process Ira Magaziner, Judy Feder, and other policy leaders have consulted with a multitude of state and local officials. Intergovernmental Affairs has been working with state legislators, through the National Conference of State Legislatures (NCSL); mayors and county officials through the United States Conference of Mayors (USCM), the National Association of Counties (NACo), and the National League of Cities (NLC); and with insurance

commissioners, attorneys general, and local and state health officials.

This will be the first time that the President has met with these leaders to discuss health care reform.

B) Summary of Issues of Concern for State and Local Governments

Attached please find a summary of the impact of the proposed reform on state and local governments.

III. PARTICIPANTS

Approximately 100 attendees:
Mayors
State Legislators
Insurance Commissioners
Attorneys General
Elected County Officials
(See attached list)

President Clinton
Vice President Gore
Ira Magaziner
Judy Feder
Marcia Hale
John Hart

IV. MEDIA: Pool spray at beginning; press availability for state and local officials after the event.

Contact: Josh Silverman (x7150)

V. SEQUENCE OF EVENTS

A. BEFORE PRESIDENT ARRIVES

3:30 to 3:35pm	Vice President Gore welcomes state and local officials to the White House. Introduces Ira Magaziner and Judy Feder. Total time: 5 min.
3:35 to 3:45pm	Ira Magaziner presents an overview of the President's health care reform plan. Total time: 5-10 min.

B. AFTER THE PRESIDENT ARRIVES

3:45 to 3:50pm	The President arrives, and makes opening remarks then turns podium

Total time: 5 min.

3:50 to 4:00pm	Ira Magaziner and Judy Feder give a presentation, addressing the ways in which the plan will effect states and localities, with an emphasis on localities. They will address the impact in terms of (1)Fiscal Impact; (2)Impact on states/localities as health care providers; and (3)Impact on states/localities as employers. Total Time: 10 min.
4:00pm to 4:15pm	The President takes questions from representatives of each of five state and local organizations. There will be no more than five questions. Total Time: 15min.
4:15pm	The President makes closing remarks. The President departs.

VI. TALKING POINTS: See attached

POTENTIAL ADVANTAGES AND DISADVANTAGES OF PROPOSED HEALTH CARE PLAN FOR CITIES AND COUNTIES

Counties and Localities: Potential Advantages

Fiscal Benefits

* The President's plan will reduce the burden on many county and local programs that now fill gaps in health coverage for the uninsured and underinsured. These programs include both various forms of direct service provision as well as General Assistance/General Relief insurance-style programs.
  --Since these governments face no maintenance-of-effort requirements (as States will under Medicaid), county and local funds may be redirected or reduced.
  --New public health initiatives will provide additional support for health care for vulnerable populations.
  --Universal coverage for personal care services will free up local resources to address population-wide prevention and protection tasks. This should also reduce the demand for health care services.

* Reduction in the costs of the acute side of the Medicaid program can help counties in those States that require counties to pay a share of Medicaid (e.g., New York). Reductions are expected from:
  --Savings because State per capita payments to alliances for AFDC and SSI recipients will be set at 95% of current levels.
  --On-going savings because Medicaid's per capita payments to the alliances and maintenance of effort requirements will be constrained by increases in the budget.
  --Reductions in the State share of disproportionate share hospital payments.
  --Reduced burden of drug benefits (because Medicare drug program will pay for drugs for Medicare-Medicaid dually eligible individuals.)

* A new community-based long-term care program for the disabled will pay for some care now covered under county and local programs as well as Medicaid.

* Expansions in coverage for substance abuse and mental health services under alliance plans will reduce the

costs of such care now borne directly by county and local budgets.

Benefits as Public Health Providers

* County and local facilities providing acute substance abuse or mental health services will no longer be subject to the institution for mental disease (IMD) exclusion under Medicaid. Acute services will be paid for by alliance plans (at present Medicaid does not pay for any services in these facilities.)

* Targeted grants for essential public health functions will allow feasibility to allocate funds to address the most pressing local public health priorities.

* Established providers of care, including city and county government direct service delivery programs, may be designated as essential providers. For a five-year period, plans will be required to contract with these essential providers or reimburse them at rates based on Medicare payment principles.

Benefits as Employers

* Subsidies for early retirees will produce large savings for county and local employee health benefit programs.

* Increases in county and local spending for public employee health benefits will be controlled under the budget.

Benefits to Local Population and in Quality of Care

* The plan provides incentives to states, alliances, plans, and health care providers to assure services in areas with inadequate health care. This will improve the choice and quality of services in rural and inner-city areas.

* The public health initiatives in the plan will complement insurance reform and assure universal access to services by focusing on the removal of non-financial barriers to care and providing the enabling services needed. New grants will be available to health agencies to support these services.

* Capacity building efforts included in the plan are designed to help integrate providers and organizations into the new system as new sites and arrangements are developed. There is a strong role for cities and

counties in the decision-making process for these capacity expansions.

* Because all persons will have insurance and access to managed systems of care, the use of emergency rooms should be reduced.

* Some additional assistance from the federal government will be provided for supplemental services and systems development to integrate public and private mental health and substance abuse services. The new adolescent/school-aged programs will assure that a currently neglected age group has better opportunities to receive care and comprehensive health education.

* Cities and counties will have new opportunities to forge more coordinated linkages between public health efforts directed to community-wide protection and prevention and individual medical services provided through alliances and plans.

* The plan promises a health care work force that better matches the needs of urban and rural areas, promoting the training of more primary health care providers and addressing shortages in inner-city and rural areas.

* Academic Health Centers, which improve urban areas by providing health care services, research, and employment, will receive special targeted payments to allow their special mission to survive in the new system.

* Surveys and data collection efforts will provide counties with clear and useful data to monitor health care access and quality. City and county health agencies will have access to these data via an electronic data network.

* City and county health care providers will benefit from expanded health services research and clinical practice guidelines to improve the quality and cost-effectiveness of the services they deliver.

POTENTIAL DISADVANTAGES

* States, counties, and local hospitals lose current federal disproportionate share hospital payments (Medicaid and Medicare).

* States, counties, and localities will need to pay at least 80% of the community-rated average premium in

each alliance for public employees, including pro-rated contributions for part-time workers. This may be more (or less) than what some localities are paying today.

* In the near term, differentials in practice patterns and payment variations across states are maintained. Low cost localities may view this as unfair.

* Alliance plans do not cover undocumented persons or prison inmates. These individuals will result in continued burdens on county and local providers and budgets. (e.g.-- TX, CA, NY, NM, Florida, Arizona)

* There will still be a need to support treatment services for the seriously mentally ill as well as residential treatment in excess of 30 days for substance abusers.

* Despite the program simplifications in the proposal, there will be a need to initially sort out roles and responsibilities and develop new working arrangements with health plans and alliances.

* Liberalizations in the continuing, long-term care side of the Medicaid program may require additional funding from counties in those States that require counties to pay a share of Medicaid (e.g., New York). Liberalizations include:
  --An increase in the personal needs allowance (from $30/month to $100/month) for institutionalized beneficiaries.
  --Federal mandate of medically needy programs for the institutionalized in all States (only about half have elected this option now.)
  --An increase in the amount of assets States must permit institutionalized individuals to retain from $2,000 to $12,000.

* Regional allocation of residency training positions may result in decreased funding for some institutions in certain geographic areas which primarily train physicians in non-priority specialties.

* The essential community provider provisions may not be popular with many States who have objected to the costs associated with Federally Qualified Health Center reimbursement in their Medicaid programs.

POTENTIAL ADVANTAGES AND DISADVANTAGES FOR STATES OF PROPOSED HEALTH CARE PLAN

POTENTIAL ADVANTAGES

* State Medicaid spending for guaranteed benefits is capped at the budgeted rate of growth, which is substantially lower than the projected increase in Medicaid spending. This provides significant fiscal relief for states.

* Subsidies for early retirees will produce large savings for state employee health programs.

* Increases in state health spending for public employees will be capped under the budget.

* Federal government is taking the political heat for imposing the mandate and implementing the budget.

* Reform at national level offers chance for states to achieve universal access. Many states are afraid that expanding access on their own would make them a magnet for those with high cost illnesses. Additionally, they fear that it would put them at a competitive disadvantage relative to employment requirements in other states -- especially if they make businesses pay for it. Under our plan the effects of an employer mandate will be reasonably consistent across the country. No one state is asking its people and businesses to do something unique.

* States are responsible for establishing alliances and administering employer/consumer payments and subsidies. Administrative funds, however, are provided through premium surcharges.

* States have considerable flexibility under federal parameters in administering alliances especially on the key issues of how, where, under what structures to establish alliances. States also have the option to establish a single-payor system.

* Federal government is assisting states financially --subsidies to small and low-wage firms and individuals up to 150% of poverty.

--reductions in Medicaid costs
--reductions in cost to state of retiree health care.
--current and projected levels of spending for public employees will decrease substantially under the budgeted system.
--federal government will provide technical assistance, start up funds.

* Medicaid long term care services that get transferred to the new long term care program are capped at the budgeted rate of growth, when fully implemented.

* States will be able to reduce spending on General Assistance/General Relief medical assistance under a system of universal coverage.

* States and localities will be able to reduce direct support to hospitals and clinics to care for the uninsured. State owned facilities providing free care will particularly benefit.

* States will be able to reduce spending for inpatient psychiatric care under universal coverage, and will be able to stretch outpatient mental health dollars further.

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* The federal government will provide the employer and consumer subsidy payments necessary to achieve universal coverage, with no financial risk to states.

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may be more (or less) than what some states are paying today.

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* States must continue to maintain eligibility to administer subsidies, although the proposed system is far simpler than the current eligibility process under Medicaid.

Participants in September 16, 1993 Briefing for State and Local Elected Officials
Time: 3:30 pm - 4:15pm
Location: The State Dining Room, The White House

Mayors

A) U.S. Conference of Mayors

Mayor Michael White (Cleveland, OH)
Mayor Kay Granger (Fort Worth, TX) -- Chair of Health Committee
Mayor Hector Luis Acevedo (San Juan, PR)
Mayor Mason Andrews, M.D. (Norfolk, VA)
Mayor James McGreevey (Woodbridge, VA) -- supports single payer
Mayor Martha Wood (Winston Salem, NC)
Mayor Thomas Barnes (Gary, IN)
Mayor John McCarthy (Everett, ME)
Mayor Sharon Pratt-Kelly (Washington, D.C.)
Mayor Frank Jordan (San Francisco)
Mayor Walter Kenney (Richmond)

Local Health Officials

Guadalupe Olivas, Ph.D
Paul Nannis
Daisy Alford
Mary DesVignes-Kendrick

USCM Staff

Tom Cochrane, Executive Director
B.J. Harris, Health Policy Advisor
Barbara Harris

B) National League of Cities (various mayors and city council members)

Tom Werth
Loch Bechum
Harry Thomas (D.C. City Council)
Maryann Mahaffey
Clay Dixon
Katie Nack (City Council of Pasadena, CA)
John Heilman (City Council of West Hollywood, CA)
Joan Campbell
Marian Tasco
Patsy Ticer (Mayor of Alexandria, VA)
Michael Thibodeaux
LuLu Smith
Dorothy Inman-Crews
Bill Gillespie
Jerrilyn Wall
Sharon Priest (Little Rock, AR)

State Legislators

A) NCSL (12)

Senator John Still (R-Delaware)
Speaker John Martin (D-Maine)
Representative David Richardson (D-Pennsylvania)
Senator Thomas O'Reilly (D-Maryland)
Senator Diane Watson (D-California)
Speaker Rober Charles "Chuck" Chambers (D-West Virginia)
Senator Thomas V. Mike Miller (D-Maryland)
Senator Joe Holland (R-New York)
Senator Ray Rawson (R-Nevada)
Senator Michael A. O'Pake (D-Pennsylvania)
Senator John Maitland, Jr. (R-Illinois)
Representative Bill Purcell (D-Tennessee)

B) NBCSL (2)
Representative Lois DeBerry (D-Tenn) -- Chair of Clinton-Gore in Tennessee
Senator Diane Watson (see above)

NCSL Staff

Jeff Wice (New York State Assembly)
Carl Tubbesing (NCSL)
Richard Michael Bird (NCSL)
Joy Johnson Wilson (NCSL)

B) Council of State Governments (CSG) (3)

Representative Jane Maroney (R-DE -- Co-Chair of Health Policy Task Force)
Ms. Nancy Feathersone (CSG Co-Chair of Health Policy Task Force)
Senator Andrew Levin (D-HI)

Insurance Commissioners (10)

Deborah Senn (D-Washington)
Stephen Foster (Virginia, Chair of NAIC)
David Walsh (Alaska, Vice Chair of NAIC)
David Lyons (Iowa)
James Long (D-North Carolina)
Josephine Musser (Minnesota)
Lee Douglass (Arkansas)
Catherine Weatherford (D-Oklahoma)
Salvatore Curiale (New York)
Robert Willis (Washington, D.C.)

NAIC Staff
David Simmons, Executive Director
Kevin Cronin, Director Washington Office
Elaina Goldstien

Carole Gates, Director of Health

Counties

1) NACo
Supervisor Barbar Shipnick (Monterey County, California -- Chair, NACo Task Force to Promote the County Role in Health System Reform)

Commissioner Marilyn Krueger (St. Louis County, Minnesota, Chair, NACo Health Steering Committee)

Commissioner John Stroger, Jr (Cook County, Illinoirs -- NACo Immediate Past President)

Commissioner Barbara Sheen Todd (Pinellas County, Florida -- NACo President)

NACo Staff

Larry Naake, Executive Director
Tom Joseph, Assoicate Legislative Director for Health
Mary Uyeda, Director, Coutny Health Policy Project
Susan White (representing LA County)

2) NAPCo/NOBCO

Webster Guillory, President of NOBCo
Hilda Pemberton, NOBCo
Thelma Moore, President of NABCo

Attorneys General (7)

Hubert "Skip" Humphrey (D-MN)
Scott Harshbarger (D-MA)
Pamela Carter (D-IN)
Charlie Oberly (D-DE)
Jay Nixon (D-MO)
Joseph Curran (D-MD)
Roland Burris (D-IL)

Native Americans

James Crawford
Susan Masten

Talking Points for the Vice President

Final Consultation with State and Local Elected Officials Prior to the Release of the Health Security Plan

DATE: Thursday September 15, 1993
TIME: 3:30 PM - 4:15 PM
LOCATION: The State Dining Room, The White House

Welcome to the White House. I want to thank each of you for taking the time out of your busy schedules to join us at this important meeting to discuss the President's plan for health security for all Americans. Each of you know first-hand the impact of health care costs in your own communities and we want your help in reforming health care. We are glad to have you here today in the midst of these exciting times at the White House, with the world witnessing the historic breakthrough for peace in the Middle East, with our coordinated push for the approval of the NAFTA agreement, and with our National Performance Review to help make our federal government function better for everyone.

As important as these efforts are for America's future, it is equally important that we achieve health care reform. With us today are two people many of you know well, the chief architects of the administrations' health care plan: Ira Magaziner and Dr. Judy Feder. Ira and Judy have met with state and local officials across America to get your input on how we, together, can best reform health care for all Americans.

I introduce you to Ira Magaziner, who will give you an overview of the plan.

Opening Remarks for President Clinton

Increasingly, state and local officials find themselves battling to maintain important programs for education and crime-fighting and economic development -- in the face of higher and higher health care costs. Public Hospitals and doctors see patients with illnesses that have gone untreated for too long, because they had no access to health insurance. And as the federal government shifts costs to the state programs, states are forced to place a greater burden on their cities.

Together state and local governments do their best to patch together health care to the millions of citizens without access, but until there is a national promise of universal coverage, they will face a battle they know they can't win. With your help, we in Washington will develop a national solution -- one that integrates the efforts of all levels of government, and lightens the load by bringing costs under control.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo	From John Hart to Ira Magaziner, Judy Feder re: Priority phone call to Ray Scheppach (partial) (1 page)	09/18/93	P6/b(6)

COLLECTION:
Clinton Presidential Records
Policy Development
Magaziner, Ira (Subject Files)
OA/Box Number: 10020

FOLDER TITLE:
Intergovernmental [2]

2006-0770-F
ry520

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

MEMORANDUM

TO: IRA MAGAZINER
JUDY FEDER

FROM: JOHN HART

DATE: SATURDAY, SEPTEMBER 18, 1993

RE: **PRIORITY** PHONE-CALL TO RAY SCHEPPACH

I spoke with Ray Scheppach today and he communicated to me that the Medicaid issues are a big problem for governors. They are planning on writing a joint letter to the President on this issue, if we can not resolve it over the week-end. Ray agreed to hold on this until Monday, providing that he speaks to the two of you. It is imperative that you call Ray about this today or tommorrow at the latest. His home phone number is (b)(6) and his office number is 624-5320. I will be around if you need to discuss. Thanks. [002]

MEMORANDUM
To: Ira Magaziner
From: John Hart
Date: October 20, 1993
Re: Democratic Governors

I would like to follow up our conversation today about democratic governors, and give you the number where they can be reached tonight.

Governor Roy Romer
Assistant: Karen Thompson
Office (Until 9:00pm EST): (303) 866-4576
Mansion: (303) 837-8350

Governor Howard Dean
Biltmore Resort, Phoenix
(602) 955-6600

MEMORANDUM FOR FIRST LADY HILLARY RODHAM CLINTON

FROM: **John Hart, Deputy Assistant to the President for Intergovernmental Affairs**

DATE: **October 20, 1993**

SUBJECT: **State Concerns and the Health Security Plan**

You should be aware that our base of Democratic governors is in serious jeapordy. Although they have not directly expressed their concerns, staff members for Governors Dean and Romer have expressed strong concern regarding the following issues:

* State exclusion from 7.9% cap.
* Limits on state flexibility, specifically prohibitions against states operating as state agencies.
* Status of Medicaid program. Democratic Governors are concerned that the new program will not look very different from the existing program. Although the new program addresses acute care needs they are concerned about the additional obligation of matching the home and community care programs.
* Requirements that SMSA's remain intact to satisfy redlining concerns. (As you are aware Jack Lew has raised this isse from the other side, expressing Congressman Waxman's concerns. We are trying to work out a compromise.)

I have already spoken with Ira about the need to gather numbers that assess the impact of reform on the states. It is important that we start running these numbers as soon as possible.

cc: Carol Rasco
Ira Magaziner
Judy Feder
Melanne Verveer

MEMORANDUM

TO: **IRA MAGAZINER**
FR: **JOHN HART**
DT: **NOVEMBER 1, 1993**
RE: **IGA ROLE IN PASSAGE OF PRESIDENT'S HEALTH SECURITY ACT**

As per our conversation on Sunday, I have detailed below my views on the strategic objectives of the health reform effort as it relates to state and local officials. I have also listed an action plan for meeting these objectives, and a description of the resources and coordination that would be necessary to implement these goals.

I believe IGA's role falls into 5 categories:

I. Mediate the tension between increased federal regulation and additional state flexibility as the Health Security Act moves through the Congress.

There will be a constant legislative tension between those in the Congress with the desire for more federal regulation and less state flexibility, and those in the states with the opposite approach. In some cases, we may lean on the side of increased federal involvement, either because it is the best policy or necessary politically. When that happens, we'll need to explain our actions to state officials and do our best to hold their support through those changes. When we make changes to the policy that go in the opposite direction, we will need to galvanize the state and local base to support and reinforce our overall Congressional strategy.

Resources - As long as there is close coordination between the policy decision making process and IGA, and one member of the policy staff is assigned to assist on state issues (i.e. - Larry Levit), there should be no additional resource needs.

II. Educate state officeholders about the specifics of the Health Security Act, and the positive implications for states.

The Health Security Act has, on balance, a number of "windfall" provisions for states. It is critical that state officials fully understand the advantages of this legislation, just as they are raising concerns about

provisions they see as disadvantages.

As a part of this effort, we need to demonstrate the positive financial impact on states as a result of specific reform policies related to cost control, slowed Medicaid spending and so-called "maintenance-of-effort" spending, the retiree health policy, public health expansions, etc. With a clear understanding of the plan and its impact on federal state issues, local and state officials, who will ultimately be responsible for implementation, can be effective advocates for the Health Security Act.

Through IGA Organizational Conferences and Regional events, we can educate state and local officials on the plan, advance our message and mobilize support. Specifically, we propose a series of regional conferences/seminars modeled on the Congressional Health Care University and designed to educate several levels of state and local officials and their staff. Setting up regional events would require a full time staffer to coordinate policy materials and speakers; and recruit and supervise volunteers and regional staff on the ground. (A staff member at the Department of Interior, Bill Vincent, is available for the next several weeks to oversee that assignment on a full time basis.)

Resources -
a) Administration surrogate speakers (policy staff as well as principles) to speak on behalf of the Administration
b) Communication materials specifically tailored to state and local issues.

III. Help mobilize state-level support for the plan, and coordinate with other outreach efforts.

1. Grassroots
Interact with the Health Reform Campaign.

2. Congressional Targeting
State consultation and reconciliation with national health reform should be conducted in coordination with the congressional targeted priorities as they evolve.

3. Surrogates

There are a number of knowledgeable and enthusiastic state and local officials who can be useful as a) validators of areas of the plan we get hit on; b) providers of quotes to counter negative press stories; c) utility surrogates for the President's plan. In order to be effective in these roles, we need to maintain a constant line of communication and keep them up to speed with the latest changes in legislation and provide them with the most current materials we produce.

4. Briefing Memos for President and First Lady

Prepare background briefings for White House trips into the states -- briefly detailing any state legislative activity on health reform, political and grassroots activity related to health reform in the state, and local media coverage on reform. This involves coordinating with the Media Affairs office and the health care Legislative Group.

Resources - To do this effectively requires an additional policy analyst knowledgeable in the area and familiar with the players. One person who comes immediately to mind is Ann Danelski who is currently on contract at HHS and formerly worked at NGA.

IV. Liaison to state and local officials with questions or concerns about the Health Security Act

This is a reactive set of activities: the IGA office should serve as a repository for all inquiries from state and local officials, ranging from governors' offices to school boards, regarding the health care plan.

Resources - The assignment of a policy staffer will be sufficient.

V. Monitoring of state reform activity, keep pulse on state response to President's plan.

Perhaps the most important activity is the monitoring of state reaction to the Health Security Act. Through consultations with states, we will be able to detect trouble spots at an early stage, support Congressional efforts (whose members will want to assess the impact of reform on their states) and anticipate state readiness for implementation of the Health Security Act.

cc - Marcia Hale, Carol Rasco and Maggie Williams

MEMORANDUM

TO: **Distribution**

FROM: **John Hart**

DATE: **November 23, 1993**

SUBJECT: **Benefits of the National Health Security Act to New York State and Minnesota**

As you are aware we have been gathering information on the potential advantages of the Health Security Act for each state. The attached memos describe the benefits of the National Health Security Act to New York and Minnesota. This document can be distributed externally at your own discretion. More states to follow.

Benefits of the National Health Security Act to New York

For years New York State has shouldered the burden of a growing uninsured population, increasing health care costs, the rising expense of health care coverage for its own employees, and increasing reliance on expensive emergency room care. Recent reforms in New York attempt to contain the costs of health care through managed care, and increased attention to primary and preventive care services. And New York's new community rating law sets a national standard for expanding access to coverage and returning insurance to what it was meant to be. But in the absence of national reform, none of these efforts will produce lasting savings or true universal coverage.

The Clinton health plan proposes national reform based on a new partnership between states and the federal government -- a partnership that ensures that every local resident will have health care coverage, that rising health care costs will be controlled, and that every state will have the flexibility to address their critical health needs.

Like the recent reforms in New York State, the Health Security Act seeks to incur savings by encouraging primary and preventive care, and discouraging unnecessary and expensive hospital stays. While New York's legislation limits costs through a rate setting system for hospitals, the Clinton legislation uses premium limits, managed competition, public evaluation data, and bidding mechanisms to contain costs. New York State will benefit from the plan's commitment to cost containment, new investments in public health, malpractice reform, expanded access to doctors, clinics and hospitals for all New Yorkers, special long-term care provisions for the elderly and disabled, and administrative simplification in the system. Most importantly, the Clinton plan will enable New York State to develop a health care system that reflects the needs of its diverse population -- from the residents of Manhattan's 12 health crisis zones to the underserved residents of rural upstate.

<u>Fiscal Benefits</u>

- New York State spent $1.4 billion on health care in 1992. Its Medicaid expenditures per person are the highest in the nation, and the State ranks 5th in cost of Medicaid as a percent of total budget. Through efficiency, cost-containment mechanisms, and subsidies, the Health Security Act will signficantly reduce New York State's health care expenditures.

<u>Medicaid</u>

- New York will realize immediate Medicaid savings from the setting of per capita payments to alliances on behalf of AFDC and SSI recipients at 95 percent of current fee-for-service levels.

- New York will achieve ongoing savings because its payments to alliances will be capped at a budgeted rate of growth, in contrast to New York's most recent rate of 15%.

- The new Medicare drug program will reduce New York's spending on drugs for the low-income elderly.

Uninsured and Underinsured

- 12.3% of New York's population is uninsured. 14.2% of the population is underserved. The Health Security Act will provide coverage for these individuals, so that all legal residents will be covered whenever and wherever they need medical services.

- Federal discounts will cover premium payments for low-income people, who will enroll in a health plan through their regional health alliance. As a result, New York's payments for uncompensated care -- including direct spending to public hospitals and clinics -- will be dramatically reduced with a system of universal coverage.

- Often Medicaid recipients as well as the uninsured access the most costly health care available: emergency room care, which is ultimately paid for with state and county funds. By encouraging preventive and primary care, the Health Security Act will drastically reduce the frequency of costly emergency room visits.

State Employees

- A new cap on employers' expenditures on employees' health care will limit New York's rapidly increasing cost for covering their employees. As of the year 2002, New York governments' costs for providing insurance to government employees will be capped at 7.9% of total payroll.

- Federal loans will support the development of community based health plans in underserved areas.

- Federal subsidies for early retirees will produce large savings for New York State employee health benefit programs.

Under the current system, health care resources are concentrated in urban and suburban areas, while rural and inner-city communities have few doctors or hospitals to choose from. In Thompkins County only one clinic -- the Groton Community Health Care Center -- provides dental services to the areas' 7800 Medicaid recipients. The Health Security Act will assure that Americans are not only insured for health care, but that Americans also have ready access to quality health care. The Clinton plan will make the investments needed to ensure broad

access to health care for underserved communities, low-income and vulnerable groups, and all other Americans.

Rural and Underserved Areas

- Currently 15.7% of New York State's population live in rural areas. Under the Health Security Act, New York will receive new federal grants to provide special assistance to rural and inner city areas and additional support for health care for vulnerable populations.

Access Initiatives

- Enhanced federal grants will be available to support public health initiatives and remove non-financial barriers to health care. New York and its counties will be able to strengthen and improve essential public health activities including:
    - * mental health and substance abuse services;
    - * residential treatment centers;
    - * and community-based ambulatory clinics in underserved areas.

Information Infrastructure

- Surveys and data collection similar to those recently proposed in New York State will be adopted establishing clear and useful data to monitor health care access and quality.

States, local hospitals, and doctors have historically provided care in needy communities, in spite of economic difficulties. Currently, 38 community and migrant health centers care for the underserved residents of New York State. The plan will ensure that these services continue to be provided, and that these hospitals, clinics, and doctors will thrive in the new health care system.

Saftey Net Providers

- Hospitals and clinics that have provided care without compensation will receive guaranteed reimbursement for the care they provide.

The Health Security Act will build upon New York's reforms to ensure that all New Yorkers will receive universal coverage within a system that is flexible enough to meet the diverse needs of New York State. New York will benefit financially from the cost savings and universal coverage at the core of the President's plan.

Benefits of the National Health Security Act to Minnesota

As one of the most progressive states pursuing state-based health care reform in the nation, Minnesota is an outstanding example of what can be achieved through bipartisan cooperation and community involvement to reach a shared goal. With the passage of MinnesotaCare in 1992, Minnesota became one of only a handful of states working to ensure that all of its residents have access to health care.

Minnesota's substantial progress in health care reform, coupled with the many parallels MinnesotaCare shares with the President's Health Care Security Act, will enable Minnesota to be among the first states to benefit from national reform.

Like MinnesotaCare, the President's plan seeks to provide universal access to comprehensive coverage, retain employment-based coverage, place a strong emphasis on managed care, and institute cost containment mechanisms which include global budget targets. The enactment of the Health Security Act will greatly facilitate Minnesota's efforts to implement these reforms. For example:

Fiscal Benefits for Minnesota State

* Under the Health Security Act, the federal government will help Minnesota achieve and finance universal coverage.

* The Health Security Act will provide Minnesota early federal financial and technical assistance.

* As a state with one of the highest Medicaid penetration rates, Minnesota will realize immediate and ongoing Medicaid savings because payments to alliances for Medicaid patients will be capped at the budgeted rate of growth.

* Minnesota will also achieve Medicaid savings from setting per capita payments to alliances on behalf of AFDC and SSI recipients at 95 percent of the current fee-for-service level.

* Additional ongoing Medicaid savings will be achieved through a federally funded program to provide "wrap-around" benefits for services not covered in the national benefits package for low-income children who would otherwise be eligible for Medicaid. Minnesota will no longer be required to match Medicaid payments for this population.

* A new Medicare prescription drug benefit will reduce state Medicaid spending on prescription drugs for low-income elderly Minnesotans.

Benefits for Minnesota State as an Employer

* The Health Security Act will protect Minnesota from the risk of increased costs resulting from reform through:

    1) A 7.9 percent cap (based on the states' total payroll costs) on the costs for covering their employees, effective 2002;

    2) Federal subsidies for early retirees which will produce large savings for the state employee health benefit program; and

    3) A slowing of the rate of growth in health care spending for current employees.

General Benefits to Minnesota

* Changes in federal law will remove barriers that stand in the way of Minnesota reform efforts.

* A new community-based long-term care program -- with a generous federal matching rate -- for persons with disabilities and the elderly will replace some care now provided by Minnesota under Medicaid.

* Federal grants will help Minnesota provide special assistance to underserved rural and urban areas.

* New investments in the National Health Service Corps and other education programs will help address physician and nurse shortages.

* Federal loans will support the development of community practice networks and health plans in underserved areas.

These elements of the Health Security Act coupled with the many similarities between MinnesotaCare and the President's proposal lay the foundation for a new partnership between the federal government and the state of Minnesota. This partnership will ensure that all Minnesotans will receive health care coverage within a system flexible enough to meet the diverse needs of the State of Minnesota.